MIDTOWN SPECIALTY GROUP, LLC

197 14TH Street N.W., Ste 100, Atlanta, Georgia 30318
P 404-343-1649 F 404-343-6615
Dawn Wilson, MD Robert Burton, MD Akinlolu Omitowoju, MD

Please complete all forms to the best of your knowledge. This confidential history will be part of your permanent record. Thank you.

Name _____ Date of Birth_____ Sex M / F

Address _____ Apt #_____ City _____ County _____ State _____ Zip _____

Social Security # _____ Home Phone _____ Cell Phone _____

Marital Status: Single Married Divorced Widowed (Circle ONE) Number of Children _____ Ages _____

Occupation: _____ Employer _____

Emergency Contact: Name _____ Phone # _____

Accident and Pain Information

What is your reason for today's visit? _____

Date of Injury _____ Cause of Injury: Motor Vehicle Accident Fall Other (Circle ONE)

Have you had this or a similar condition in the past? _____

Which body positions RELIEVE your symptoms? _____

Which body positions make your symptoms WORSE? _____

Is this condition GETTING BETTER UNCHANGED GETTING WORSE since the accident? (Circle ONE)

List ANY Doctors or Therapist who have treated this condition, other than Midtown Specality Group, since the accident. _____

List any past surgical procedures and the years they were done: _____

Name and address of your PRIMARY CARE PHYSICIAN: _____

All medications, dosage and frequency: _____

Auto Accident or Personal Injury Information

Have you retained a lawyer? YES Name and Phone Number of Attorney_____
NO Would you like one to contact you? _____

Health Insurance/ Auto Insurance/ Worker's Compensation

Primary Insurance Co.: _____ Address: _____ Phone # _____
Policy #: _____ Group #: _____ Type: Group Private
Secondary Insurance Co.: _____ Address: _____ Phone # _____
Policy #: _____ Group #: _____ Type: Group Private
Complete if Insured is DIFFERENT than patient: Insured's Name _____ DOB _____
Relationship to patient _____ Insured's Employer _____
Automobile Accident/Worker's Compensation:
Insurance Company: _____ Address: _____ Phone#:_____
Adjuster's Name: _____ Phone #: _____ EXT: _____
Claim # _____ Policy # _____ Date of Injury _____

RELEASE AND ASSIGNMENT

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I HEREBY ASSIGN AND REQUEST PAYMENT DIRECTLY TO MY HEALTH CARE PROVIDER.

Patient's Signature: _____Date: _____
Parent or Guardian: _____ Date: _____

HEALTH HISTORY

Name: _____ Sex: M / F Age: _____ Height: _____ Weight _____

Handedness: Right Left Both (Circle One) Primary Care Physician: _____

SYMPTOMS

Please check if you currently have or have had in the past

GENERAL
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of Weight
Nervousness
Numbness
Sweats

Muscle/Joint/Bone
Pain, Weakness/numb
Arms Hips
Back Legs
Neck Feet
Hands Shoulder

Genito-Urinary
Blood in Urine
Frequent Urination
Lack of bladder control
Painful Urination

GASTROINTESTINAL
Poor Appetite
Bloating
Bowel Changes
Constipation
Diarrhea
Excessive Hunger
Excessive Thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach Pain
Vomiting
Vomiting Blood

Cardiovascular
Chest Pain
High Blood Pressure
Irregular heart beat
Low Blood Pressure
Poor Circulation
Rapid heartbeat
Swelling of Ankles
Varicose Veins

EYE, EAR, NOSE, THROAT
Bleeding gums
Blurred Vision
Crossed Eyes
Difficulty Swallowing
Double Vision
Earache
Hay Fever
Hoarseness
Loss of Hearing
Nosebleeds
Ear Discharge
Persistent Cough
Ringing in Ears
Sinus Problems
Vision- Flashes
Vision- Halos

Skin
Bruise Easily
Hives
Itching
Change in moles
Rash
Scars
Sores that will not heal

MEN ONLY
Breast Lump
Erection Difficulties
Lump in Testicles
Penis Discharge
Sore on Penis
Other

Women ONLY
Abnormal Pap Smear
Bleeding between periods
Breast Lump
Extreme menstrual pain
Hot Flashes
Nipple discharge
Painful Intercourse
Vaginal Discharge
Other
Last Menstrual _____
Last Pap Smear _____
Last Mammogram _____
Pregnant? Yes No
Number of Children _____

CONDITIONS

Please check if you currently have or have had in the past

AIDS
Alcoholism
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding disorders
Breast Lump
Bronchitis
Bulimia
Cancer
Cataracts
Sickle Cell Anemia
Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herpes
High Cholesterol
HIV positive
Kidney Disease
Liver Damage
Measles
Migraine Headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Pacemaker
Pneumonia
Polio
Prostate Problems
Psychiatric Care
Rheumatic Fever
Scarlet fever
Stroke
Suicide Attempt
Thyroid Problems
Tonsillitis
Tuberculosis
Typhoid Fever
Ulcers
Vaginal Infections
Venereal Disease

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

_____

_____

LIST ALL ALLERGIES (i.e. Medicine, Shell Fish, Nuts, Dairy, etc.)

_____

_____

FAMILY HISTORY

Fill in health information regarding blood relatives

Relation	Age	State of Health	Age of Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				

CHECK IF	YOU OR A BLOOD RELATIVE HAS HAD ANY OF THE FOLLOWING.	RELATIONSHIP TO YOU
	Arthritis or Gout	
	Asthma or Hay Fever	
	Cancer	
	Chemical Dependency	
	Heart Disease, Heart Attacks, or Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	
YEAR OF ANY HOSPITALIZAITIONS	**REASON FOR HOSPITALIZATION**	**HOSPITAL**
YEAR OF ANY BIRTHS	**COMPLICATIONS IF ANY WHILE PREGNANT OR WHILE IN LABOR.**	**SEX OF BABY**

✓	Check which substance you use	How much on a daily basis?	✓	OCCUPATIONAL CONCERNS: Check if your work exposes you to the following
	Caffeine			Stress
	Tobacco			Hazardous Substances
	Drugs			Heavy Lifting
	Other			Other

HAVE YOU EVER HAD A BLOOD TRANSFUSION? NO YES IF YES LIST DATES _____

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

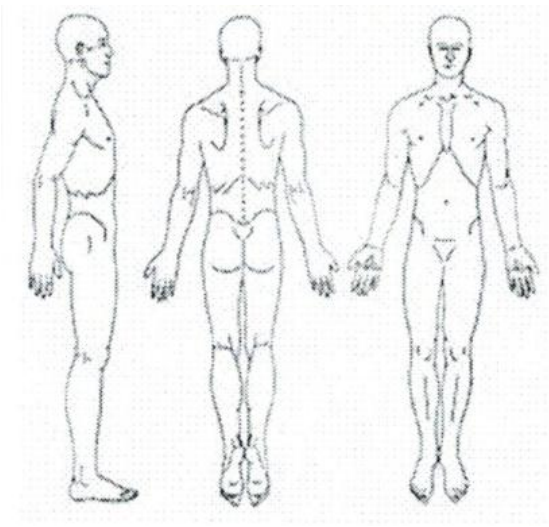
Patient Signature _____ Date _____

Reviewed By _____ Date _____

PAIN QUESTIONNAIRE

Patient Name _____ Date of Birth _____Today's Date_____

INDICATE THE LOCATION OF YOUR PAIN ON THE PICTURES BELOW.



PLEASE RATE YOUR PAIN ON THE SCALE BELOW.

0	NO PAIN
1	VERY MILD
2	DISCOMFORTING
3	TOLERABLE
4	DISTRESSING
5	VERY DISTRESSING
6	INTENSE
7	VERY INTENSE
8	UTTERLY HORRIBLE
9	EXCRUCIATING / UNBEARABLE
10	UNIMAGINABLE / UNSPEKABLE

PLEASE CHECK IF ANY OF THE FOLLOWING DAILY TASKS INCREASE PAIN

- o Bathing
- o Showering
- o Washing Hair
- o Making Bed
- o Getting Dressed
- o Putting on Shoes/tying Shoes
- o Cooking
- o Cleaning
- o Doing Laundry
- o Taking Out Trash
- o Going to the bathroom
- o Standing
- o Sitting
- o Laying Down
- o Walking
- o Squatting
- o Kneeling
- o Bending
- o Twisting
- o Prolonged Sitting
- o Prolonged Standing
- o Prolonged Driving
- o Prolonged Walking
- o Child Care
- o Sleeping
- o Sexual Activity
- o Work Related Duties (specify)

  _____
  _____
  _____
- o Other (Hobbies, etc., specify)

  _____
  _____
  _____

AUTOMOBILE ACCIDENT DESCRIPTION

Please answer the questions below. If you are unsure or do not know an answer, please leave it blank.

1. VEHICLE TYPE

Car SUV Van Truck
Bus Commercial Vehicle
Public Transportation
Other _____

2. YOUR POSITION IN THE VEHICLE

Driver Front Passenger
Left Rear Passenger
Right Rear Passenger
Other _____

3.WHAT WAS YOUR VEHICLE DOING

Stopped in Traffic Stopped at Light
Intersection Left / Right Turn
Slowing Down Accelerating
Other _____

4. TIME/SPEED/DAMAGE

Time of Accident _____AM / PM
YOUR Speed _____
THEIR Speed _____
Damage to **YOUR** Vehicle
Mild Moderate Totaled
Dollar Amount $_____
Year/Make of your car _____

5. DETAILS OF ACCIDENT

Visibility at the time of Accident
Poor Fair Good

Who Hit Whom/What?
You Hit Other Vehicle
Other Vehicle Hit You
You Hit Object _____

6. ROAD CONDITION

Road condition at time of Accident
Icy Wet Sandy Dry Dark

Point of Impact
HEAD ON Left Front Right Front
REAR-END Left Rear Right Rear

7. BODY POSITION, ETC.

Did you see the accident coming? Yes / No
Where you braced for impact? Yes / No
Did you have your seat belt on? Yes / No
Did you have your shoulder strap on? Yes / No
Did SIDE Airbags Deploy? Yes / No
Did the DRIVER'S SIDE Airbags Deploy? Yes / No

Does your vehicle have Head Rests? Yes / No
Position of your head rest at the time of Impact:
Even w/ top of head Even w/ Bottom of head Middle of neck
What was the direction of your head at time of impact?
Facing Forward Turned Right Turned Left Facing Down
Did PASSENGER'S Airbags Deploy? Yes / No

8. ADDITIONAL ACCIDENT INFORMATION

_____
_____
_____

9. DURING THE ACCIDENT

Did your body strike the inside of vehicle? Yes / No If yes, describe: _____
Did you lose consciousness? Yes / No If yes, how long: _____
Damage to **THEIR** vehicle? Mild Moderate Totaled
Did the police show up at the scene? Yes / No If yes, was an accident report filed? Yes / No

10. After the Accident

Circle any of your symptoms following the accident

Headache	Dizziness	Mid Back Pain
Neck Pain	Nausea	Low Back Pain
Neck Stiffness	Confusion	Nervousness
Depression	Tension	Anxious

Lacerations, If so where? _____
Other _____

11. Emergency Room and Treatment History

Where did you go after the accident? Home Work Hospital Doctor
How did you get there? Drove Self Ambulance Friend/Family
Were X-rays taken? Yes / No Medications given? Yes / No
Type of Lab Work _____
Any other tests (MRI, CAT SCAN, ETC.) _____
Fill in other doctor's seen prior to your visit here including hospital visits
1 _____ Date _____
2_____ Date _____

Have you missed any days of work/school due to your injuries from THIS accident?

No _____ Yes (List ALL Dates) _____

Attorney Name: _____
Phone # _____
Fax #_____

AUTO INSURANCE ADJUSTOR _____
Phone #_____ Ext _____
Claim # _____

AUTHORIZATION AND RELEASE

CONSENT FOR TREATMENT

I, the undersigned hereby authorize the Doctors of Midtown Specialty Group, LLC and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment when necessary.

I, also, certify that no guarantee or assurance has been made to the results that they may be obtained.

I understand and agree that accident insurance policies are an arrangement between and insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature _____ Date _____ Witness _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature _____ Date _____ Witness _____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the _____ Insurance company/Insurance Administer to pay by check, and for it to be mailed directly to Midtown Specialty Group, LLC the expense benefits allowable and otherwise payable to me under my current policy and other wise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature _____ Date _____ Witness _____

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient, am directing my Attorney, _____ to pay an outstanding bills out of my settlement and, in effect, protecting any such balance,. I hereby make and declare the instructions herein contained to be contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Patient's Signature _____ Date _____ Witness _____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize the Doctors of Midtown Specialty Group, LLC and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my _____(indicate relationship to child) _____ (child's name).

Guardian's Signature _____Date _____ Witness _____

X-RAYS/MEDICAL RECORDS RELEASE

I have requested the release of record of _____(patient's name) which are part of the records at

Midtown Specialty Group, LLC.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and Photostat copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment, or opinion concerning any condition that may have had in the past, no have or may have in the future.

Please forward this information to Midtown Specialty Group, LLC **197 14th Street NW, Suite 100, Atlanta GA 30318**

Patient's Signature _____ Date _____ Witness _____

VERIFICATION OF NON-PREGNANCY

Due to the nature of the treatment you are about to receive it is not recommended during pregnancy. If at anytime during your treatment you think there is a possibility you may be pregnant please let the office know immediately.

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. If this status should change at any time I will notify Midtown Specialty Group, LLC of the change immediately.

_____ _____

Patient Signature Witness

DATE: _____

NAME: _____ **SS#**_____

ADDRESS: _____

City State Zip

PHONE # _____

EMERGENCY CONTACT_____

Name Phone#

WOMEN ONLY

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Name of Parent or Guardian if Patient a Minor: _____

Patient's Complete Social Security # _____ - _____ - _____ Patient's Date of Birth: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Work / Cell: _____

I authorize representatives from the following facility/facilities to disclose the health information as directed below (name of hospital/facility) _____

to release: □ Complete Medical Records □ Itemized Billing Statements

Mail or fax copies of my records to: **Midtown Specialty Group, LLC**
ATTN: _____
197 14th Street NW, Suite 100
Atlanta, GA 30318

This authorization applies to the following date(s) of service _____

Purpose of Use or Disclosure: □ At the request of the individual (patient) □ Medical Follow Up

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the dates of service indicated, and for the purpose written above.

I further understand that this Authorization will expire one year from the date signed. _____ Initial

_____ _____ _____

Patient's or Legal Representative's Signature Print Name Today's Date

As Legal Representative my relationship to the patient is _____. Any document proving such authority **must be attached.** The patient is unable to sign because _____

_____