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 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)

Patient Name: _____DOB: _____ Date: _____

Health History

Chief Complaint: _____

History of Present illness:

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 _____

_____
(What other associated problems have you been having?)

Modifying Factors _____

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

Current Primary Care:

Physician: _____ Phone: _____

Medication: *(include nonprescription)*

_____ _____

_____ _____

Known Allergies:

_____ _____

_____ _____

Preferred Pharmacy:

Name: _____ Phone: _____

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		Muscular/Skeletal	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5
Wheezing	1 2 3 4 5		

Neurological		General	
Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	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

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:** _____

Patient Name: _____DOB: _____ Date: _____

Patient Social History:

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:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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

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

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