WELCOME

Chart #:_____

Patient Information

Name: _____
Last First MI

Mailing Address: _____ **City;** _____ **Zip:** _____

Phone# (H)_____ (M) _____ **(E-Mail)** _____

Date of Birth:_____ **Sex:** ☐ Male ☐ Female **SS#:**_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Employer:_____ Phone:_____

May we call you at work? ☐ Yes ☐ No Can we leave a voicemail/message? ☐ Yes ☐ No

Emergency contact: Name:_____

Relation:_____Phone: _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other_____

Date of Accident: ____/ _____/ _____ Has it been reported? ☐ Yes ☐ No If yes to whom?_____

Attorney Name: _____ **Contact #;** _____

Financial Information

Do you have health insurance? ☐ Yes ☐ No Name of Carrier:_____

Do you have Automobile Med-Pay insurance? ☐ Yes ☐ No Name of Carrier:_____

Name of the policy holder of the insurance:_____ SS#: _____

Relationship to patient (if other than self):_____ DOB: _____ Phone:_____

ID #_____ **Group #**_____**Phone number** _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment, Consent of Care and Release

I certify that I (or my dependent) have insurance coverage with _____ and I authorize, request and assign my insurance companies to pay directly to this practice the insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. Lab tests maybe filed directly by laboratory. I hereby authorize the doctor/s to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions. If I obtain an attorney, I instruct my attorney to directly pay this clinic for services rendered to me by this clinic, its affiliate clinics and its healthcare providers, any money received from my insurance and/or a third party insurance company for services rendered to me. I agree not to revoke this instruction before payment in full has been made. I also agree to make the same instruction to any associate or successor attorney who may represent me regarding the same.

HIPAA

I was given the opportunity to receive and review the office's Patient Notice of Privacy Practices policy.

PATIENT SIGNATURE (X)_____ **DATE**_____

SIGNATURE OF PARENT/GUARDIAN_____ **DATE**_____

Name: _____ **Chart #:**_____

HEALTH HISTORY

Who is your primary care physician (doctor and/or practice)? _____

Please check to indicate if you are currently experiencing any of the following conditions:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Other _____
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain_____

Please list any medications you are currently taking:_____

_____

Please list any surgeries and/or hospitalizations you have had (type & date):_____

_____

_____

Please list any allergies:_____

Please list any supplements you are currently taking (vitamins/herbs/minerals):_____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

- ❑ Heart Disease_____
- ❑ Cancer_____
- ❑ Diabetes_____
- ❑ Arthritis_____
- ❑ Other_____

Do you exercise? ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a cervical pillow? ☐ Yes ☐ No

What is your daily/weekly intake of the following?

Caffeine_____ cups/day Alcohol_____ drinks/week Cigarettes_____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

PATIENT/PARENT GUARDIAN INITIALS:_____

Name: _____ **Chart #** _____

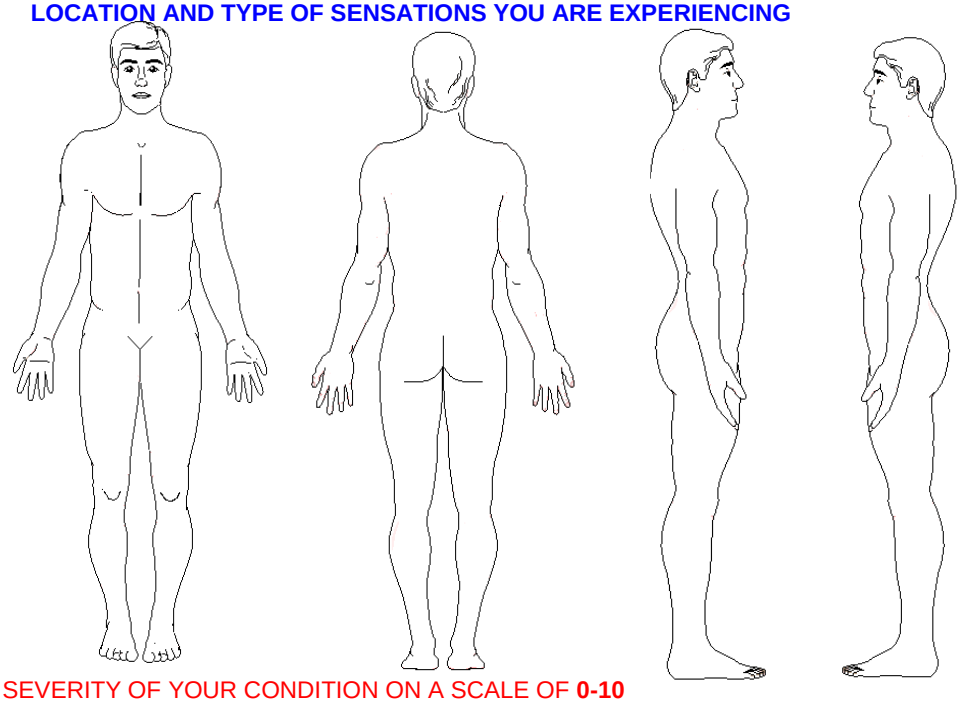
CURRENT SYMPTOM (S)

Reason for visit_____

_____

_____

*** PLEASE USE THE LETTER (S) BELOW TO MARK THE DRAWING(S) WITH THE LOCATION AND TYPE OF SENSATIONS YOU ARE EXPERIENCING**



KEY:

T = Tight
D = Dull
A = Ache
S = Sharp
N = Numb
B = Burning
ST = Stiff
TG = Tingling
SH = Shooting
TH = Throbbing
O = Other

* PLEASE INDICATE THE SEVERITY OF YOUR CONDITION ON A SCALE OF **0-10**

(0 being no pain, 10 being the worst possible pain) 1._____ currently 2._____ at it's worst

When did you first notice the symptoms?_____

Did anything cause the pain/symptoms?_____

Is the pain: ☐ Constant OR ☐ intermittent (Come and Go)

Is it getting progressively worse? ☐ No ☐ Yes

Type of Pain? ☐ Tight ☐ Stiff ☐ Ache ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Burning ☐ Dull ☐ Numb ☐ Tingling ☐ Other

Does anything make it worse?_____

Does anything make it better?_____

Does it radiate? ☐ No ☐ Yes ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

Do you experience the pain at a particular time of day?_____

Do you experience night pain? ☐ No ☐ Yes, explain_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreational Activities

What activities do you enjoy, but do poorly, or not all because of the pain? _____

Painful movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What have you done to treat the pain before today?_____

PATIENT/PARENT GUARDIAN INITIALS:_____

Name _____ **Chart #**_____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
    Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment: _____
14. Do you suffer from a reduced hearing capacity or ringing in the ears? NO YES
    Comment: _____
15. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment: _____
16. Do you have difficulty sleeping, lifting or interacting with others since your injuries? NO YES
    Comment: _____

PATIENT/PARENT GUARDIAN INITIALS: _____

MEDICAL RECORDS REQUEST

DATE:_____

Please list the name of the physician(s) who referred you to us or any physician, person(s), business(s) you would allow us to request or release your personal Health information.

To:_____ (primary care physician)

_____ (significant other)

_____ (attorney/case manager)

_____ (other care takers)

I, _____ hereby request that my recent medical records be released to:

_____ **Physician of** _____ **practice.**

236 Johnson Ferry Road, NE

Sandy Springs, Georgia 30328

Phone: 404-255-0666 **Fax: 404-705-9942**

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at anytime. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

PATIENT NAME:_____

PATIENT ADDRESS:_____

PATIENT'S DATE OF BIRTH:_____

PATIENT/GUARDIAN SIGNATURE:_____

1. Do you think you suffer from allergies? _____ Yes _____ No
2. Are the symptoms all year around or seasonal? Year Long / Seasonal
3. How long are your symptoms per week? Less than 7 days / All 7 days
4. What time of the day are your symptoms the worse? Morning / Afternoon / Night / All day
5. Are the symptoms worse in the spring, fall, or both? Spring / Fall / Both
6. Do you have any sinus drainage issues? _____Yes _____ No If yes, when? AM / PM / All Day
7. Do you ever have watery or itchy eyes? Always / Most Times / Sometimes / Never
8. Do you cough or sneeze on a regular basis? _____Yes _____ No If yes, When? _____
9. Do you have regular upper respiratory infections? _____Yes _____No If Yes, < 3 or >3 per year
10. Do you think you might be allergic to animals? _____ Yes _____ No
11. Have you been diagnosed with asthma? _____Yes _____No If yes, When? _____
12. Do you have a family history of asthma? _____Yes _____No
13. How long have you lived in Georgia? _____ Years _____ Months
14. How long have you lived in your current residence? _____ Years _____ Months
15. Did you have allergies in your previous residence or state? _____ Yes _____ No
16. Do you wear a mask when you cut your grass? _____ Yes _____ No
17. Do you have a HEPA filter on your vacuum cleaner? _____ Yes _____ No
18. Do you use an inhaler? _____ Yes _____ No
19. Are you currently taking any allergy medications? _____ Yes _____ No

    If yes, please list all medications including any over the counter (OTC) medications as well.

    _____ _____ _____

20. Are you currently taking any blood pressure medications? _____Yes _____ No

    If yes, please list: _____ _____ _____

SCHEDULE FOR TESTING _____ YES _____ NO Date/Time Scheduled _____

INFORMED CONSENT TO PROCEDURES & TREATMENTS

Dr. _____

Dr. _____

I hereby request and consent to the performance of joint manipulations/ mobilizations, perform injections, prescribed medications, natural herbs & supplements, homeopathic remedies and other procedures including various modes of physiotherapy, exercise rehab and diagnostic testing on me (or on the patient named below, for whom I am legally responsible) by the doctor/s named above and/or other doctor/s who now or in the future treat me while employed by working or associated with serving as back up for the doctor/s or with the doctor/s named above, including those working at the clinic or office listed above. I have had an opportunity to discuss with the doctor/s named above and /or with other office or clinic personnel the nature and purpose of such and understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, chiropractic, physiotherapy and other health care disciplines, there are some risks to the treatments including but not limited to reactions to medications, infections, fractures and strains. I do not expect the doctor/s to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/s to exercise judgement during the course of the procedures which the doctor/s feels at the time, based on fact then known, is in my best interests. I also understand such practice disciplines and procedures involve touching some parts of my body; therefore, I authorize such touching by the doctor/s or their associates or back up, for now and future.

I have read, or have read to me above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-mentioned. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make it known to the doctor.

TO BE COMPLETED BY PATIENT OR PATIENT'S REPRESENTATIVE, IF NECESSARY. IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

_____ _____

PRINT PATIENT'S NAME ***SIGNATURE***

_____ _____

REPRESENTATIVE ***RELATIONSHIP***

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Georgetown Clinic, its affiliate clinics and its healthcare providers, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Providers/clinic for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Providers all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____
(Patient signature)

_____
(Please Print Patient name)

X_____
(Signature of Guardian if applicable)