

Clark Integrated Medical Clinics
130 Rue Beauregard, Suite A, Lafayette, LA 70508

Patient Name _____ Date: _____ Email: _____

SS # _____ DOB _____ Male Female Home phone _____ Cell Phone _____

Check appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's Address _____ City _____ State _____ Zip _____

Employer Name: _____

Spouse or Patient's Guardian name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

If patient is a minor, it is ok to treat in my absence.

Parent or Guardian _____ Date

Are you, or is there a possibility you may be pregnant? *O yes O no*

If Motor Vehicle Collision - Attorney / At Fault Party Insurance Information

Injury Date _____ Were the Police Contacted _____ Seen at other facility/hospital? NO YES

If yes where _____ When _____

Firm / Insurance Name _____

Attorney / Adjuster Name _____

Health Insurance:

Name of the insured _____ Relationship to patient _____

Birthdate _____ SS#/SIN _____ Name of Employer _____ Work Phone _____

Insurance Company _____ Member ID # _____ Group # _____

**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 **CLARK INTEGRATED MEDICAL CLINICS** 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 Healthcare Provider 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 Healthcare Provider 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 Healthcare Provider 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 Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, 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 Healthcare Provider 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 Healthcare Provider.* A photocopy or scan of 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)

Health History

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint: _____

History of Present Illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal vs abnormal color, activity, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____

Modifying Factors _____

(What other associated problems have you been having?)

(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO	YES	Anemia	NO	YES	Back Trouble	NO	YES	Hepatitis	NO	YES
Mumps	NO	YES	Bladder Infection	NO	YES	High Blood Pressure	NO	YES	Ulcer	NO	YES
Chicken Pox	NO	YES	Epilepsy	NO	YES	Low Blood Pressure	NO	YES	Kidney Disease	NO	YES
Whooping Cough	NO	YES	Migraine Headaches	NO	YES	Hemorrhoids	NO	YES	Thyroid Disease	NO	YES
Scarlet Fever	NO	YES	Tuberculosis	NO	YES	Date of Last Chest X-Ray	_____	Bleeding Tendency	NO	YES	
Diphtheria	NO	YES	Diabetes	NO	YES	Asthma	NO	YES	Any Other Disease	NO	YES
Small pox	NO	YES	Cancer	NO	YES	Hives of Eczema	NO	YES	(Please List):	_____	
Pneumonia	NO	YES	Polio	NO	YES	AIDS & HIV	NO	YES	_____		
Rheumatic Fever	NO	YES	Glaucoma	NO	YES	Infectious Mono	NO	YES			
Arthritis	NO	YES	Hernia	NO	YES	Bronchitis	NO	YES			
Venereal Disease	NO	YES	Blood or Plasma Transfusion	NO	YES	Mitral Valve Prolapses	NO	YES			
						Stroke	NO	YES			

Previous Hospitalizations/Surgeries/Serious Illnesses _____ **When?** _____ **Hospital, City, State** _____

Medication: (include nonprescription)

Preferred Pharmacy:

Name: _____

Phone: _____

Known Allergies:

CLINICIAN SIGNATURE: _____

DATE REVIEWED: _____

Name: _____ DOB _____ Date: _____

Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____
Excessive Exposure
At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma 1 2 3 4 5
Stuffy Nose 1 2 3 4 5
Hay Fever 1 2 3 4 5
Sore throat 1 2 3 4 5
Chronic Cough 1 2 3 4 5
Chest Congestion 1 2 3 4 5
Frequent Sneezing 1 2 3 4 5
Itchy/Watery Eyes 1 2 3 4 5
Drainage 1 2 3 4 5
Earache or Ear Infection 1 2 3 4 5
Itching 1 2 3 4 5
Hoarseness 1 2 3 4 5
Shortness of Breath 1 2 3 4 5
Wheezing 1 2 3 4 5

Muscular/Skeletal

Muscle Aches 1 2 3 4 5
Fibromyalgia 1 2 3 4 5
Arthritis 1 2 3 4 5
Joint Pain 1 2 3 4 5
Low Back Pain 1 2 3 4 5
Neck Pain 1 2 3 4 5
Wrist/Hand Pain 1 2 3 4 5
Elbow Pain 1 2 3 4 5
Shoulder Pain 1 2 3 4 5
Hip Pain 1 2 3 4 5
Knee Pain 1 2 3 4 5
Ankle/Foot Pain 1 2 3 4 5
Pain b/t shoulder blades 1 2 3 4 5

Neurological

Headaches 1 2 3 4 5
Migraines 1 2 3 4 5
Dizziness 1 2 3 4 5
Numbness 1 2 3 4 5
Tingling 1 2 3 4 5
Pins/needles in hands or feet 1 2 3 4 5

General

Fatigue 1 2 3 4 5
Malaise 1 2 3 4 5
Weakness, tiredness 1 2 3 4 5
Lightheadedness 1 2 3 4 5
Irritability 1 2 3 4 5
Constipation 1 2 3 4 5
Diarrhea 1 2 3 4 5
Feeling foggy 1 2 3 4 5
Forgetfulness 1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of the Patient, Parent or Guardian

Date

Doctor's Review

Signature of Doctor

Date