WELLNESSMEDICINE

Chart #:_____

## Patient Information

Name: _____
Last First MI

Mailing Address: _____

Phone# (H)_____ (M) _____

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

Marital Status: Single Married Divorced Widowed Separated Minor

Employer:_____ Phone:_____

May we call you at work? Yes No Can we leave a voicemail/message? Yes No

Who referred you to our practice? _____ Insurance Book Yellow Pages

**Emergency contact:** Name:_____ Relation:_____

Phone: (H)_____ (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?_____

## Financial Information

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

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

Name of person whose is the policy holder of this insurance:_____ SS#: _____

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

ID #_____ Group #_____member services phone number _____

**We can not file your insurance if this section is left uncompleted and the bill will be sent to you.**
**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

## Assignment, Consent of Care and Release

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.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make it known to the doctor.

PATIENT SIGNATURE (X)_____ DATE_____

SIGNATURE OF PARENT/GUARDIAN_____ DATE_____

## HIPAA

I was given the opportunity to receive and review the office's Patient Notice of Privacy Practices policy.

PATIENT SIGNATURE (X)_____ DATE_____

Form 5

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

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

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

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

Please list any medications you are currently taking: _____

_____

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 _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Arthritis _____
- ❑ Other _____

Do you exercise? Frequently Moderately Occasionally None

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

Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

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.

PATIENT SIGNATURE (X) _____ DATE _____

PARENT/GUARDIAN SIGNATURE (X) _____ DATE _____

 CHART #_____

# Current Symptom(s)

NAME: _____ Chart #: _____

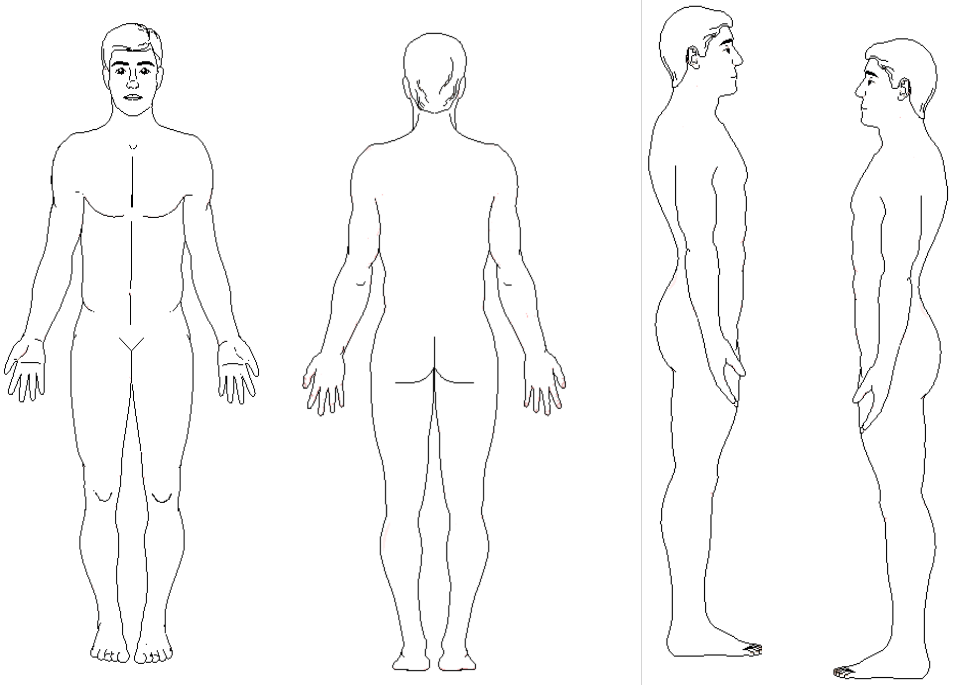
Reason for visit_____

_____

*** PLEASE USE THE LETTER (S) BELOW TO MARK THE DRAWING(S) WITH THE LOCATION AND TYPE OF SENSATIONS YOU ARE EXPERIENCING**

**KEY:**

**T = Tight**
**D = Dull**
**A = Ache**
**S = Sharp**
**N = Numb**
**B = Burning**
**ST = Stiff**
**TG = Tingling**
**SH = Shooting**
**TH = Throbbing**
**O = Other**



* PLEASE INDICATE THE SEVERITY OF YOUR CONDITION ON A SCALE OF **0-10**

(0 being no pain, 10 being the worst possible pain) 1._____ currently 2._____at it's worst

When did you first notice the symptoms?_____

Did anything cause the pain/symptoms?_____

Is the pain: Constant OR intermittent (Come and Go)

Is it getting progressively worse? No Yes

Type of Pain? Tight Stiff Ache Sharp Shooting
Throbbing Burning Dull Numb Tingling Other

Does anything make it worse?_____

Does anything make it better?_____

Does it radiate? No Yes Right Arm Left Arm Right Leg Left Leg

Do you experience the pain at a particular time of day?_____

Do you experience night pain? No Yes, explain_____

Does it interfere with your: Work Sleep Daily Routine Recreational Activities

What activities do you enjoy, but do poorly, or not all because of the pain? _____

Painful movements: Sitting Standing Walking Bending Lying Down

What have you done to treat the pain before today?_____

PATIENT SIGNATURE (X)_____DATE_____

PARENT/GUARDIAN SIGNATURE (X)_____DATE_____

WELLNESSMEDICINE

# HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

**1. Authorization**

I _____, authorize Wellness Medicine to use and disclose the protected health information described below for the purpose of medical diagnosis, treatment, consultation, referral, billing and claims, or any other purpose related to my healthcare needs.

**2. Effective Period**

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____. **OR**

b. ☐ all past, present, and future periods.

**3. Extent of Authorization**

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**OR** b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records □ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment □ Other (please specify):

_____

4. This medical information may be used by the entity I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect indefinitely

□Yes □No until _____ (date or event),

at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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

Signature of patient or personal representative: _____

Printed name of patient or personal representative:

_____

Date: ____/____/_____

WELLNESSMEDICINE

## Medical Records Request

Date___/___/_____

Please list the name of your referring physician as well as any physician(s), person(s), or businesses you authorize Wellness Medicine to request or release your personal health information to. Please provide name and contact number.

(Referring Physician) _____

(Specialist)_____

(Family or Friends)_____

(Other)_____

I _____, herby request that my medical records be released to:

_____, physician of _____ practice.

Wellness Medicine
990 Bear Creek Blvd.
Hampton, Georgia 30228
Phone: (678) 479-1234
Fax: (678) 479-5678

I understand that this authorization allows the release of all information in my medical information in my medical records to include: lab test results, x-rays, and any surgical information. This authorization allows such records to be mailed or faxed. I understand that I may revolt this consent at anytime. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

Patient Name:_____

Patient Address:_____

Patient Date of Birth: ___/___/_____

Patient/Guardian Signature:_____