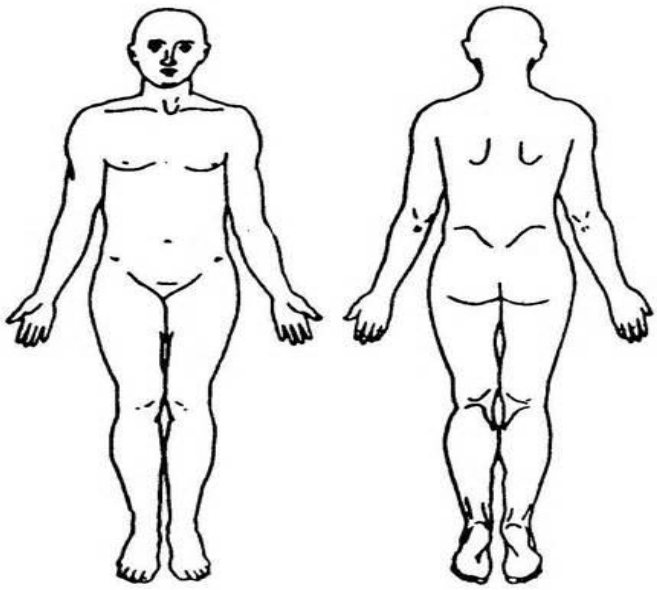
PATIENT INTAKE FORM

GEORGIA ADVANCED HEALTHCARE

DATE: _____

DEMOGRAPHICS / NUMBERS / EMAIL / CONTACT	Patient Condition
Name:_____ **First MI Last** **Date of Birth:____/____/_____ Age: _____ Sex: M/F** **Mo Day Year** **Address: (street)_____** **(city/state) _____ (zip)_____** **Phone #: (H)(____)_____-_____ (C)(____)_____-_____** **Email:_____** **Emergency Contact Information** **Name:_____** **Relationship:_____** **(H)_(___)_____-_____ (C)_(___)_____-_____** **Date of Birth: ____/____/_____ Sex: M/F** **How did you hear about us?_____**	**Reason for Visit:_____** **_____** **_____** **Is this condition getting worse? (circle) Yes , No , Unsure** **What the condition feels like: (circle all that apply)** • **Sharp, Dull, Ache, Shooting, Numb, Tingling** • **Burning, Cramps, Stiff, Swelling, Other** **Other:_____** **How long has the condition been present?:_____** **Is it constant or OFF/ON?: _____** **Does it interfere with your activity? (check all that apply)** **___Work ___Sleep ___Daily Routine ___Recreation** **What makes the problem worse? (check all that apply)** **___Standing ___Sitting ___Walking ___Laying Down** **___Driving ___Exercise ___Twisting/Turning** **___other:_____**
Accident Information ONLY	**Place "X" on areas of the Condition on Portrait**
Is your visit due to an accident? (circle) Yes / No **Date of accident:_____** **What type of accident did you have?(circle)** **Auto Home Work Recreational Sport Other** **Please Explain:_____** **_____** **Have you missed work or school? (circle) Yes / No** **If yes how much?_____** **Are you under workers comp? (circle) Yes / No** **Do you have an attorney? (circle) Yes / No** **If yes please provide contact information** **_____** **_____**	

Health History (list and date)	Social / Family / Occupational
Surgeries: **Allergies:** **Medications:** **Supplements:** **Hospitalized:** 	**Social History: (Circle all that apply to you)** • Caffeine use: occasional , often , never • Drink Alcohol: ___p/week or ____p/day ____none • Exercise: occasional , often , never • Drink Water: 64 oz/day , >64 oz/day , very little • Cigarettes: <1 pack/day , >1 pack/day , never • Sleep: <8 hours/night , 8 hours/night or more , Insomnia **Family History: (Indicate you and family members)** • Arthritis: _____ • Cancer: _____ • Diabetes: _____ • Heart Disease :_____ • Hypertension:_____ • Stroke:_____ • Thyroid:_____ • Other:_____ **Occupation(s):**_____

INSURANCE INFORMATION

- **Insurance Company**_____
  - **Plan ID #**_____
  - **Group #**_____
  - **Insurance Company Address**_____
    - **City**_____ **State**_____ **Zip**_____
    - **Phone (____)_____-_____**

- **Primary insured same as patient? (circle) YES , NO – if "no" please fill out below**
  - **Patient Relationship to Insured: Spouse , Child , Other**
  - **Insured Name**_____
  - **Insured Address**_____
    Address City State zip
  - **Insured D.O.B.**_____/_____/_____
  - **Insured Gender: (circle) M , F**
  - **Insured Phone (_____)_____-_____**

Appointments cancelled less than 24 hours of scheduled appointment will be charged a $35 cancellation fee.
(initial _____)

INFORMED CONSENT

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic treatment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle
strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and
risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read (initial ___) or have had read to me (initial_____ the above explanation of the Chiropractic adjustment and related treatment.

By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

I understand that Georgia Advanced Healthcare can use an open room adjusting approach. If this approach is unfavorable or undesirable to me, I understand that private rooms will be available upon request.

Print Name(s) of Doctor Treating This Patient: _____

Printed Name of Patient & Date: _____

Signature of Patient & Date: X_____

Signature of Patient's Representative & Date: _____

Witness to Patient's Signature &Date: _____

Translated by Signature/ Date: _____
(If applicable)

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the Physician named above and/or other licensed Physicians who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for Physician named above.

I have read and understand the *patient privacy policy* document:

Signature and Date X_____

Consent to Treatment and Insurance Billing

Georgia Advanced Healthcare's transition to a Multidisciplinary Practice and updated taxonomy code.

I acknowledge and consent to receive services from an integrated team of healthcare professionals.

I authorize Georgia Advanced Healthcare to bill my health insurance for all services rendered by the medical team on staff. I understand that this consent applies to the full scope of care provided within the practice.

Print Name: _____
Parent or Patient Signature: _____

Date: _____