

WELCOME

Chart #: _____

Patient Information

Name: _____
Last First MI

Mailing Address: _____

Phone# (H) _____ (M) _____

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

Who referred you to our practice? _____ Insurance Book Yellow Pages

Emergency contact: Name: _____ Relation: _____

Phone: (H) _____ (W) _____

Accident Information

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

Has it been reported? Yes No If yes to whom? _____

Financial Information

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

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

Name of person whose is the policy holder of this insurance: _____ SS#: _____

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

ID # _____ Group # _____ member services phone number _____

We can not file your insurance if this section is left uncompleted and the bill will be sent to you.

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 COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor 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.

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.

PATIENT SIGNATURE (X) _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

HIPAA

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

PATIENT SIGNATURE (X) _____ DATE _____

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:

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

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

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

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)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> 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 SIGNATURE (X) _____ DATE _____

PARENT/GUARDIAN SIGNATURE (X) _____ DATE _____

CHART # _____

Current Symptom(s)

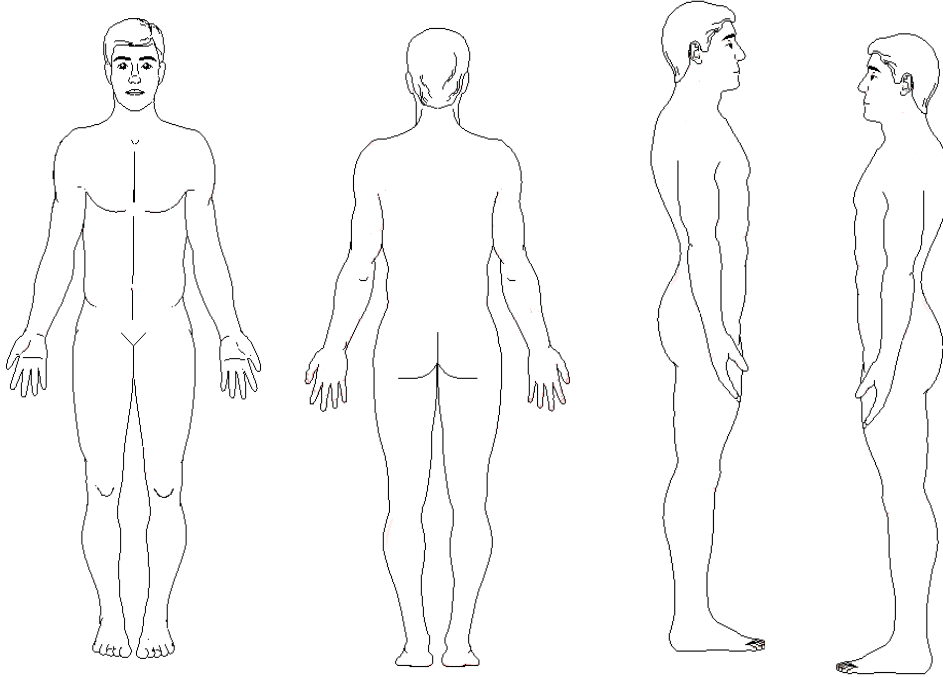
NAME: _____ Chart #: _____

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 SIGNATURE (X) _____ DATE _____

PARENT/GUARDIAN SIGNATURE (X) _____ DATE _____

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.

Executive Medical Healthcare

990 Bear Creek Blvd. Ste G

Hampton, Georgia 30228

Phone: 678-479-1234

Fax: 678-479-5678

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: _____