

WELCOME

Patient Information

Date: _____ MP _____

Name: _____
Last First MI

Email address: _____

Mailing Address: _____
(City) _____ (State) _____ (Zip) _____

Phone # (H) _____ (W) _____ (Other) _____

Can we call you at work? Yes No

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

Marital Status: Single Married Divorced Widowed Separated Minor Partner

Race Caucasian African American Asian Native American Latin American Other _____

Number of Children and ages _____

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to a recent accident? Yes No If yes, Is there an open claim? Yes No

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

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 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 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 _____

Form 2

Name: _____

Date: _____

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:

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

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

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

What is your chief complaint or primary reason for your visit? _____

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**)

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | | | |

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.

SIGNATURE (X) _____ **DATE** _____

Review of Systems

Name _____

Date _____

Please circle YES or NO if you have experienced any of these symptoms recently:

Yes	No	<u>Neurological</u>
Y	N	Migraines
Y	N	Headaches
Y	N	Slurring of speech
Y	N	Ringing in Ear
<u>Ear/Nose/Throat</u>		
Y	N	Altered taste/smell
Y	N	Night Blindness
Y	N	Sore Throat
Y	N	Gingivitis
Y	N	Nose bleeds
<u>Cardiovascular</u>		
Y	N	Chest pain
Y	N	Palpitations-racing heart beat
Y	N	Swelling in hands/feet
Y	N	Anemia
<u>Respiratory</u>		
Y	N	Recurrent Respiratory Infections
Y	N	Asthma
Y	N	Chest Congestion
Y	N	Wheezing
Y	N	Frequent Sneezing
<u>GI</u>		
Y	N	Stomach Pains or Cramping
Y	N	Constipation
Y	N	Reflux or Heartburn
Y	N	Bloating
Y	N	Gas
Y	N	Nausea or Vomiting
<u>Musculoskeletal</u>		
Y	N	Joint Pain
Y	N	Arthritis
Y	N	Chronic pain
Y	N	Muscle Aches

Yes	No	<u>Skin</u>
Y	N	Eczema
Y	N	Dermatitis
Y	N	Excessive Sweating
Y	N	Rashes
Y	N	Brittle Nails
Y	N	Hair Loss
Y	N	Easy Bruising
Y	N	Increased Bleeding
Y	N	Numbness/tingling
<u>Genitourinary</u>		
Y	N	Uterine fibroids
Y	N	Ovarian cysts
Y	N	Cancer (breast, ovarian, prostate, uterine)
Y	N	Prostate problems
<u>Emotional/Mental</u>		
Y	N	Depression
Y	N	Anxiety
Y	N	Mood Swings
Y	N	Irritability
Y	N	Memory Loss
Y	N	Confusion
<u>Energy</u>		
Y	N	Fatigue
Y	N	Hyperactivity
Y	N	Restlessness
Y	N	Insomnia
Y	N	Decreased Libido
Y	N	Stress
<u>Weight</u>		
Y	N	Decreased Appetite
Y	N	Weight Gain
Y	N	Inability to Lose Weight
Y	N	Food Cravings
Y	N	Binge Eating
Y	N	Water Retention

Food Intolerance and Sensitivity Survey

Date: ___/___/_____

Patient Name: _____

Gender: M/F

Height: Feet _____ Inches _____

Weight: _____ lbs.

Please list all medications you are currently taking: _____

Please complete the following food intolerance and sensitivity questionnaire. Score each symptom based upon your experiences over the last 60 days.

Symptom Scoring System:

- ○ ○ ○ = No Symptoms (Zero Points)
- ● ○ ○ = Experience Mild Symptoms (One Point)
- ○ ● ○ = Experience Moderate Symptoms (Two Points)
- ○ ○ ● = Severe Symptoms (Three Points)

Digestive Symptoms

- ○ ○ ○ Stomach Pains or Cramping
- ○ ○ ○ Constipation
- ○ ○ ○ Diarrhea
- ○ ○ ○ Reflux or Heartburn
- ○ ○ ○ Bloating
- ○ ○ ○ Gas
- ○ ○ ○ Nausea or Vomiting

Weight

- ○ ○ ○ Inability to Lose Weight
- ○ ○ ○ Food Cravings
- ○ ○ ○ Binge Eating
- ○ ○ ○ Water Retention

Sinus/Respiratory

- ○ ○ ○ Stuffy or Runny Nose
- ○ ○ ○ Asthma
- ○ ○ ○ Chest Congestion

Head/ Ears

- ○ ○ ○ Migraines
- ○ ○ ○ Headaches
- ○ ○ ○ Earaches
- ○ ○ ○ Ear Infection
- ○ ○ ○ Ringing in Ears

Eyes/Throat

- ○ ○ ○ Itchy Eyes
- ○ ○ ○ Watery Eyes
- ○ ○ ○ Sore Throat
- ○ ○ ○ Persistent Canker Sores

Emotional/Mental

- ○ ○ ○ Depression
- ○ ○ ○ Anxiety
- ○ ○ ○ Mood Swings
- ○ ○ ○ Irritability
- ○ ○ ○ Poor Concentration

Energy

- ○ ○ ○ Fatigue
- ○ ○ ○ Hyperactivity
- ○ ○ ○ Lethargy
- ○ ○ ○ Restlessness
- ○ ○ ○ Insomnia

Skin Disorders

- ○ ○ ○ Eczema
- ○ ○ ○ Dermatitis
- ○ ○ ○ Rashes
- ○ ○ ○ Hives

Other Symptoms:

- ○ ○ ○ Joint Pain
- ○ ○ ○ Arthritis
- ○ ○ ○ Irregular Heartbeat
- ○ ○ ○ Chest Pains
- ○ ○ ○ Muscle Aches

Please list any symptoms not mentioned:

Total Score: _____

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.

I agree that any claim or dispute, that I may have with and/or against any of these persons and/or entities, will be resolved and finalized between the patients' legal officials and Seneca Healthcare Physical Medicine authorized delegates.

Patient's Signature

Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

Date of last menstrual period: _____

Patient's Signature

Date

Notice of Privacy Practices Acknowledgement

Notice of Privacy Practices (NPP) is provided to all patients. This **Notice of Privacy Practices** identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

Please initial below:

_____ I acknowledge that it is the policy of Superior Healthcare 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 regarding my rights, I may speak with the Front Desk about my concerns to be forwarded to the appropriate department.

The undersigned certifies that he/she has read the foregoing, received a copy of the **Notice of Privacy Practices** and is the patient, or the patient's personal representative.

Name of Patient

Signature of Patient

Date

Name of Patient's Personal Representative

Signature of Representative

Please list any parties that may be allowed access to your personal health/financial information below:

Printed Name

Relationship

FOR INTERNAL USE ONLY

Signature of Office Representative

Date Signed

