Dr. Stuart Schlein, D.C.
2855 Candler Road Suite 5
Decatur, GA 30034
(404) 244-9009

Date:

CONFIDENTIAL PATIENT INFORMATION

Name: Cell Phone: Hm Phone:

Address: City: State/Zip:

Occupation: Employer:

Address: Office Phone:

Spouse Name: Occupation:

Employer: Office Phone:

Other Doctors Seen For This Condition:

Insurance Companies Involved:
My Company:
Company of Person Responsible For Injury

Date of accident: ☐ Am ☐ Pm Location:

How did accident occur if not in automobile?

If Auto collision, were you struck from:
☐ Behind ☐ Right side ☐ Left side ☐ Front

Have you had similar accidents or injuries before? ☐ Yes ☐ No

What operations have you had?
When?

Unusual Diseases?
When?

Serious Illness?
When?

In case of an emergency, please list below a relative or loved one that can always get in touch with you. This person should have a stable telephone number and address:

Name: Phone:

Address:

Have you lost any days of work? No Dates:

Have you been treated for any health condition by a Physician in the last year? ☐ Yes ☐ No

Description:

Check symptoms you have noticed since the accident:

☐Headache
☐Neck Pain
☐Neck Stiff
☐Sleeping Problems
☐Back Pain
☐Nervousness
☐Tension
☐Irritability
☐Chest Pain
☐Dizziness
☐Head Seems Too Heavy
☐Pins & Needles in Arms
☐Pins & Needles in Leg
☐Numbness in Fingers
☐Numbness in Toes
☐Shortness of Breath
☐Fatigue
☐Depression
☐Lights Bother Eyes
☐Loss of Memory
☐Ears Ring
☐Face Flushed
☐Buzzing in Ears
☐Loss of Balance
☐Fainting
☐Loss of Smell
☐Loss of Taste
☐Diarrhea
☐Feel Cold
☐Hands Cold
☐Stomach Upset
☐Constipation
☐Cold Sweets
☐Fever

Symptoms other than above:

What medication or drugs are you taking?

I understand and agree that health and accident insurance are an agreement between an insurance carrier and myself. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due immediately.

Patient's Signature: SS#: Date:
Guardian or Spouse:

Signature authorizing care: Date: