PATIENT INFORMATION:

Today's Date: ______________________

Name: ______________________

Address: ______________________

City:______________ State:______Zip:_____

Home Phone: ______________________

Cell Phone: ______________________

Business Phone: ______________________

E-mail address: ______________________

Sex: ☐M ☐F
Marital Status: ______________________

Social Security #: ______________________

Date of Birth: ______________________

Occupation/School: ______________________
Employer: ______________________

Notify In Case of Emergency:

____

Emergency Contact Number:

____

Relationship to Patient: ______________________

Whom may we thank for referring you?

____

ACCIDENT INFORMATION:

Is condition due to an ACCIDENT? ☐ Y ☐ N

Type of Accident:
☐Auto ☐ Work ☐ Home ☐ Other
Date of Accident: ______________________

To whom have you reported this accident?
☐ Auto Insurance Carrier
☐Workers Compensation Carrier
☐ Employer ☐ Other______________

INSURANCE INFORMATION:

Insurance Carrier: ______________________

Address: ______________________

City: ______________ State: _____ Zip: _______

Telephone: ______________________

Policy #: ______________________

Effective Date:______________________

Policyholder's Name:______________________

Relationship to Patient: ______________________

Policyholder's Social Security #______________

Policyholder's Date of Birth: ______________

Employer: ______________________

SECONDARY INSURANCE:

Name:______________________

Address: ______________________

Telephone: ______________________

Effective Date: ______________________

Policy #:______________________

Policyholder: ______________________

Policyholder's Social Security #:______________

Policyholder'sDate of Birth:______________

ATTORNEY INFORMATION (If applicable):

Attorney Name:______________________

Address:______________________

Telephone Number: ______________________

AdvancedWellness

Patient Medical History Form

5. Is Your Pain: ☐ Constant ☐ Intermittent
6. What Makes The Pain Worse? ____________________
   What Makes The Pain Better? ____________________

7. What Treatments Have You Had For This Condition?: ____________________
____

8. Are Your Symptoms: ☐ Better ☐ Worse ☐ The Same Since Their Onset

9. Had Any Other Neck, Back or Joint injuries in the past? ☐ No ☐ Yes (Describe):____________________

10. Previous Health History: ____________________
____

11. Previous Surgeries: ____________________
____

12. Allergies: ____________________

13. Medications: ____________________

14. Family History:____________________

15. Social History: Do you use alcohol? ☐ No ☐ Yes If yes, how much? ____________________
Do you use tobacco? ☐ No ☐ Yes If yes, how much? ____________________
Do you use recreational drugs? ☐ No ☐ Yes If yes, explain? ____________________
Occupation:____________________ ☐ Full Time ☐ Part Time
☐ Unemployed Date you last worked:____/____/_____
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: ____________________
Do you have children? ☐ No ☐ Yes If yes, How many? ____________________
Level Of Education: ☐ High School ☐ College ☐ Graduate School ☐ Other: ____________________

16. Place A Mark To Indicate If You Have Any Of The Following:

☐ Chills	☐ Hypertension	☐ Pain on Urination	☐ Seizures
☐ Fever	☐ Palpitations	☐ Increase Urination	☐ Tremors
☐ Headache	☐ Cough	☐ Urinary Retention	☐ Depression
☐ Weight loss	☐ Shortness Of Breath	☐ Hay Fever	☐ Suicide
☐ Blurry vision	☐ Wheezing	☐ Joint pain	☐ Excessive Thirst
☐ Double Vision	☐ Abdominal Pain	☐ Boils	☐ Feeling Too Hot Or Cold
☐ Ear Infection	☐ Diarrhea	☐ Swollen Glands	☐ Feeling Tired or Sluggish
☐ Sore Throat	☐ Constipation	☐ Itching	☐ Blood clots
☐ Sinus Problems	☐ Nausea	☐ Skin Rash	☐ Ring In The Ears
☐ Chest Pain	☐ Vomiting	☐ Dizziness	☐ Other: ____________

17. Diagnostic Studies (X-Rays, MRI's, CT Scan, Labs, ect.): ____________________
____

18. Height: _____feet _____inches Weight: _____ lbs.

Patient Medical History Form

I have completed this form & carefully reviewed its contents. I attest to the accuracy & correctness of the information

Patient or Guardian Signature: ______________________ Date: ______________________

Reviewed By: ______________________

AdvancedWellness

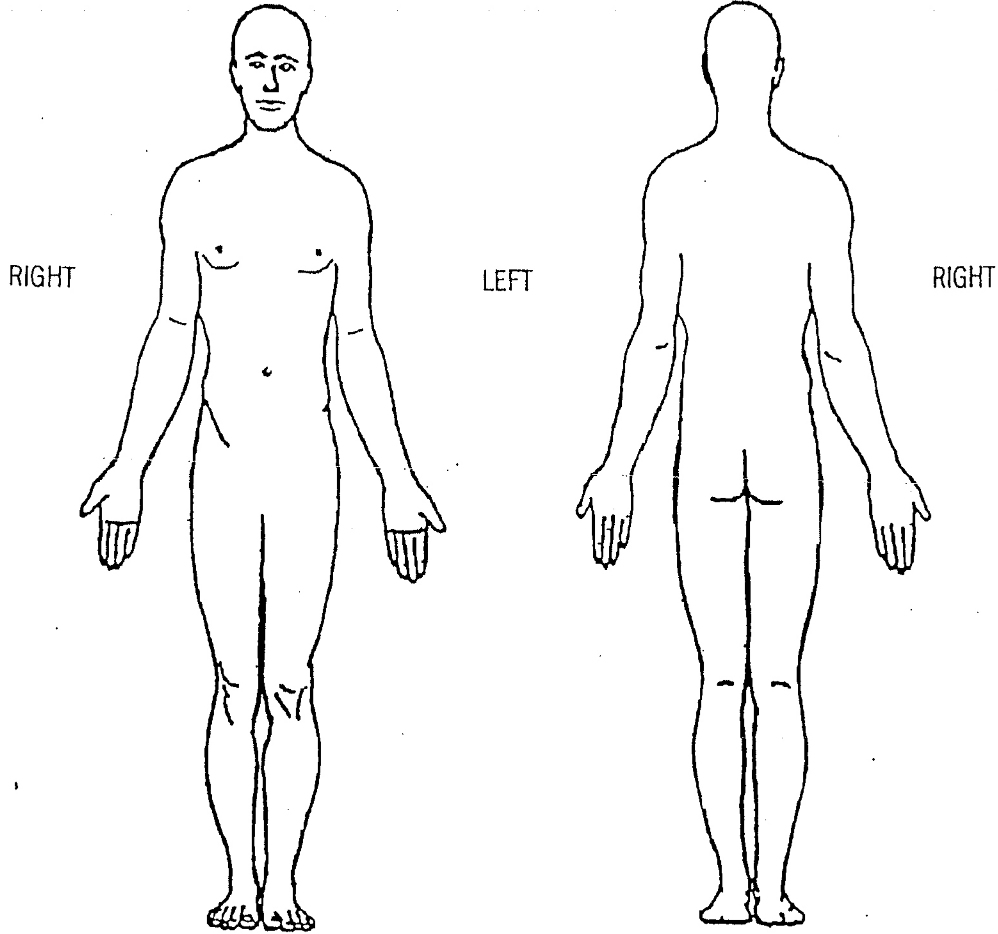
Patient Medical History Form

NAME: ______________________________ DOB: ____/____/____

Age: _____ ☐ Right Handed ☐ Left Handed

PAIN DRAWING

/// STABBING   XXX BURNING   *** TINGLING   OOO NUMBNESS   +++ACHING



Pain Level 0 1 2 3 4 5 6 7 8 9 10

None Mod Severe

1. Reason For Visit: ______________________________
____
____

2. Date Of Onset Of Symptoms Or Injury: ____/____/____

3. Associated signs and symptoms: ______________________________

4. Please Describe Your Pain: ☐ Aching ☐ Burning ☐ Dull ☐ Numbness ☐ Sharp ☐ Stabbing ☐ Tingling

Office Policies

Our office is a zero balance office. All services including co-payments must be paid for at the time of service unless other arrangements have been made.

All missed appointments must be made up according to your care plan.

Please call 24 hours in advance if you need to reschedule your appointment.

Assignment of Benefit/HIPAA Guidelines

I certify that, I, and/or dependent(s) have insurance coverage with

__________________________ and assigned directly to Advanced Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

The above-named facility may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I am aware that Advanced Wellness Center (AWC) will abide by the HIPAA regulations for the purpose of keeping my records confidential and only upon my written consent will my records be allowed to leave AWC.

Signature of patient, parent or guardian **Date**

Print name of patient, parent or guardian **Date**

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZATION FORM
ADVANCED WELLNESS CENTER

Financial Responsibility
I have requested professional services from ADVANCED WELLNESS (“Provider”) on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits
I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent’s behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full.

Authorization to Release Information
I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization
I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. Furthermore, the Provider shall have every right and I hereby authorize the Provider to request a Summary Plan Description (“SPD”) on my behalf.

A photocopy of the Assignment/Authorization shall be as effective and valid as the original.

____

Patient Date

____

Policyholder/Insured Date

AUTHORIZATION OF RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient:____

Date of Birth: ____

I hereby authorize medical providers and personnel of Advanced Wellness Center of Marlboro to discuss my protected health information with:

____
(Relationship) (Name)

____
(Relationship) (Name)

____
(Relationship) (Name)

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
_____ Psychotherapy notes from a Psychiatrist or Psychotherapist
_____ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from ______________ until ________________ at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

____
Signature of Patient Date