

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------|--|--------------------------------------------------------------|--|------|--|-----------|--|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Patient Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                           |  |  | DOB:                                                     |  |                                                              |  |      |  |           |  |
| Mailing Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                           |  |  | City:                                                    |  | ST:                                                          |  | Zip: |  |           |  |
| Home Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                           |  |  | Consent to Call:                                         |  | <input type="checkbox"/> Yes <input type="checkbox"/> No     |  |      |  |           |  |
| Cell Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                           |  |  | Consent to Call:                                         |  | <input type="checkbox"/> Yes <input type="checkbox"/> No     |  |      |  |           |  |
| Work Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                           |  |  | Email:                                                   |  |                                                              |  |      |  |           |  |
| Spouse's Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Do you authorize your spouse to receive medical information on your behalf?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                           |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                                              |  |      |  |           |  |
| <b>**Care Team**</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Primary Care Provider:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                           |  |  |                                                          |  | Phone Number:                                                |  |      |  |           |  |
| Cardiologist:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                           |  |  |                                                          |  | Phone Number:                                                |  |      |  |           |  |
| Pulmonologist:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                           |  |  |                                                          |  | Phone Number:                                                |  |      |  |           |  |
| Other Specialist:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                           |  |  |                                                          |  | Phone Number:                                                |  |      |  |           |  |
| Pharmacy Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                           |  |  |                                                          |  | Phone Number:                                                |  |      |  |           |  |
| Pharmacy Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Pharmacy City:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Race:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic<br><input type="checkbox"/> Other: _____ |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Ethnicity:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino                                                                                                                                                                     |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Language Spoken:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Sex:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender                                                                                                                                                        |  |  |                                                          |  |                                                              |  |      |  |           |  |
| <b>**Emergency Contact Information/Release of Information other than Spouse**</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Emergency Contact Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                           |  |  |                                                          |  | Phone Number:                                                |  |      |  |           |  |
| Relationship to Patient:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                           |  |  |                                                          |  | <input type="checkbox"/> Medical information may be released |  |      |  |           |  |
| Secondary Contact Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                           |  |  |                                                          |  | Phone Number:                                                |  |      |  |           |  |
| Relationship to Patient:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                           |  |  |                                                          |  | <input type="checkbox"/> Medical information may be released |  |      |  |           |  |
| <b>**Guarantor/Responsible Party (if other than self)**</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Guarantor Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                           |  |  |                                                          |  | Phone Number:                                                |  |      |  |           |  |
| Guarantor Date of Birth:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| <b>**Additional Information**</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Do you have an Advanced Directive?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                           |  |  | Yes    No                                                |  | Can you provide us with a copy?                              |  |      |  | Yes    No |  |
| Power of Attorney for medical decisions?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                           |  |  | Yes    No                                                |  | If Yes who?                                                  |  |      |  |           |  |
| How Did You Hear About Us? Who Referred You?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| <b>ASSIGNMENT AND RELEASE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| <p>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 THAT ARE 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.</p> |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                           |  |  |                                                          |  |                                                              |  |      |  |           |  |
| Patient or Representative Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |  |  |                                                          |  | Date                                                         |  |      |  |           |  |

## **Assignment of Benefits**

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I authorize, request, and assign my insurance company to pay directly to Atlanta Spine & Orthopaedics insurance benefits otherwise payable to me.

Insurance is designed to help you meet the cost of medical services. If you gave us all the requested information, including a copy of your insurance card, we will submit a claim to your insurance company as a courtesy to you. However, your insurance is a contract between you and your carrier or employer. Therefore, the ultimate responsibility for payment rests with you.

**PATIENT RESPONSIBILITY:** I understand and acknowledge that I am responsible for all charges for services provided to the patient listed below which are not covered by my insurance plan or for which I am responsible for payment under my insurance plan. To the extent no coverage exists under my insurance plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance when services are rendered or when I am notified of charges not covered by insurance. I further agree that, if permissible by law, I will reimburse Atlanta Spine & Orthopaedics for costs, expenses, and attorney's fees that may be incurred by Atlanta Spine & Orthopaedics to collect those charges. This agreement will be in force until balance is paid in full for all services rendered.

| <b>PRIMARY INSURANCE</b>                                                                                             |                               |
|----------------------------------------------------------------------------------------------------------------------|-------------------------------|
| Insurance Company:                                                                                                   |                               |
| Policy Holder:                                                                                                       | Policy Holders Date of Birth: |
| Subscriber ID:                                                                                                       |                               |
| Group Number:                                                                                                        |                               |
| Policy Holders Relationship to Patient:                                                                              |                               |
| <b>SECONDARY INSURANCE</b>                                                                                           |                               |
| Insurance Company:                                                                                                   |                               |
| Policy Holder:                                                                                                       | Policy Holders Date of Birth: |
| Subscriber ID:                                                                                                       |                               |
| Group Number:                                                                                                        |                               |
| Policy Holders Relationship to Patient:                                                                              |                               |
| <b>ADDITIONAL BILLING INFORMATION</b>                                                                                |                               |
| Is this a Workers Compensation Case? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date of Injury:   |                               |
| Carrier:                                                                                                             | Employer:                     |
| Is this a Motor Vehicle Accident Case? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date of Injury: |                               |
| Please provide Attorneys Name:                                                                                       | Phone Number:                 |

Patient's Name \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature \_\_\_\_\_

## **CONSENT TO CARE**

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis, analysis, and treatment. I hereby authorize the physicians and staff at Atlanta Spine & Orthopaedics to diagnose and treat my case or the case of my child as they deem appropriate.

The medications prescribed and clinical procedures performed are usually beneficial and seldom cause any serious problems. In rare cases, underlying physical defects, deformities, pathologies, or physiological conditions may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, deformities, or physiological conditions which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, and agree and acknowledge that they will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Patient Initials: \_\_\_\_\_

## **PATIENT MISSED APPOINTMENT POLICY**

It is our wish that every one of our patients receive the very best care and service possible. For that reason, it is our office policy that patients must give us at least a 24-hour notice for any appointment changes or cancellations. If you are more than 15 minutes late beyond your scheduled arrival time, you will be considered to have missed your appointment and will need to be rescheduled. There is a \$75 service charge for all no call/missed appointments.

Patient Initials: \_\_\_\_\_

## **HIPAA/PRIVACY PRACTICES**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Privacy Rule to help ensure that personal health care information is protected for privacy. Their Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive always to take reasonable precautions to protect your privacy.

I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, to my insurance company, adjuster, attorney, or any other payer involved in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submission. A photocopy of this agreement shall be considered just as effective and valid as the original.

I acknowledge that I have reviewed the Notice of Privacy Practices of Atlanta Spine & Orthopaedics.  
(Please initial one of the following options and sign below.)

\_\_\_\_\_ I wish to receive a paper copy of the Privacy Notice.  
\_\_\_\_\_ I do not request a copy of the Privacy Notice currently. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

*Answering Machine Voicemail:*

\_\_\_\_\_ Do not leave message other than to return our call      \_\_\_\_\_ You may leave messages with information

*Authorization:*

\_\_\_\_\_ I authorize the following identified individuals to request my treatment records on my behalf or speak with my provider on behalf at Atlanta Spine & Orthopaedics:

- |                  |                     |
|------------------|---------------------|
| 1. _____         | _____               |
| <i>Full Name</i> | <i>Relationship</i> |
| 2. _____         | _____               |
| <i>Full Name</i> | <i>Relationship</i> |

I acknowledge that I have received a copy of Privacy Practices, if requested. This notice describes how the practice will disclose my protected healthcare information. I also understand that I may revoke this authorization at any time or receive a copy of this authorization.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **FINANCIAL POLICY**

We are committed to providing the best care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our Financial Policy, which we ask you to *read, initial beside each policy*, and return to us prior to your treatment.

\_\_\_\_\_ It is imperative that complete personal information and a copy of your current insurance card is provided prior to being seen to ensure accurate billing. **PLEASE NOTE:** If incorrect insurance information is given by the patient or patients guarantor, any denial or unpaid claim will be financial responsibility of the patient.

\_\_\_\_\_ All applicable co-pays, deductibles, and prior balance are due in full at time of service.

### **Regarding Insurance:**

\_\_\_\_\_ We participate with Medicare (NOT MEDICAID) and most insurance plans. However, you must realize that your insurance is a contract between you and the insurance company and/or your employer. While we may be a provider, we are not a party to the contract.

\_\_\_\_\_ Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary. In these instances, you will be responsible for these amounts. Some Policies have deductibles for surgical procedures. The insurance companies consider procedures such as epidurals, joint injections, or other small procedures as "surgery". If you have a surgical deductible that has not been met and have one of these procedures, you will be responsible for payment at the time of service.

\_\_\_\_\_ Please be aware that insurance companies require a co-payment to be collected for every visit with a provider, whether it be a doctor, physician's assistant, or nurse practitioner.

\_\_\_\_\_ Our office can **NEVER** guarantee coverage for any service provided because insurance companies will not guarantee benefits until they receive the claim for services. It is important that you educate yourself about your individual insurance benefits. If you are unsure of your coverage benefits, call the customer service number on your insurance card.

\_\_\_\_\_ If my current policy prohibits direct payment to the physician, then I agree to direct all payments received from my insurance company or any other payer by signing the checks received over to Atlanta Spine & Orthopaedics for services rendered. In the event I fail to direct all payments/make all payments to Atlanta Spine & Orthopaedics I can be legally responsible for all outstanding balances, deductibles, interest, legal fees, collection costs, mediation and court costs. Further, if I forget to have the insured/patient sign the check when leaving it at the clinic, I hereby give permission for the clinic to endorse my name to said check.

**Past Due Accounts:**

\_\_\_\_\_ Overdue accounts will be turned over to a collection agency. Please be aware that a \$50.00 processing/filing fee as well as a fee of 40% of your balance will be added to your account.

*Example: \$200 owed +\$50 processing +\$80(40%) =\$330 will be your new account balance*

**Returned Checks:**

\_\_\_\_\_ For checks returned to us as unpaid by your bank, we will charge a \$45 fee.

I have read, understand, and agree to the above policy. My signature below indicates that I understand and agree to the above policy. If I had any questions regarding the policy I have asked and have received sufficient explanation.

---

Printed Patient Name

Patient Signature

Date

Patient Name: \_\_\_\_\_

### MEDICATIONS TRIALED

Circle **ALL** medications which you have **PREVIOUSLY** been prescribed and write the dosage.

**Opioids:**

|                         |               |             |               |
|-------------------------|---------------|-------------|---------------|
| Tramadol                | Dosage: _____ | Morphine ER | Dosage: _____ |
| Hydrocodone (Norco)     | Dosage: _____ | Xtampza     | Dosage: _____ |
| Oxycodone/Acetaminophen | Dosage: _____ | Dilaudid    | Dosage: _____ |
| Oxycodone (Percocet)    | Dosage: _____ | Oxycontin   | Dosage: _____ |
| Morphine IR             | Dosage: _____ | Other:      | _____         |

**Muscle Relaxants:**

|                            |               |            |               |
|----------------------------|---------------|------------|---------------|
| Flexeril (Cyclobenzaprine) | Dosage: _____ | Metaxalone | Dosage: _____ |
| Robaxin (Methocarbamol)    | Dosage: _____ | Baclofen   | Dosage: _____ |
| Tizanidine                 | Dosage: _____ | Other:     | _____         |
| Soma                       | Dosage: _____ |            |               |

**NSAIDS/Other Pain Meds:**

|                    |               |              |               |
|--------------------|---------------|--------------|---------------|
| Ibuprofen (Motrin) | Dosage: _____ | Indomethacin | Dosage: _____ |
| Naproxen (Aleve)   | Dosage: _____ | Meloxicam    | Dosage: _____ |
| Celebrex           | Dosage: _____ | Tylenol      | Dosage: _____ |
| Diclofenac Sodium  | Dosage: _____ | Other:       | _____         |

**Adjuvants:**

|               |               |               |               |
|---------------|---------------|---------------|---------------|
| Gabapentin    | Dosage: _____ | Amitriptyline | Dosage: _____ |
| Lyrica        | Dosage: _____ | Cymbalta      | Dosage: _____ |
| Nucynta       | Dosage: _____ | Topamax       | Dosage: _____ |
| Nortriptyline | Dosage: _____ | Other:        | _____         |

**OIC Meds:**

|                 |               |                     |               |
|-----------------|---------------|---------------------|---------------|
| Relistor        | Dosage: _____ | Polyethylene Glycol | Dosage: _____ |
| Senna/Bisacodyl | Dosage: _____ | Other:              | _____         |
| Docusate        | Dosage: _____ |                     |               |

**Other Significant Meds:**

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### THERAPIES TRIALED

Please **WRITE** location, frequency, and date range of **ANY** therapies.

|                      |       |
|----------------------|-------|
| Physical Therapy     | _____ |
| Chiropractic Therapy | _____ |
| Massage Therapy      | _____ |
| Dry Needling         | _____ |
| Acupuncture          | _____ |
| Tens Unit            | _____ |
| Heat Pads            | _____ |
| Ice Packs            | _____ |

### INTERVENTIONAL AND SURGICAL PROCEDURES COMPLETED

Please **CIRCLE** type of procedure and **NOTATE** the dates of any procedures.

|                           |             |                  |
|---------------------------|-------------|------------------|
| Corticosteroid Injections | Date: _____ | Body Part: _____ |
| Trigger Point Injections  | Date: _____ | Body Part: _____ |
| Epidural Injections       | Date: _____ | Body Part: _____ |
| PRP Injections            | Date: _____ | Body Part: _____ |
| Prolotherapy              | Date: _____ | Body Part: _____ |
| Nerve Blocks              | Date: _____ | Body Part: _____ |
| Medial Branch Blocks      | Date: _____ | Body Part: _____ |
| Radio Frequency Ablation  | Date: _____ | Body Part: _____ |
| Viscosupplementation      | Date: _____ | Body Part: _____ |
| Other: _____              | Date: _____ | Body Part: _____ |
| _____                     | _____       | _____            |

### Surgical History

|                         | YES   | DATE  |                        | YES   | DATE  |
|-------------------------|-------|-------|------------------------|-------|-------|
| Appendectomy            | _____ | _____ | Neck Surgery (Specify) | _____ | _____ |
| Gall Bladder Removal    | _____ | _____ | Back Surgery (Specify) | _____ | _____ |
| Tonsil/Adenoid Removal  | _____ | _____ | Knee Surgery           | _____ | _____ |
| Hysterectomy            | _____ | _____ | Hip Surgery            | _____ | _____ |
| Kidney Surgery          | _____ | _____ | Gastric Bypass         | _____ | _____ |
| Heart Surgery (Specify) | _____ | _____ | Other:                 | _____ | _____ |

### PREVIOUS DIAGNOSTIC STUDIES

Please indicate approximate date, location, and type. (If known)

|         | Date  | Location | Type (Body Part, Contrast) |
|---------|-------|----------|----------------------------|
| MRI     | _____ | _____    | _____                      |
| CT-Scan | _____ | _____    | _____                      |
| X-Rays  | _____ | _____    | _____                      |
| EMG/NCS | _____ | _____    | _____                      |

Patient Name: \_\_\_\_\_

### MEDICATION LIST

Please include prescription, over the counter, vitamins, or herbal medications that you are currently taking.

| DRUG NAME | DOSE (ex: 5mg) | Times per Day | Why are you taking it? |
|-----------|----------------|---------------|------------------------|
|           |                |               |                        |
|           |                |               |                        |
|           |                |               |                        |
|           |                |               |                        |
|           |                |               |                        |
|           |                |               |                        |
|           |                |               |                        |

### ALLERGIES

☐ NKDA

| ALLERGIC TO: | REACTION TO MEDICATION (ex: rash, facial swelling, hives, etc.) |
|--------------|-----------------------------------------------------------------|
|              |                                                                 |
|              |                                                                 |
|              |                                                                 |
|              |                                                                 |

### FAMILY HISTORY

Please mark all that apply.

|         | ALIVE | DECEASED | DIABETES | HYPERTENTION | HEART<br>ATTACK | STROKE | MENTAL<br>ILLNESS | CANCER | OTHER |
|---------|-------|----------|----------|--------------|-----------------|--------|-------------------|--------|-------|
| MOTHER  |       |          |          |              |                 |        |                   |        |       |
| FATHER  |       |          |          |              |                 |        |                   |        |       |
| SISTER  |       |          |          |              |                 |        |                   |        |       |
| BROTHER |       |          |          |              |                 |        |                   |        |       |

### SOCIAL HISTORY

Tobacco Smoker: ☐ Yes ☐ No IF yes: 2pack/day, 1 pack/day, ½ pack /day \_\_\_\_\_

What age did you start using Tobacco? \_\_\_\_\_ Chewing Tobacco: ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Have you ever served in the Armed Forces? Yes No

Are you currently employed? ☐ Yes ☐ No If yes, what is your Occupation: \_\_\_\_\_

Are you able to care for yourself? ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No If yes, how often: \_\_\_\_\_

Recreational Drug use: ☐ Yes ☐ No If yes explain: \_\_\_\_\_

Deaf or Difficulty hearing: ☐ Yes ☐ No Blind or Difficulty seeing: ☐ Yes ☐ No

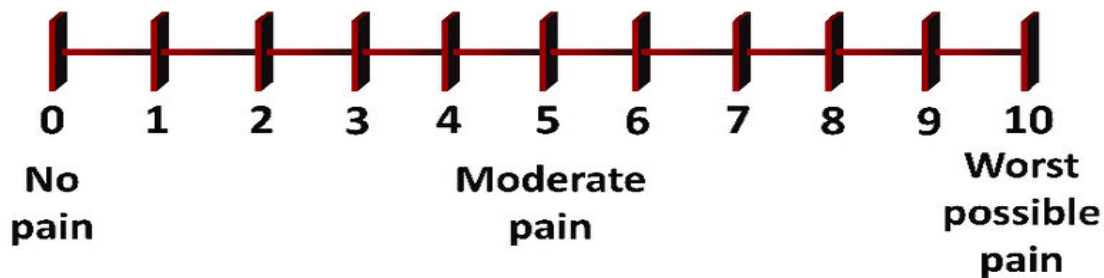
**PAST MEDICAL HISTORY:** Please indicate if you have any of the following medical conditions.

|                                                    |                                                          |                                                      |
|----------------------------------------------------|----------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Acid Reflux (Gerd)        | <input type="checkbox"/> Dental Abnormalities/Disorder   | <input type="checkbox"/> MRSA                        |
| <input type="checkbox"/> Adverse Reaction to Anes. | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Multiple Sclerosis          |
| <input type="checkbox"/> AIDS/HIV                  | <input type="checkbox"/> Fibromyalgia                    | <input type="checkbox"/> Nasal Polyps                |
| <input type="checkbox"/> Alzheimer's               | <input type="checkbox"/> Gout                            | <input type="checkbox"/> Orthotics                   |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Head Trauma/Injury              | <input type="checkbox"/> Osteoporosis                |
| <input type="checkbox"/> Anxiety/Depression        | <input type="checkbox"/> Headaches/Migraines             | <input type="checkbox"/> Pacemaker                   |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Heart Attack (MI)               | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Heart Problems (Explain: _____) | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Atrial Fibrillation       | <input type="checkbox"/> Hepatitis                       | <input type="checkbox"/> Psychiatric Disorder        |
| <input type="checkbox"/> Back Injury               | <input type="checkbox"/> Hernia                          | <input type="checkbox"/> Pulmonary Embolism          |
| <input type="checkbox"/> Bladder Problems          | <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Rheumatoid Arthritis        |
| <input type="checkbox"/> Bleeding Disorder         | <input type="checkbox"/> High Cholesterol                | <input type="checkbox"/> Seizures/Epilepsy           |
| <input type="checkbox"/> Bleeding Ulcer            | <input type="checkbox"/> Home Oxygen ____liters/min      | <input type="checkbox"/> Sick Cell                   |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Hypertension                    | <input type="checkbox"/> Significant Memory Loss     |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Infections: _____               | <input type="checkbox"/> Sleep Apnea/CPAP            |
| <input type="checkbox"/> Chest Pain on Exertion    | <input type="checkbox"/> Irregular Heartbeat             | <input type="checkbox"/> Stroke:CVA/TIA              |
| <input type="checkbox"/> Chronic Ear Infections    | <input type="checkbox"/> Kidney Disease                  | <input type="checkbox"/> Thyroid Disease             |
| <input type="checkbox"/> Congestive Heart Failure  | <input type="checkbox"/> Liver Disease                   | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> COPD                      | <input type="checkbox"/> Lupus/Autoimmune Disease        | <input type="checkbox"/> Ulcers                      |
| <input type="checkbox"/> Coronary Artery Disease   | <input type="checkbox"/> Menier's Disease                | <input type="checkbox"/> Other: _____                |

*\*Menopause: If Post-Menopausal, age of menopause? \_\_\_\_\_*

**CURRENT PAIN LEVEL**

Circle your current pain intensity. "0" represents No pain and "10" represents the most severe pain imaginable.



Patient Name: \_\_\_\_\_

Has your family or medical history changed since your last visit? \_\_\_\_Yes \_\_\_\_No

Have your medications changed since your last appointment? \_\_\_\_Yes \_\_\_\_No

**Please check any of the following systems in the past 30 days?**

**Constitutional**

- \_\_\_\_\_ Fever
- \_\_\_\_\_ Night Sweats
- \_\_\_\_\_ Significant Weight Gain
- \_\_\_\_\_ Significant Weight Loss
- \_\_\_\_\_ Malaise
- \_\_\_\_\_ Chills
- \_\_\_\_\_ Exercise Intolerance

**Cardiovascular**

- \_\_\_\_\_ Chest Pain
- \_\_\_\_\_ Arm Pain on Exertion
- \_\_\_\_\_ Shortness of Breath walking
- \_\_\_\_\_ Shortness of Breath lying down
- \_\_\_\_\_ Palpitations
- \_\_\_\_\_ Known Heart Murmur
- \_\_\_\_\_ Leg/Ankle Swelling
- \_\_\_\_\_ Lightheaded on Standing

**Genitourinary**

- \_\_\_\_\_ Incontinence
- \_\_\_\_\_ Difficulty Urinating
- \_\_\_\_\_ Hematuria
- \_\_\_\_\_ Increased Urinating Frequency
- \_\_\_\_\_ Painful Urination

**Respiratory**

- \_\_\_\_\_ Cough
- \_\_\_\_\_ Wheezing
- \_\_\_\_\_ Shortness of Breath
- \_\_\_\_\_ Coughing up Blood
- \_\_\_\_\_ Sleep Apnea
- \_\_\_\_\_ COPD
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Chronic Bronchitis

**Hematologic/Lymphatic**

- \_\_\_\_\_ Swollen Glands
- \_\_\_\_\_ Bruising
- \_\_\_\_\_ Excessive Bleeding
- \_\_\_\_\_ Anemia

**Eyes**

- \_\_\_\_\_ Blurred Vision
- \_\_\_\_\_ Loss of Vision
- \_\_\_\_\_ Double Vision
- \_\_\_\_\_ Eye Pain
- \_\_\_\_\_ Dry Eyes
- \_\_\_\_\_ Irritation

**Gastrointestinal**

- \_\_\_\_\_ Abdominal Pain
- \_\_\_\_\_ Nausea
- \_\_\_\_\_ Vomiting
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Abnormal Appetite
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Vomiting Blood
- \_\_\_\_\_ Dyspepsia
- \_\_\_\_\_ Gerd
- \_\_\_\_\_ Blood in Stool

**Musculoskeletal**

- \_\_\_\_\_ Muscle Aches
- \_\_\_\_\_ Muscle Weakness
- \_\_\_\_\_ Arthralgias/Joint Pain
- \_\_\_\_\_ Back Pain
- \_\_\_\_\_ Swelling in Extremities
- \_\_\_\_\_ Neck Pain
- \_\_\_\_\_ Difficulty Walking
- \_\_\_\_\_ Cramps
- \_\_\_\_\_ Osteoporosis
- \_\_\_\_\_ Fractures
- \_\_\_\_\_ Stiffness

**Integumentary**

- \_\_\_\_\_ Abnormal Mole
- \_\_\_\_\_ Jaundice
- \_\_\_\_\_ Rashes
- \_\_\_\_\_ Laceration
- \_\_\_\_\_ Non-Healing Areas
- \_\_\_\_\_ Changes in Hair/Nails
- \_\_\_\_\_ Psoriasis
- \_\_\_\_\_ Change in Skin Color
- \_\_\_\_\_ Breast Lump
- \_\_\_\_\_ Itching
- \_\_\_\_\_ Redness

**HEENT**

- \_\_\_\_\_ Hoarseness
- \_\_\_\_\_ Trouble Swallowing
- \_\_\_\_\_ Hearing Loss
- \_\_\_\_\_ Ear Pain
- \_\_\_\_\_ Nose Bleeds
- \_\_\_\_\_ Sore Throat

**Neurologic**

- \_\_\_\_\_ Loss of Consciousness
- \_\_\_\_\_ Weakness
- \_\_\_\_\_ Numbness
- \_\_\_\_\_ Seizures
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Migraines
- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Tremor
- \_\_\_\_\_ Gait Dysfunction
- \_\_\_\_\_ Paralysis
- \_\_\_\_\_ Loss of Coordination
- \_\_\_\_\_ Bowel Incontinence

**Psychiatric**

- \_\_\_\_\_ Depression
- \_\_\_\_\_ Sleep Disturbance
- \_\_\_\_\_ Feeling Unsafe in a Relationship
- \_\_\_\_\_ Alcohol/Drug Abuse
- \_\_\_\_\_ Anxiety
- \_\_\_\_\_ Hallucinations
- \_\_\_\_\_ Suicidal Thoughts
- \_\_\_\_\_ Mood Swings
- \_\_\_\_\_ Memory Loss
- \_\_\_\_\_ Agitation
- \_\_\_\_\_ Dementia
- \_\_\_\_\_ Delirium
- \_\_\_\_\_ Illegal Drug Use
- \_\_\_\_\_ Pres. Med. Use for Non-Medical reason
- \_\_\_\_\_ Craving Medications
- \_\_\_\_\_ Homicidal Thoughts
- \_\_\_\_\_ Difficulty Controlling Medication Use

**Endocrine**

- \_\_\_\_\_ Fatigue
- \_\_\_\_\_ Heat Intolerance
- \_\_\_\_\_ Cold Intolerance
- \_\_\_\_\_ Increased Thirst
- \_\_\_\_\_ Hair Growth

**Immunologic**

- \_\_\_\_\_ Runny Nose
- \_\_\_\_\_ Sinus Pressure
- \_\_\_\_\_ Itching
- \_\_\_\_\_ Hives
- \_\_\_\_\_ Frequent Sneezing

**Patient Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I am requesting my health information to be released **from** the following:

Organization Name: \_\_\_\_\_  
Address/Location: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

I am requesting that my health information to be **sent** to the following:

Organization Name: \_\_\_\_\_  
Address/Location: \_\_\_\_\_  
Phone Number: 678-369-6934 Fax Number: 770-679-5556

**Information to be released:**

|                                                                     |                                                              |
|---------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> All Health Information                     | <input type="checkbox"/> Discharge Letter                    |
| <input type="checkbox"/> Progress Notes/Office Notes                | <input type="checkbox"/> Emergency Department Records        |
| <input type="checkbox"/> Diagnostic Studies, Lab Results, Radiology | <input type="checkbox"/> Care Plan                           |
| <input type="checkbox"/> Surgical Reports                           | <input type="checkbox"/> Other _____                         |
| <input type="checkbox"/> Medications                                | <input type="checkbox"/> Medical Records from _____ to _____ |

I understand that by signing this form, I am consenting that my health information will be released to the above place, and that this authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is completed.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

Patient Rights: I have the right to revoke this authorization at any time. I may inspect/copy the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used/disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal/state law. I may refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand released information may include a communicable disease diagnosis such as HIV.