ADVANCED HEALTHCARE

Patient Information

Appointment Date: ______________________

Name: ____
Last First MI

Email Address: ____

Mailing Address: ____
City State Zip

Phone #: (H) ____________________ (Cell) ____________________ (W) ______________________________

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____________ Gender: ❑ M ❑ F ❑ ____ Sex at Birth: ❑ M ❑ F 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:___________________________________ Relation: ______________________________

Phone #: (H) ____________________ (Cell) ____________________ (W) ______________________________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? □ Auto □ Work □ Other: ___________

Has it been reported? ❑ Yes ❑ No If yes, to whom? ____________________________________

Insurance Information

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

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

Policy Holder Name: ____ DOB: ____________________________

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

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

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _________________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. 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 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 the signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ____ **DATE:** ____________________

ADVANCED HEALTHCARE

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the above consent form.

Signature: X____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Advanced Healthcare PLLC.
(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. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

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.

X____ ______________________
Signature of Patient/Guardian Date

X____ ______________________
Witness (Office Staff) Date

ADVANCED HEALTHCARE

Name: ______________________ DOB: ______________ Date: ______________

Health History

Vitals: Ht: _____ Wt: _____ BP: _____ P: _____ SP02: _____

Medical History:

- ❑ Arthritis
- ❑ Herniated Disc
- ❑ Migraines
- ❑ Osteoporosis
- ❑ Pinched nerve
- ❑ Ulcers
- ❑ Bleeding Disorders
- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Pacemaker
- ❑ Stroke
- ❑ Cancer
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Rheumatoid Arthritis
- ❑ Thyroid Issues

Please Describe (if applicable): ______________________________

____

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Are you currently under drug and/or medical care? ❑ Yes ❑ No Who is your primary care doctor? ______________

Please all medications: (*Be sure to include dosage and frequency*) ______________________________

____

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Supplements (*vitamins/herbs/minerals*):______________________________

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Allergies: ______________________________

____

Surgeries and/or hospitalizations (*type & date*): ______________________________

____

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Approximate Date of last Flu vaccine: __________

WOMEN ONLY Date of LMP: ______________ ***Any possibility of pregnancy***? ❑ Yes ❑ No

Is there a family history of any of the following conditions? <u>(Indicate family member including parents, grandparents & siblings):</u>

- ❑ Heart Disease ______________________
- ❑ Diabetes ______________________
- ❑ Other ______________________
- ❑ Cancer ______________________
- ❑ Arthritis ______________________

Intake of following: Cigarettes _____ packs/day Alcohol_______ drinks/week Caffeine ____ cups/day

Exercise frequency: ❑Never ❑Daily ❑ Weekly_________ ❑Walks ❑Runs ❑Swims___________

Occupation: ________________ Does work mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Reviewed with patient by: __________

Notes: ______________________________

____

____

Review of Systems

Y N **Neurological**
___ ___ Migraines
___ ___ Headaches
___ ___ Slurring of Speech
___ ___ Ringing in Ear(s)
___ ___ Pins & Needles- Arms
___ ___ Pins & Needles- Legs
___ ___ Cold Hands/Feet
___ ___ Dizziness

Ear/Nose/Throat
___ ___ Altered taste/smell
___ ___ Night Blindness
___ ___ Sore Throat
___ ___ Gingivitis
___ ___ Nose Bleeds
___ ___ Loss of Smell
___ ___ Loss of Taste
___ ___ Blurred Vision

Cardiovascular
___ ___ Chest Pain
___ ___ Heart Palpitations
___ ___ Swelling in hands/feet
___ ___ Anemia

Respiratory
___ ___ Recurrent Respiratory Infections
___ ___ Allergies
___ ___ Asthma
___ ___ Chest Congestion
___ ___ Wheezing
___ ___ Frequent Sneezing
___ ___ Shortness of Breath

Y N **GI**
___ ___ Stomach Pains/Cramping
___ ___ Constipation
___ ___ Reflux /Heartburn
___ ___ Bloating
___ ___ Gas
___ ___ Nausea/Vomiting

Musculoskeletal
___ ___ Joint Pain
___ ___ Arthritis
___ ___ Chronic Pain
___ ___ Muscle Aches
___ ___ Jaw Problems
___ ___ Tension

Skin/Hair/Nails
___ ___ Eczema
___ ___ Dermatitis
___ ___ Excessive Sweating
___ ___ Rashes
___ ___ Brittle Nails
___ ___ Hair Loss
___ ___ Easy Bruising
___ ___ Increased Bleeding
___ ___ Numbness/Tingling

Emotional/Mental
___ ___ Depression
___ ___ Anxiety
___ ___ Nervousness
___ ___ Mood Swings
___ ___ Irritability
___ ___ Memory Loss
___ ___ Confusion

Y N **Energy**
___ ___ Fatigue
___ ___ Hyperactivity
___ ___ Restlessness
___ ___ Insomnia
___ ___ Decreased Libido
___ ___ Stress

Weight
___ ___ Decreased Appetite
___ ___ Weight Gain
___ ___ Inability to Lose Weight
___ ___ Food Cravings
___ ___ Binge Eating
___ ___ Water Retention
___ ___ Sudden Weight Loss

Genitourinary
___ ___ Uterine Fibroids
___ ___ Ovarian Cysts
___ ___ Cancer (breast, ovarian, prostate, uterine)
___ ___ Prostate Problems

Other Symptoms Not Listed:____
____
____
____
____
____

ADVANCED HEALTHCARE

Name: ______________________________ DOB: ____________ Date: ____________

Date and time of accident? ______________________________

Where were you in the car? (Driver, passenger, etc.) ______________________________

Who else was in the car with you? ______________________________

What happened? (Rear-ended, T-boned, side swiped, etc.) ______________________________

____

How fast were you going? ______________________________

How fast was the other person going? ______________________________

Did you see it coming? Did you brace yourself? ______________________________

Which direction was your head turned at impact? ______________________________

Were you wearing your seatbelt? Did airbags deploy? ______________________________

Did any part of your body strike any part of the interior of the car? ______________________________

____

How did you feel immediately afterwards? (Pain, stunned, woozy, etc.) ______________________________

____

Did you go to the hospital? Were you taken by ambulance? ______________________________

____

What procedures were done at the hospital? (X-rays, MRI, CT, etc.) ______________________________

____

Have you seen other healthcare providers relating to this accident? What procedures did they perform, if any? __________

____

Do you have an attorney? Who is it? ______________________________

Were tickets issued? To whom? ______________________________

ADVANCED HEALTHCARE

Please describe the accident in your own words:

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