RYAN FAMILY CHIROPRACTIC, INC.

PATIENT INFORMATION

TODAY'S DATE_____

NAME_____ CELL PHONE_____ HM PHONE_____

MAILING ADDRESS _____ CITY _____ STATE_____ ZIP _____

HOME ADDRESS (IF DIFFERENT THAN MAILING ADDRESS) _____

CITY _____ STATE_____ ZIP_____ EMAIL ADDRESS _____

SSN ____-____-____ DOB: ____/____/_____ HEIGHT___' ____" WEIGHT_____ MARITAL STATUS: S M D W

OCCUPATION_____ EMPLOYER_____ WK PHONE _____

PRIMARY CARE PHYSICIAN_____ **REFERRED TO OUR OFFICE BY _____**

EMERGENCY CONTACT & PHONE _____

CURRENT HEALTH CONDITION

REASON FOR APPOINTMENT _____CONDITION BEGAN _____

- HOW OFTEN DO YOU EXPERIENCE SYMPTOMS: CONSTANTLY____ FREQUENTLY____ OCCASIONALLY ____
- CHECK ALL THAT DESCRIBE YOUR SYMPTOMS:

  SHARP_____DULL ACHE_____NUMB_____ SHOOTING_____TINGLING_____ BURNING_____
- DOES DISCOMFORT: TRAVEL_____ RADIATE_____
- WHAT MAKES IT FEEL BETTER OR WORSE: **(Indicate with a "B" for Better or "W" for Worse)**

  SITTING_____STANDING____WALKING_____ EXERCISING____ BENDING_____ LIFTING_____ SLEEPING_____
- WHEN DOES IT BOTHER YOU THE MOST: MORNING_____ AFTERNOON_____ NIGHT_____
- DO YOU GET ANY RELIEF WITH: TYLENOL____ ADVIL____IBUPROFEN____OTHER_____
- FOR RELIEF HAVE YOU USED: ICE_____ HEAT_____
- IS CONDITION: JOB RELATED_____ AUTO RELATED_____ OTHER_____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION_____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR_____

HOW LONG AGO_____ DATE(S):_____ DESCRIBE_____

HAVE YOU BEEN TREATED FOR ANY MAJOR HEALTH CONDITION IN THE LAST YEAR? NO_____ YES _____

DATE & DESCRIPTION OF TREATMENT _____
CURRENT MEDICATIONS_____

ARE YOU PREGNANT? NO____ YES___ IF PREGNANT, YOUR DUE DATE_____

DO YOU HAVE A PACE MAKER? YES / NO

PAST HEALTH HISTORY; DATE AND DESCRIBE:

MAJOR SURGERY OR OPERATIONS_____

MAJOR ACCIDENTS OR FALLS_____

FRACTURES OR DISLOCATIONS_____

KNOCKED UNCONSCIOUS OR STUNNED_____

HOSPITALIZATION (other than above) _____

HABITS

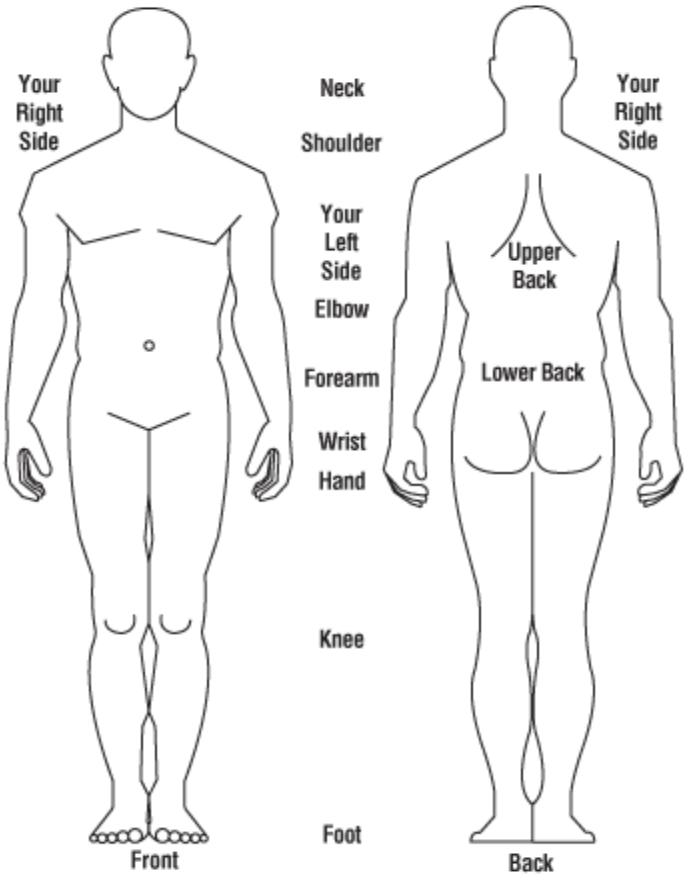
DAILY HIGH STRESS: NO_____ YES _____

DO YOU EXERCISE ON A REGULAR BASIS: NO_____YES_____ FREQUENCY_____

HOURS OF SLEEP IN AN AVERAGE NIGHT_____ HOW OLD IS YOUR MATTRESS_____

USE THE DIAGRAM BELOW TO INDICATE YOUR AREA AND LEVEL OF PAIN

0 = NO PAIN 10 = SEVERE PAIN



RYAN FAMILY CHIROPRACTIC, INC.
303 Donehoo St.
Statesboro, Ga. 30458
(912) 489-5559 or Fax (912) 489-3028

Authorization and Assignment of Benefits

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Ryan Family Chiropractic, Inc. will prepare any necessary reports and forms so that any amount authorized to be paid will be paid directly to the Ryan Family Chiropractic, Inc. and will be credited to my account on receipt. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services provided to me will be immediately due and payable in full.

I am aware that Ryan Family Chiropractic will not file claims to secondary insurance carriers. In the event that I have a secondary insurance carrier, I may request Ryan Family Chiropractic to prepare any necessary reports and forms to assist me in making collection directly from the insurance company. I understand that I will be responsible for the original amount due to Ryan Family Chiropractic in full regardless of insurance coverage.

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Ryan Family Chiropractic for all covered medical services provided to me during all course of treatment and care. I understand and agree this Assignment of Benefits will have continuing effect for as long as I am being treated or cared for by Ryan Family Chiropractic, and will constitute a continuing authorization, maintained on file with Ryan Family Chiropractic which will authorize and allow for direct payment to Ryan Family Chiropractic of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services and care.

I authorize RYAN FAMILY CHIROPRACTIC to obtain a copy of my medical records, imaging reports or any other medical document that might be needed to determine my treatment at their office.

I hereby agree that if my bill has to be turned over to a third party collection agency for non-payment, there will be a collection fee added to my bill of 33%. This is pursuant to Georgia Statutory Law "O.C.G.A.-13-1-11". (Initial_____)

I hereby authorize Dr. Jason Ryan to treat my condition as he deems appropriate.

_____ _____

Patient/Guardian Signature Date

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Patient/Guardian Signature Date