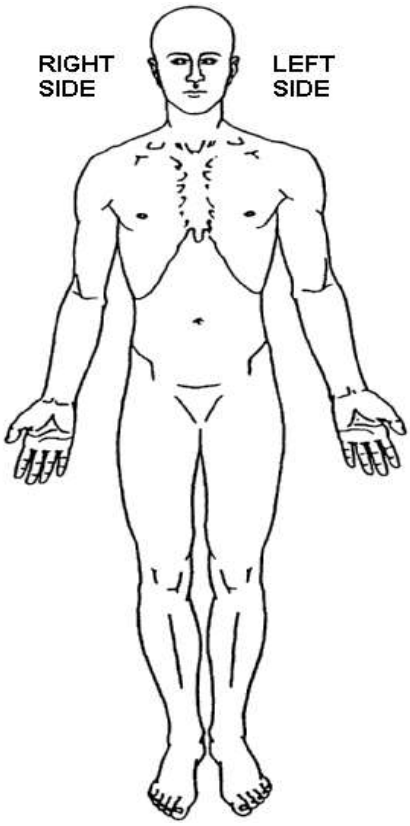
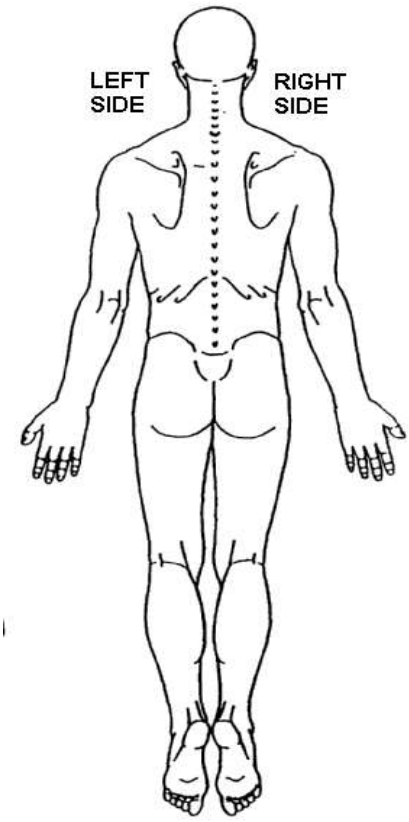
SHADE THE AREAS OF YOUR BODY WHICH YOU WOULD LIKE THE DOCTOR TO TREAT.





When did your primary area of complaint begin?_____
How?_____

_____

Have you had any recent Headaches? ❑ Yes ❑ No

Patient Signature:_____Date:_____

Please Give to Front Desk. They will give you tablet to complete your check in.

Office Use Only:	**Functional Indexes:**	**Previous Scores:**	
NDI Score:_____	FL: M MD S C BB	Date:_____	Score:_____
ODI Score:_____	FL: M MD S C BB	Date:_____	Score:_____
Dash Score:_____	FL: M MD S C BB	Date:_____	Score:_____
LEFS Score:_____	FL: VM M MD S	Date:_____	Score:_____
HA Score:_____	FL: M MD S C BB	Date:_____	Score:_____

Patient Name:_____ DOB:_____
nickname:_____

Address:_____
SS#: _____ Sex:____ Birthdate _____
Patient Home Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____
Work Phone: (_____) _____-_____
Email Address: _____

Spouse Name: _____ phone #: _____

Consent for mail, messages, and text:

I hereby authorize Matthew W. Ryan, DC PC dba Stewart Clinic of Winder to mail reminders, birthday cards, newsletters, and special event notifications to my mailing address, including postcards.

I hereby authorize Matthew W. Ryan, DC PC dba Stewart Clinic of Winder to contact me by any telephone numbers, email addresses, or other contact points provided by me or on my behalf by text message, email, or by telephone for reasons related to the services I received at Matthew W. Ryan, DC PC dba Stewart Clinic of Winder or payment for the services I received including but not limited to debt collection purposes. Including appointment reminders. I authorize messages to be left on voicemail system or answering machine to number provided above.

If you do NOT wish to have us leave messages or send you text please check below.

- ❑ **I do NOT authorize the above numbers to be utilize to leave messages.**
- ❑ **I do NOT authorize the above cell phone number to be used to send text messages.**

How did you hear about us? (Please give name of referral)
❑Google Reviews ❑Facebook ❑ Our Webpage ❑PPO/HMO listing ❑Phone book
❑Friend_____ ❑ Family _____ ❑Patient_____
❑Doctor_____ ❑ Office sign ❑Other_____

Emergency Contact_____ Phone:_____

Consent to Release Medical Information to a Spouse, Family Member, Significant other, or Doctor
Tell us with whom we may discuss your protected Health information (name and relation: example: Jane Doe, wife).
1)_____ 2)_____
3)_____ 4)_____
If you do NOT authorize information to be released to anyone please check this statement

- ❑ **I do NOT authorize any information to be released to anyone other than myself**

Assignment of Benefits
I hereby authorize any insurance benefits to be paid directly of Matthew W. Ryan DC PC, dba Stewart Clinic of Winder. I recognize my responsibility to pay for all non-covered services. I also authorize the release of information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment. For any balance on your account we will mail you bills or call you.

Patients Signature: _____ Date: _____
Guardians Signature: _____ Date: _____

Patient Name:_____ **DOB:**_____

Primary Care Physician Name:_____ Phone:_____

Have you had any recent X-rays?_____ If so where?_____

Have you ever seen another chiropractor? ❑Yes ☐No If yes, date of last visit: ___/___/_____

List all Current Medications with Dose/Frequency

(if you brought a list please give to the front desk)

_____

_____

_____

_____

_____

_____

List all Allergies with Reaction

_____

_____

_____

_____

List all Surgeries with date

_____

_____

_____

_____

_____

Work Status: Working Full Time, Part time, unemployed, homemaker, disabled, Unable to work due to reason of visit
Occupation: _____ Employer:_____
Work Activity: (Circle One) Sitting, Standing, Light Labor, Heavy Labor
Job Duties:_____

Please check all that you that apply to you:

❑Stroke:Last Stroke Date: ___/___/_____ ❑Medically implanted devices: Current/had in past
❑Seizure: Last Seizure Date:___/___/_____ ❑Taking blood thinners: Current/had in past
❑Rheumatoid arthritis ❑Aneurysm: Current/had in past
❑Osteoporosis

Are you Pregnant or think you may be pregnant? ❑ Yes _____ wks ❑ NO ❑ N/A
Patient Signature:_____
Date:_____

Patient Name:_____ DOB:_____

Informed consent for Chiropractic Care

A patient, in coming to the Chiropractor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, analysis, and treatment. The Chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or healthcare if he is aware that such care may be contraindicated. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

I understand that if I am accepted as a patient by a chiropractor at Stewart Clinic of Winder, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Authorization regarding care being provided in an "open-bay" therapy and "open-bay" adjusting room.

It is the design of this office to provide therapy care and adjustments in an "open-bay" therapy environment. An "open-bay" approach involves the patient receiving therapy care in an open area with other patients. As a result, patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting report of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the finds of matter related in an "open-bay" environment are incidental matter, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

If you choose not to have therapy or an adjustment in an "open-bay" environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Matthew W. Ryan, DC PC dba "Stewart Clinic of Winder" or your relationship with our staff.

Acknowledgement of Privacy Rights.

By signing the below I acknowledge that I am aware of the "Notice of Patients Rights and Privacy Protections under Federal Privacy Laws (HIPAA)" and was offered a copy. A full copy of this office's HIPAA Compliance Manual is available upon request. We may use or share your medical information with personnel involved in your care at Matthew W. Ryan, DC PC dba Stewart Clinic of Winder. We also my disclose your medical information to people outside our office, such as your insurance company, attorney, or imaging center.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights. I do hereby consent to the use of my health information in a manner consistent with Notice of Patients Rights and Privacy Protections under Federal Privacy Laws (HIPAA) , the HIPAA Compliance Manual, State law and Federal Law.

Patients Signature: _____ Date: _____

Guardians Signature: _____ Date: _____