Name: ______________________________ Birthdate: ___/__/_____ Sex: Male_____Female_______

Address: ________________________ City: ___________________ State: _____ Zip Code: ______

Home#:____________ Work#:_________________ Cell#:___________________________

Email: ________________________________ Preferred Language: ________________________

Preferred method of communication for office appointments: Text______ Email ____________________

Marital Status: Married ____ Divorced ____ Single ____

Occupation: _____________ Employer: ________________________________Yrs Employed: _____

Employer Address: ______________________City: ____________________State:_____Zip:_______

Spouse's Name: _______________Occupation: __________________Employer: _______________

Emergency Contact and Phone Number: ____

Insurance Provider: ________________________ Subscriber/Member #: _______________________

What is your chief complaint: ____

Cause of condition: ____

Have you had similar conditions in the past? Yes __ No __

How did you hear about us? ____

<u>ACCIDENT INFORMATION</u> *** Notify Front Desk of Auto Medpay Benefits***

Did your accident occur while at work? Yes __ No __ Injury Reported to Employer? Yes __ No __

Were you involved in an automobile accident? Yes __ No __ Date: _____________Time: _____________

Do you have an attorney? If so, Provide name and phone number: ______________________________

I clearly understand that all services rendered to me are charged directly to me & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered to me will be immediately due & payable.

Patient Signature: ____ Date:______________

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (we) hereby consent to the performance of examination and treatment on me or on ________________________________, by the licensed doctors of chiropractic, medical doctors, and/or therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts of information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts know that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strains/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment

Female patients: By my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period __________.

Patients Name: ____Date: __________

Patient Signature: ____

Relationship/authority if not signed by patient: ___________________________________

Witness: ____

TEXT MESSAGE POLICY

Hamilton Mill Chiropractic uses automated text messaging for appointment confirmation and reminders. These are sent via out automated system as an SMS message to your cell phone. Consent to this service may incur additional charges to your cellular bill if your provider charges you for text messages. If you consent to this notification, please provide your cell number and cell provider below

CELL NUMBER____________________________ CELL PROVIDER__________________________

REQUEST FOR RELEASE OF RECORDS

Name: ____ Acct #: ________________

Address: ____City: _________________ State: _____ ZIP: _________

Home Phone: ______-______-________

S.S.N.: ______-____-____ Birth Date: __________________

I hereby request the release of the records of my treatment at:

____to:

HAMILTON MILL CHIROPRACTIC

3613 Braselton Hwy #101

Dacula, GA 30019

678-482-2014

Reason for records release:

____Independent Medical Examination

____Second Opinion

____Patient Moving

____Other: _______________________

Patient/Parent/Guardian's Signature: ____Date: ____________

Note: *Upon the receipt of your signed authorization, compiling of your records will begin. Depending upon the extent of the file, there may be a charge to provide the records. If there is a charge, you will be notified of the amount and once payment is received on our office, records will be forwarded.*

Health History Form

Name ____

Age ____________ Date of birth ______________ Sex ____________

Occupation ____

Patient's Chief Complaint ____

____

____

Medications (List all medications you are currently taking.)		Allergies (List all allergies)

Patient's Past History:

Do you have or have you ever had the following? Check each box that is answered "yes".

__Headaches, dizziness, fainting
__Blurred vision
__Sinus trouble
__Asthma
__Sore throats
__Shortness of breath
__Persistent cough
__Night sweats
__Arthritis
__ Chest pain
__ High blood pressure
__ Heartburn or indigestion
__ Nausea and/or vomiting
__ Stroke
__ Ringing in Ears
__ Sudden weight gain or loss
__ Kidney disease or stones
__ Painful and/or difficult nutrition
__ Become tired or upset easily
__ Depression
__ Convulsions
__ Back pain or injury
__ Diabetes
__ Prior spinal surgeries

Please use the space below to explain any "yes" answers.

Serious Illness/Injuries/Hospitalizations	**Date**	**Outcome**

Patient's Family and Social History:

	Yes	No	Amount/How Often
Do you use tobacco?	○	○	______________
Do you use drugs?	○	○	______________
Do you use alcohol?	○	○	______________
Do you exercise regularly?	○	○	______________

Relation	**Age**	**State of Health**	**Serious Illness and/or Cause of Death**
Father			
Mother			
Brother			
Sister			

Patient Signature: ______________________________ **Date:**____________