Atlanta Health & Wellness

Confidential Healthcare Information

Today's Date: _______________

Name: ____SS#:_______-_____-_________

Address: ____

City: _____________________________ State: ____ Zip: ______________ Gender: (M) (F) Age____ Date of Birth: ___/___/______

HMPhone: __________________________ WKPhone: __________________________ Cell Phone: __________________________

Occupation: _________________________________Employer:____

Number of Children: ______ Martial Status: (M) (S) (D) (W) (O) e-mail:____

Spouse's Name: __________________________________ *WK#*:__________________________ *Cell:* ________________________

Activities/Sports/Hobbies: ____

Guardian's Name (if under 18) ______________________________________ Phone: __________________________________

Have you seen a chiropractor before? (Y) (N) whom may we thank for referring you? ___________________________________

IN CASE OF EMERGENCY

Nearest Relative not living with you: _______________________ Phone: __________________________ Relationship: __________

Contact that is not a relative: _____________________________Phone: __________________________Relationship: ___________

Primary Care Physician: _________________________________ Office Phone: ____

Address: ____ City: __________________ State: ______ Zip: ______________

MEDICAL HISTORY

(*Check all that apply, past or present symptoms)*

___Headaches

___High Blood Pressure

___Leg Cramps

___Weakness of Limbs

___Allergies

___Stress

___Joint Pain

___Neck Pain

___Lower Backaches

___Fatigue (A.M.) (P.M)

___Asthma

___Dizziness

___Upper Backaches

___Nervousness

___Digestive

___Stiff Neck, Low Back

Are you tired when you wake up? (Y)(N)

Pain Level 0=no pain 10=worst pain ☺ **0-1-2-3-4-5-6-7-8-9-10** ☹

Are you taking any medications? List: ____

List any accidents/traumas/surgeries: ____

Any others not listed above? ____

Is there a family history of? Cancer, Heart Disease, Diabetes Other: ____

Females: Are you pregnant? (Y)(N)

Do you have health insurance? (Y)(N) Company? ____

Insurance Customer Service #: ________________________________Policy ID# __________________________________

<u>Please read the following carefully and sign that you understand and agree to the terms listed below</u>

___I authorize the release of any information pertinent to my case to any insurance company of adjuster for purposes of obtaining payment for my bills.

___I further authorize and direct my insurance company, listed above, to pay Atlanta Health & Wellness (AHW) directly for services rendered at 2000 Cheshire Bridge RD Ste: E Atlanta, GA or any other location where I may receive healthcare services from AHW.

___In case of insurance, I understand that AHW submits my claims to my carrier as a courtesy to me, the patient. Furthermore, I understand that whatever amounts are not collected from insurance, I am personally responsible for.

___I understand that in the event of a returned check a $35 return check fee will apply.

___I acknowledge that I have received and read the notice of privacy practices.

Patient Signature: ____ Date: ____________________

If patient is a minor: I herby give my consent and permission for ____________________________________ to be treated in this office and furthermore agree to the aforementioned.

Parent/Guardian's Signature: ____