TAYLOR CHIROPRACTIC CLINIC
DR. VIRGIL TAYLOR

DATE_____

CONFIDENTIAL PATIENT INFORMATION

LAST NAME_____ FIRST_____ MIDDLE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE#_____ WORK#_____ CELL#_____ DOB_____

AGE____ SEX____ SOCIAL SECURITY#_____ EMAIL_____

EMPLOYER_____ CITY_____ STATE_____

NAME OF SPOUSE_____ SPOUSE DATE OF BIRTH_____

SPOUSE EMPLOYED BY_____ PHONE#_____

NAME OF RELATIVE_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE#_____

REFERRED TO THIS OFFICE BY:_____

GENERAL PHYSICIAN_____ CITY_____ PHONE#_____

INSURANCE:PRIMARY_____ SECONDARY_____

PLEASE DO NOT WRITE BELOW THIS LINE!FOR DOCTORS USE ONLY

CHIEF COMPLAINT:

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY NOTICES

TAYLOR CHIROPRACTIC CLINIC
DESIGNATED PRIVACY OFFICIAL
601-925-1080

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED A COPY OF TAYLOR CHIROPRACTIC CLINICS NOTICE OF PRIVACY PRACTICES.

PATIENT NAME:_____DATE_____

PATIENT SIGNATURE_____

TELEPHONE:_____

IF NOT SIGNED BY PATIENT, PLEASE INDICATE RELATIONSHIP

____PARENT OR GUARDIAN OF MINOR PATIENT
____GUARDIAN OR CONSERVATOR OF AN INCOMPETANT PATIENT
____BENEFICIARY OR PERSONAL REPRESENTATIVE OF DECEASED PATIENT.
____OTHER(SPECIFY)_____
_____

TCC STAFF
SIGNATURE:_____
ACKNOWLEDGEMENT REFUSAL_____
EFFORTS TO OBTAIN_____
REASONS FOR REFUSAL_____

PATIENT'S NAME:_____

PATIENT PROMISSORY NOTE OF RESPONSIBILITY

I do hereby authorize Dr. Virgil Taylor to render chiropractic services and care as he deems necessary.
I agree and understand that all charges occurred at Taylor Chiropractic Clinic, INC. is my sole responsibility. I understand that payment is due at the time that care is rendered. If I failed to pay in full for any charges due, I understand that Taylor Chiropractic Clinic, INC. can pursue legal assistance in financial collection procedures. Have such legal assistance has to be obtained by Taylor Chiropractic Clinic, INC., all attorney fees, court cost and any other fees incurred will be paid by me.

I have read, understand and agree to the policy so stated in the above paragraphs.

INSURANCE VERIFICATION

It is our pleasure to verify your insurance information as it is given to us from you.
When your insurance company quotes your benefits to us, it is standard procedure, that a disclaimer is stated that the quote is not a guarantee of payment, that actual payment will be decided upon receipt of claim forms.
It will also be your benefit to verify the information also, as given to us from the insurance company to avoid any misunderstanding of insurance obligation.

INSURANCE FILING AND COLLECTIONS POLICY

I understand that Taylor Chiropractic Clinic is filing my insurance as a courtesy to me. We will verify your insurance coverage, however, as the insurance company states, the information they gave us is not a guarantee of payment. If your insurance companies denies coverage it is yours, the patience, responsibility to follow up with your insurance company to resolve the reason for non payment. If your insurance company request a narrative report, the cost of the report is a patient's responsibility.

I have read, I agree with and understand the above information and I understand that Taylor Chiropractic Clinic must implement this policy in an effort to keep office fees to a minimum. I agree to pay any charges not covered or not paid by my insurance company stating the charges were covered. Any balance not paid by the insurance company within 30 days will be moved to your personal account balance. You will be responsible for a 1.5% per month finance charge for any unpaid balance.

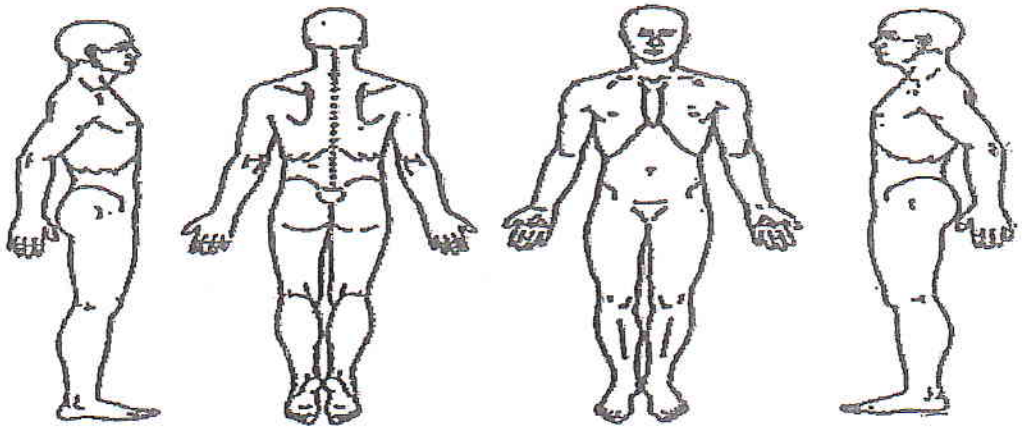
PATIENT SIGNATURE:_____ **DATE:**_____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◻ Auto Accident ◻ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?
   - ◻ Constantly (76-100% of the time)
   - ◻ Frequently (51-75% of the time)
   - ◻ Occasionally (26-50% of the time)
   - ◻ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - ◻ Sharp
   - ◻ Dull
   - ◻ Diffuse
   - ◻ Achy
   - ◻ Burning
   - ◻ Shooting
   - ◻ Stiff
   - ◻ Numb
   - ◻ Tingly
   - ◻ Sharp with motion
   - ◻ Shooting with motion
   - ◻ Stabbing with motion
   - ◻ Electric like with motion
   - ◻ Other:_____

5. How are your symptoms changing with time?
   ◻ Getting Worse ◻ Staying the Same ◻ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
   ◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

8. How much has the problem interfered with your social activities?
   ◻ Not at all ◻ A little bit ◻ Moderately Quite a bit ◻ Extremely

9. Who else have you seen for your problem?
   - ◻ Chiropractor
   - ◻ ER physician
   - ◻ Massage Therapist
   - ◻ Neurologist
   - ◻ Orthopedist
   - ◻ Physical Therapist
   - ◻ Primary Care Physician
   - ◻ Other:_____
   - ◻ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?
    ◻ Yes ◻ Yes, at times ◻ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders		□	Depression
□	□	Wrist Pain	□	□	Bladder Infection		□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain		□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26, Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ Date:_____