Elite Integrative Medical

153 South Doheny Drive, Beverly Hills, California 90211

Patient Name____ Date: ______________________
Email: ____
SS #/SIN__________________ 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:_________________________
In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account _____________________________
Relationship to Patient ____________________
Address ____
Home Phone ____________________________ Cell Phone ______________________________
E-Mail ____
Driver's License # ________________________________ Date of Birth:___________________________
Is the person currently a patient at our office? □ Yes □ No
Do you have any Medical insurance? □ Yes □ No if yes, complete the following:
Name of the insured____
Relationship to patient____
Birthdate__________________ SS#/SIN________________________
Name of Employer____ Work Phone____________________
Address of Employer____ State _______ Zip____________
Insurance Company____________________________ Group #_________________
Union or local # __________________________
Ins. Co. Address____
City__________________________________ State____________________Zip______________________

____ ______/______/______
Patient Signature Date

____ ______/______/______
Parent/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 **Elite Integrative 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 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)

Health History

Patient Name:____DOB:_____________________Date:_______________

MUST BE COMPLETED

*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 __________________
____
(What other associated problems have you been having?)

Modifying Factors ________________________
____
(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			Mitral Valve Prolepses...	NO	YES	___________________________		
Transfusion...........	NO	YES	Stroke....................	NO	YES						

Previous Hospitalizations/Surgeries/Serious Illnesses

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
______________________________	______________	__________________
______________________________	______________	__________________
______________________________	______________	__________________

Medication: (include nonprescription)

____
____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: ______________________________

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: ______

CLINICIAN SIGNATURE: _______________________________________ **DATE REVIEWED:**____________________

PATIENT NAME: ____ **DATE:**_________________________

Name:______________________________ DOB ______________ Date:______________

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