# New Patient Form

**This Form needs to be completely filled out in accordance to the federal HIPAA. Please print legibly. Thank You!**

## Patient Information

| Last Name | First Name | MI | Date of Birth | SSN | |
|---|---|---|---|---|---|
| Mailing Address | | | City | State | Zip Code |
| Can we leave a voicemail?<br>• Yes<br>• No | Email Address: (to send results/parents email for minors) | | Cell Phone: | Home Phone: | |

| Marital Status | Gender | Advance Directives/Living Will | Emergency Contact : | Emergency Contact Phone: |
|---|---|---|---|---|
| • Single<br>• Married<br>• Partner<br>• Other | • Male<br>• Female | • Yes<br>• No<br>*You may provide us a copy at your discretion.* | Relation: | |

***Race**

___Black/African American ___American Indian ___Native Hawaiian * Referred by: ______________________

___Hispanic ___Pacific Islander

___White ___Asian

***Release of Information**

List names of those who may receive your Protected Health Information: (medical records, prescriptions, lab results, etc.)

## Primary Insurance

| Insurance Name | ID# | Group# | Insurance Phone Number(s) | |
|---|---|---|---|---|
| Policy Holder Name | Date of Birth | SSN | • Male<br>• Female | Relationship to Patient |
| Policy Holders Address (if different then above) | | Employer (if insurance is through work) | | |

## Secondary Insurance

| Insurance Name | ID# | Group# | Insurance Phone Number(s) | |
|---|---|---|---|---|
| Policy Holder Full Name | Date of Birth | SSN | • Male<br>• Female | Relationship to Patient |
| Policy Holder Address (if different then above) | | Employer (if insurance is through work) | | |

By signing this form, I confirm that:

- All information provided is true and correct.
- It is my responsibility to know my insurance benefits.
- Should there be a denial in claims, I am liable to pay for services rendered including fees for attorney and collections.
- I must pay the penalty charge: $30.00 no-show fee, $30.00 same-day cancellation fee and other applicable charges.
- I consent to the use and disclosure of my Protected Health Information unless otherwise noted.
- I know my right to review Premier Health and Medical's Notice of Privacy Policy: If need be, I will submit my repeal or restrictions in written form.
- I received a copy of Premier Health and Medical's Policies and Agreements Form, which outlines my rights and responsibilities as a patient.

## Responsible Party Information

| Name (if other than patient) | Relationship to Patient | Date of Birth |
|---|---|---|
| Signature | Today's Date | |

| **FOR OFFICIAL USE ONLY** | Accepted By: | Checked By: | Account ID |
|---|---|---|---|

Premier Health
MEDICAL• CHIROPRACTIC•THERAPY

Name ________________________________

## Medical Information

**Allergies to Medications and Reactions**

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
________________________________________________________________________________

**Surgery History** (procedure, reason and date)

________________________________________
________________________________________
________________________________________
________________________________________
______________________________________

**Pregnancies** (# of pregnancies, # of births, # of miscarriages)

__________________________________________
__________________________________________
__________________________________________
__________________________________________
_____________________________________

**Menstrual History** _______age of onset  Painful Periods: YES / NO  Irregular Periods: YES / NO

## Past Medical History (*Check if you have or had the following)*

- Asthma
- Angina
- Gout
- Stroke
- Ulcers
- Thyroid
- Valley Fever
- Heart Failure
- COPD
- Tuberculosis
- Kidney Stones
- Osteoporosis
- Endometriosis
- Degenerative Arthritis
- Rheumatoid Arthritis
- Venereal Disease
- High Blood Pressure
- Emphysema
- HIV/ARC/AIDS
- Bleeding tendency
- High Cholesterol
- Diabetes at Age _________________
  Type _________________________
- Heart Attack at age________________
- Cancer type ____________________
- Erectile Dysfunction
- Migraines
- Other _________________________

Have you ever had a blood transfusion? YES / NO  If yes, what year?_____________________

## Family History

Mother's Age: ______ If deceased, age and cause of death: ___________________________________________

Father's Age: _______ If deceased, age and cause of death: ___________________________________________

*Indicate which family member, has the following:*

(F)Father (M)Mother (S)Sister (B)Brother (GM)Grandmother (GF)Grandfather

___Stroke ___Diabetes ___High Cholesterol ___Rheumatoid Arthritis ___Cancer ___Alcoholism ___ Heart Attack
___High Blood Pressure ___HIV

## Social History

Type of work: ____________________________________  ___Stressful  ___Hazardous  ___Heavy Lifting

Exercise: YES / NO #_____times per week

Alcohol: YES / NO #_____drinks per day  *If you used to, when did you quit? ___________

*Do you smoke? YES / NO  Did you ever? YES / NO  How Many Daily?: ______________

When did you quit? ______________  Are you: ____left handed or ____right handed?

## Current Medication ***(List name, dosage and frequency)***

| |
|---|
| |
| |
| |
| |

## CONSENT FORM

I hereby request and consent to the performance of medical care and all things involved in complete family medicine, chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures on me (or on the patient named below, for whom I am legally responsible) by the medical and/or chiropractic team at Premier Health and Medical who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the medical doctor or doctor of chiropractic named below the nature and purpose of treatment, chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_________________________ Date _________________

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS**
**AS WELL AS AN**
**APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Premier Health and Medical as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Premier Health and Medical for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Premier Health and Medical as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Premier Health and Medical all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Premier Health and Medical, myself, and/or my family members as a result of services rendered by Premier Health and Medical, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Premier Health and Medical can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by* Premier Health and Medical. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of _________________, 20 ____.

X_______________________________________________ (SEAL)
(patient signature)

X__________________________________________(SEAL)
(signature of Guardian if applicable)

X_______________________________________________
(please print patient name)

**CONSENT TO USE OR DISCLOSE INFORMATION**
**FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS**

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information" (PHI)) by Premier Health and Medical in order to carry out treatment, payment, or health care operations. The Patient should review Premier Health and Medical's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such notice prior to signing this consent form.

Premier Health and Medical reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Premier Health and Medical does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice requesting a copy.

Patient retains the right to request that Premier Health and Medical further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Premier Health and Medical is not required to agree to such requested restrictions; however, if Premier Health and Medical does agree to Patient's requested restriction(s), such restrictions are then binding on Premier Health and Medical.

I understand that, and consent to, the following appointment reminders that will be used by Premier Health and Medical, in writing, such as a post card, a telephone call at designated number and leaving a message on a voice mail or with person answering the phone, by text, or by email.

This consent is valid for seven years. At all times, patient retains the right to revoke this consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective except to the extent that Premier Health and Medical has already taken action in reliance on the Consent.

Premier Health and Medical may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that Premier Health and Medical is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, Premier Health and Medical has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that Premier Health and Medical is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Print Name of Patient: _________________________________

Relationship to Patient: ________________________________

Signature: __________________________________________

Date: __________________________