Dr. G Mac Miller

Optimal Health Center of Canton
1030 Marietta Rd. Canton, GA 30114
PH: 770-720-8668 Fax: 866-281-9900

About You

Name: _____ What do you prefer to be called? _____
Birthdate: _____/_____/_____ Age: _____ SS#: _____-_____-_____ Male_____ Female_____
Address: _____
_____
Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____
Referred By: _____ Email Address: _____
Employer: _____ How Long: _____ Occupation: _____
Status: Minor___ Single___ Divorced___ Separated___ Widowed___ Spouse's name: _____
Do you have children: _____ If so, how many: _____

Please tell us what types of care you are interested in: (check all that apply)

_____ Chiropractic Care
_____ Acupuncture
_____ Symptomatic Relief
_____ Spinal Decompression
_____ Massage Therapy
_____ Wellness Care

Would you like to be added to our email list?

☐ YES! Sign me up!
☐ No thank you.

Account Information
[Person ultimately responsible for account]

Name: _____ *or* Self [initial] _____
Relation: _____
Billing Address: _____
_____

___ [initial] I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. (If offered at this office)

Insurance Information

Primary Insurance: _____
Insured's Name: _____
Insured's Relation: _____ DOB: __/__/__
Insured's Employer: _____

Secondary Insurance: _____
Insured's Name: _____
Insured's Relation: _____ DOB: __/__/__
Insured's Employer: _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. [initials] ____ [date] ___/___/___
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. [initials] ____ [date] ___/___/___

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. [initials] ____ [date] ___/___/___

Patient Signature: _____ Date: _____

In Event of Emergency

Whom should we contact: _____ Relation: _____

Home #: (____)____-_____ Work #: (____)____-_____ Cell #: (____)____-_____

Who is your Medical Doctor: _____ Medical Doctor's Phone #: _____

Reason for visit

Reason for today's visit: Emergency___ New injury___ Old injury___ Chronic pain ___ Wellness___

Are you in pain: Yes___ No___ Rate your pain on the following scale _____

1 2 3 4 5 6 7 8 9 10 [intensity]

Did your injury occur during: Work___ Sports/play___ Auto Accident___ Routine/Household Activity___

When did your condition/accident occur? ___/___/___ Where did your injury occur?_____

Please explain what happened? _____

Is your condition getting worse? Yes___ No___ Constant___ Comes & Goes___

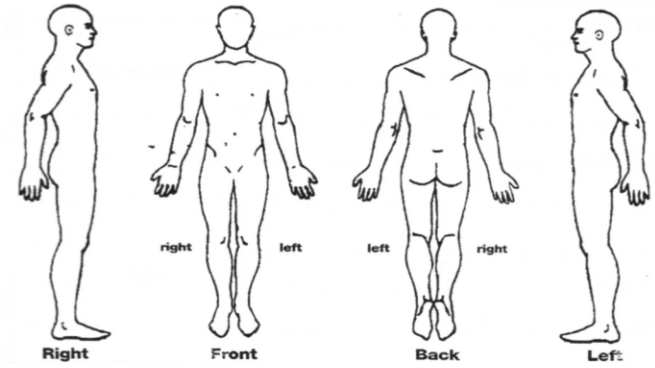
Is your condition interfering with your: Work___ Sleep___ or Daily routine___? If so, how: _____

Has this or something similar happened in the past?
Yes___ No___ Explain: _____
_____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? Yes___ No___ If so, where? ___
_____

Have you ever been treated by a Chiropractor?
Yes___ No___
Clinic or Dr's name: _____
Clinic phone #: _____



Health History

Are you taking any of the following medications? Nerve Pills___ Pain Killers (including aspirin)___
Muscle Relaxers___ Blood Thinners___ Tranquilizers___ Insulin___ Others_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Frequent Neck Pain	Y N Severe/Frequent Headaches
Y N Artificial Valves	Y N Rheumatic Fever	Y N Emphysema/Asthma
Y N Shingles	Y N Sinus Problems	Y N Artificial Bones/Joints/Implant
Y N Heart Surgery/Pacemaker	Y N Lower Back Problems	Y N Mitral Valve Prolapse
Y N Alcohol/Drug Abuse	Y N Congenital Heart Defect	Y N HIV + / AIDS / ARC
Y N Cancer	Y N Hepatitis	Y N Anemia/Diabetes
Y N Heart Murmur	Y N Glaucoma	Y N Kidney Problems
Y N High/Low Blood Pressure	Y N Ulcers/Colitis	Y N Difficulty Breathing
Y N Psychiatric Problems	Y N Fainting/Seizures/Epilepsy	Y N Chemotherapy
Y N Tuberculosis	Y N Arthritis	Y N Venereal Disease

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:_____
_____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you exercise? Yes___ No___ _____hours per week Are you dieting: Yes___ No___ Since__/__/__

For women: Are you taking Birth Control? Yes___ No___ Are you nursing? Yes___ No___

Are you Pregnant? Yes No If so, how many weeks?