Dr. Sean Savedoff
11705 Jones Bridge Rd., D-102, Johns Creek, GA 30005
Located Inside Scoliosis Specialists
(404) 431-5370

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City_____ State_____ Zip_____

Phone # (M)_____ (H) _____ (W) _____

Can we call you at work? ❑ Yes ❑ No Can we email you reminders, events, and newsletters? __Yes __No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity: ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Mobile #: _____

Phone #: (H) _____ (W) _____

Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

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Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)_____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

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Review of Systems

SIGNATURE (X) _____ **DATE** _____

Please mark if you have experienced any of these symptoms within the last month:

Y	N	**Neurological**
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Eyes/Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Twitching eye lids
___	___	Sensitivity to light
___	___	Sensitivity to smells, chemicals
___	___	Gingivitis
___	___	Nose bleeds
___	___	Sensitivity to sound
___	___	Bad breath
___	___	Mouth sores
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Frequent muscle cramping
___	___	Muscle Aches
___	___	Pain in shoulders or upper back
___	___	Muscle twitching

Y	N	**Skin**
___	___	Eczema
___	___	Dry skin
___	___	Receive static shock more often
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
___	___	Low Body Temp.
___	___	Persistent fungal or viral infections, including athletes foot, warts, jock itch or candidiasis
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
___	___	Excessive thirst or frequent urination
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
___	___	Indecisiveness
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

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NEUROLOGICAL/TOXICITY QUESTIONNAIRE

For any YES answer, please include details.

Heavy Metals

1. Do you have amalgam (silver) fillings in your teeth? NO YES
   Comment: _____
2. Have you ever had them in the past? NO YES
   Comment: _____
3. Did your mother have amalgam filings when pregnant with you? NO YES
   Comment: _____
4. Have you ever worked in a dental office? If so, how long? NO YES
   Comment: _____
5. Have you had any dental crowns, bridges, root canals, dry sockets or extractions? NO YES
   Comment: _____
6. Do you have any dental implants or other metal in your mouth? NO YES
   Comment: _____
7. Did you wear contact lenses during the 1980's or early 1990's? NO YES
   Comment: _____
8. Did you take oral contraceptives during the 1980's or early 1990's? NO YES
   Comment: _____
9. Did you receive yearly flu shots or have you recently received a flu shot or vaccination? NO YES
   Comment: _____
10. Have you noticed any adverse reactions to these shots? NO YES
    Comment: _____
11. Do you have any tattoos with red ink? NO YES
    Comment: _____
12. Do you eat large amounts (more than twice a week) of tuna, shark, or Atlantic salmon? NO YES
    Comment: _____
13. Does your occupation involve soldering, metal salvage, old home repair? NO YES
    Comment: _____
14. Have you remodeled a home built before 1978? NO YES
    Comment: _____
15. Have you lived in a home built before 1978 for more than 5 years? NO YES
    Comment: _____
16. Have you ever worn cosmetics containing kohl? NO YES
    Comment: _____

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General Toxicity

17. Have you ever lived near, on or by a golf course, freeway or tension wires? NO YES
    Comment: _____

18. Have you ever had any chemical exposures? NO YES
    Comment: _____

Mold

How old is the house you are living in? _____How long have you lived there?_____

19. Do you see mold growing at home, work or school? NO YES
    Comment: _____

20. Have you ever had water damage at home, work or school? NO YES
    Comment: _____

21. Does your home, workplace or school have a damp or mildew smell? NO YES
    Comment: _____

22. Does spending time in your basement cause or worsen your symptoms? NO YES
    Comment: _____

23. Does your basement ever get wet?? NO YES
    Comment: _____

24. Does spending time in a different location cause a decrease in your symptoms? NO YES
    Comment: _____

Lyme Disease

25. Have you ever been diagnosed with Lyme disease? NO YES
    Comment: _____

26. Have you ever been bitten by a tick or recluse spider? NO YES
    Comment: _____

27. Have you ever seen a bulls-eye rash appear on any part of your body? NO YES
    Comment: _____

28. Did the bulls-eye rash appear shortly after following a tick, spider bite? NO YES
    Comment: _____

29. Was your mother ever diagnosed with Lyme Disease? NO YES
    Comment: _____

30. Do you frequently go camping, hunting or are you involved in outdoor activities? NO YES
    Comment: _____

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Health

31. Any family been diagnosed with fibromyalgia, chronic fatigue or chemical sensitivity? NO YES
    Comment: _____

32. Do you have any history of kidney dysfunction? NO YES
    Comment: _____

33. Is there a family history of breast, uterine, cervical or other female cancers? NO YES
    Comment: _____

34. Is there a family history of PMS, fibroids or ovarian cysts? NO YES
    Comment: _____

35. Do you have any history of heart disease, myocardial infarction (heart attack), etc? NO YES
    Comment: _____

36. Are you currently having any thoughts of suicide? NO YES
    Comment: _____

37. Have you ever been diagnosed with bipolar disorder, schizophrenia or depression? NO YES
    Comment: _____

38. Do you have a history of strokes? NO YES
    Comment: _____

39. Have you ever been diagnosed with diabetes mellitus? NO YES
    Comment: _____

40. Have you ever been in an auto accident, fallen or received a major physical injury? NO YES
    Comment: _____

41. Are you in menopause? NO YES
    Comment: _____

42. Do you have any allergies to food or medication? NO YES
    Comment: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Revolution Health LLC. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date