Chart #:_______________________

WELCOME

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
- ❑ Radiating pain into Rt. Arm/Hand or Lt. Arm/Hand
- ❑ Radiating Pain into RT. Leg/Foot or LT. Leg/Foot
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Anxiety
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Changes in Appetite
- ❑ 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____________
- ❑ Diabetes______________________
- ❑ Cancer_____________________
- ❑ 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 ____

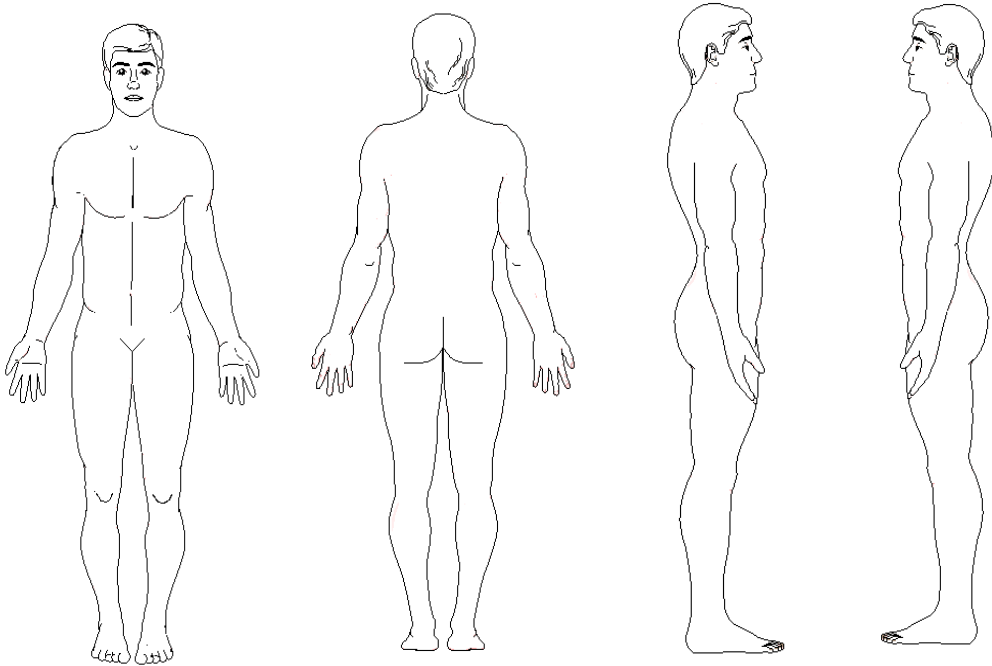
____

____

*** 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
R = Radiating
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 its 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 difficulty sleeping, lifting objects or interacting with others since your injuries? NO YES
    Comment: ______________________________

PATIENT/PARENT GUARDIAN INITIALS: ______________________________

Georgetown Clinics

Medical Records Release Authorization Form

Patient Name: ____ Account #: _________________

D.O.B: ____________________________________ SSN: ___________________________________

Home Phone: ______________________________ Work: __________________________________

I hereby authorize ____
(Hospital, Urgent Care &/Or Other Doctors Office)
to release my records to Georgetown Clinics any of the following information:

OFFICE USE ONLY

___History & Physical
___Operation Report(s)
___Discharge Summary
___Complete Medical Records
___Other, Specify____
___Radiology Report(s)
___Laboratory Report(s)
___Pathology Report(s)

I want this information released in writing, verbally, via fax, audiovisual format to:

____

____
Street Address City State Zip Code

for the purpose of ____

I understand and acknowledge that the records I have requested to be released pursuant to this authorization may contain Psychiatric, drug, alcohol abuse and/or infectious disease information, which is protected under the laws of the State of Georgia and Federal Regulation (42 CFR part 2). I hereby release ____ (Facility of Physician) from all legal liability that may arise from the release of any information from my medical record pursuant to the Authorization, including but limited to the release of psychiatric , psychological, alcohol, drug abuse or infectious disease (HIV or AIDS) information protected under state and Federal Laws. This authorization, except for action already taken, may be revoked by any time. This authorization is valid for 90 days unless otherwise specified.

____ ______________________
Patient/Representative's Signature **Date**

____ ______________________
Relationship to Patient **Date**

____ ______________________
Witness's Signature **Date**

PATIENTS NAME: ____ D.O.B _____ / ______ / ______

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)