Print Form


# Joseph J. Cipriano, D.C.

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**Atlanta, GA 30305**
**(404) 261-9522**


***PLEASE FILL IN ELECTRONICALLY AND CLICK THE PRINT BUTTON ABOVE***

**TODAY'S DATE:** _____ **SOCIAL SECURITY #:** _____

**NAME:** _____ **ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**HOME PHONE:** _____ **WORK:** _____ **OTHER #:** _____

**NAME OF EMPLOYER:** _____ **EMAIL ADDRESS:** _____

**BIRTHDATE:** _____ **SEX:** _____ **HEIGHT:** _____ **WEIGHT:** _____

**CHECK ONE:** ☐ **MARRIED** ☐ **SINGLE** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **SEPARATED**

**NAME OF SPOUSE/PARENT:** _____

**SPOUSE/PARENT'S EMPLOYER:** _____

**AGE(S) OF YOUR CHILDREN:** _____ **ARE YOU THE PRIMARY INSURED:** _____

**NAME OF INSURED (if other than yourself):** _____

**DATE OF BIRTH OF INSURED:** _____ **SOCIAL SECURITY # OF INS.:** _____

**IN CASE OF EMERGENCY NOTIFY?:** _____

**ADDRESS:** _____ **PHONE:** _____

**WHO IS RESPONSIBLE FOR YOUR BILL?:**

☐ **SELF** ☐ **SPOUSE** ☐ **EMPLOYER** ☐ **GROUP INSURANCE**
☐ **AUTO INSURANCE** ☐ **OTHER** ☐ **MEDICARE** ☐ **WORKER'S COMP**

**AUTHORIZATION, ASSIGMENT AND RELEASE FORM**

**I hereby give my permission to Dr. Cipriano to administer treatment and to perform such procedures as may be deemed necessary by him. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits.**

**SIGNATURE:** _____ **DATE:** _____

**Please list any accidents or falls you may have had, or date of onset of symptoms:**

**PLEASE CHECK ALL OF THE SYMPSOMS YOU HAVE NOW**

**GENERAL SYMPTOMS**

- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Lossof Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ L ossof W eight
- ☐ Numbnessof arms, hands, legs
- ☐ Allergies
- ☐ W heezing
- ☐ Neuralgia
- ☐ Eye Pain
- ☐ Blurred Vision
- ☐ Nose Bleeds
- ☐ Urine Trouble

**MUSCLE & JOINT**

- ☐ Neck Pain
- ☐ M id-Back Pain
- ☐ Low Back Pain
- ☐ Swollen Joints
- ☐ Tremors
- ☐ Painful Tail Bone
- ☐ Foot Trouble
- ☐ Pain between Shoulders
- ☐ H ernia
- ☐ Spinal curvature
- ☐ Faulty Posture
- ☐ Shoulder Pain
- ☐ Chest Pain
- ☐ Elbow Pain
- ☐ W rist Pain
- ☐ Arm Pain
- ☐ Knee Pain
- ☐ Ankle Pain
- ☐ Hip Pain

**CARDIO-VASCULAR**

- ☐ Rapid Beating Heart
- ☐ SlowBeating Heart
- ☐ High Blood Pressure
- ☐ Low BloodPressure
- ☐ Pain Over Heart
- ☐ Previous Heart Stroke
- ☐ Hardening of Arteries
- ☐ Swelling of Ankles
- ☐ Poor Circulation
- ☐ Paralytic Stroke

**FEMALE: ARE YOU PREGNANT?** ☐

**LAST DATE OF MENSTRUAL CYCLE**

_____

**OTHER: Please describe**