Clark INTEGRATED MEDICAL CLINICS — Medical, Chiropractic, Rehab

Patient Name_____ Date_____ ☐ Male ☐ Female

SS #_____ DOB_____ Email _____

Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Address _____City _____

State_____ Zip_____ Home phone_____ Cell Phone _____

Employer Name: _____ Job Title: _____

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

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_____

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.

X_____ (Patient signature) X_____ Signature of Guardian, if applicable

X_____ (Please print patient name) Signed this _____ day of _____, 20 ____.

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

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: _____

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

Medication: *(include nonprescription, vitamins, herbals and OTC)*

DRUG	DOSE/FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ **I take no medications, vitamins, herbals or any other over-the-counter prescriptions.**

Preferred Pharmacy:

Name: _____ Phone: _____

Known Allergies:

ALLERGY	REACTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ **I have no drug allergies.**

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

Patient Name: _____ DOB: _____ Date: _____

Personal Medical History

Indicate which of the below you have experienced recently by circling all that apply.

Fever	Feeling tired/fatigued	Malaise	Recent weight gain
Chills	Feeling Foggy	Lightheadedness	Recent weight loss
Feeling poorly	Forgetfulness	Irritability	

Eye pain	Eyesight problems	Dry eyes	Vision changes
Red eyes	Discharge from eyes	Eyes itch	

Easy bleeding	Easy bruising	Swollen glands

Earache	Stuffy Nose	Frequent Sneezing	Ringing in ears
Loss of hearing	Discharge from nose	Sore throat	Sinus problems
Nosebleeds	Chest Congestion	Hoarseness	

Chest pain	Fast heartbeat	Cold hands/feet	Swelling in legs	History of heart attack
Palpitations	Slow heartbeat	Muscle pain	Heart murmur	

Shortness of breath	Cough	lying down/sleeping	Coughing up phlegm	Coughing up blood
Wheezing	Difficulty breathing while			

Abdominal pain	Heartburn	Pain with urination	Frequent urination at night
Vomiting	Black, tarry stools	Urinary incontinence	
Constipation	Blood per rectum	Urinary frequency	
Diarrhea			

Muscle/joint pain	Limb weakness	Neck Pain	Hip Pain	Pain b/t Shoulder Blades
Joint swelling	Back pain	Wrist/Hand Pain	Knee Pain	
Joint stiffness	Fibromyalgia	Elbow Pain	Ankle/Foot Pain	Difficulty walking
Limb pain	Arthritis	Shoulder Pain		

Skin lesions	Nail discoloration	Dizziness	Numbness/tingling
Skin wound	Nail deformity	Fainting	Frequent falls
Itching	Confusion	Headaches	
Change in mole	Convulsions/seizures	Migraines	

Suicidal	Anxiety	Change in personality
Sleep disturbances	Depression	Emotional problems

Decreased libido/sexual desire	Deepening of voice	Hair loss

Other symptoms: _____

_____

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Family Medical History

Please indicate if <u>your family</u> has a history of the following: (Only include parents, grandparents, siblings, and children.)

- ☐ I am adopted and do not know biological family history.
- ☐ Family history unknown

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung/Respiratory Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Other Cancer
- ☐ Rectal Cancer
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Stroke/CVA of the brain
- ☐ Thyroid Problems
- ☐ NONE of the above
- ☐ Mother, grandmother, or sister developed heart disease before the age of 65.
- ☐ Father, grandfather, or brother developed heart disease before the age of 55.

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

AIDS & HIV	YES	NO	Epilepsy	YES	NO	Polio	YES	NO
Anemia	YES	NO	Glaucoma	YES	NO	Rheumatoid Arthritis	YES	NO
Arrhythmias	YES	NO	Heart Attack	YES	NO	Rheumatic Fever	YES	NO
Arthritis	YES	NO	Hepatitis	YES	NO	Scarlet Fever	YES	NO
Asthma	YES	NO	Hernia	YES	NO	Small Pox	YES	NO
Bleeding Tendency	YES	NO	High Blood Pressure	YES	NO	Stroke/CVA of the brain	YES	NO
Blood Transfusion	YES	NO	Hives of Eczema	YES	NO	Thyroid Disease	YES	NO
Bronchitis	YES	NO	Infectious Mono	YES	NO	Tuberculosis	YES	NO
Plasma Transfusion	YES	NO	Kidney Disease	YES	NO	Ulcer	YES	NO
Cancer	YES	NO	Low Blood Pressure	YES	NO	Venereal Disease	YES	NO
(Please List): _____			Measles	YES	NO	Whooping Cough	YES	NO
Chicken Pox	YES	NO	Migraine Headaches	YES	NO	Any Other Disease	YES	NO
Congestive Heart Failure	YES	NO	Mitral Valve Prolepses	YES	NO	(Please List): _____		
Diabetes	YES	NO	Mumps	YES	NO	_____		
Diphtheria	YES	NO	Pneumonia	YES	NO	Date of Last Chest X-Ray: _____		

Patient Social History

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

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

☐ **I have never been hospitalized.**

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

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