Patient Information:

First Name: _____ Middle Initial:_____ Last Name:_____

Date of Birth:_____ SSN:_____- _____-_____

Gender: Male Female Transgender Non-Binary/Non-Conforming Prefer not to respond

Address: _____ Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone: (____) -_____ Cell Phone: (____) -_____

Work Phone: (____) -_____ Email Address: _____

Marital Status: Single Married Divorced Widowed Other

Height:_____ Weight:_____

Race: White Hispanic Asian Black/African American American Indian Other Decline

Ethnicity: Not Hispanic Hispanic/Latino Other Decline

Employment Information:

Employer:_____

Job Title:_____

Address: _____ City:_____ State:_____

Zip Code: _____ Phone Number: (____) - _____

Employment Status: Full Time Part Time Retired Self Employed Unemployed

Emergency Contact:

Name:_____ Relationship:_____

Phone Number: (____)-_____

Insurance Information:

Primary Policy: **Secondary Policy:**

Insurance Carrier:_____ Insurance Carrier:_____

ID/Policy Number: _____ ID/Policy Number:_____

Name of Policy Holder:_____ Name of Policy Holder:_____

Date of Birth of Policy Holder:_____ Date of Birth of Policy Holder:_____

Visit Reason:

Why are you seeing us today?_____

Is there pain associated with this condition? YES NO

If so on a scale of 1-10 what would you rate your pain? 0 1 2 3 4 5 6 7 8 9 10

What causes or aggravates the pain?_____
_____

What works best to relieve the pain?_____
_____

Any additional factors you would like to mention?_____
_____

Whom may we thank for your referral?**:**_____

Pharmacy Information:_____

Allergies:

1. Please Indicate all allergies to medications:
   - **O** NO Known Drug Allergies

Medication:_____
Reaction: _____

Medication:_____
Reaction: _____

Medication:_____
Reaction: _____

Other Allergies: Adhesives Bandaids/Tape Gloves Latex

2. Do you have any complications due to Anesthesia? Yes No
   IF yes describe_____

Medications:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History:

Constitutional/General
Cancer/Type:_____
Elevated Temperature
Night Sweats

Cardiovascular
Angina
Blood clots/DVT
Easy Bruising/ Bleeding
Heart Attack
Hypertension
Irregular Heart Beat
Poor Circulation
Rheumatic Fever
Valve Problems

Infectious Disease
HIV/AIDS
Tuberculosis/TB

Hematologic Disease
Anemia Type_____
Sickle Cell

Gastrointestinal
Acid Reflux/GERD
Gallbladder
Hiatal Hernia
Irritable Bowel Syndrome
Stomach/Bowel Problems
Ulcer

Genito-Urinary
Bladder or Kidney Stones
Kidney Failure
Dialysis
Prostate Disease

Endocrine
Heat/Cold Intolerance
Diabetes & Type:_____
Hyperthyroid
Hypothyroid

Vision/Hearing
Double/Blurred Vision
Glaucoma
Hearing Aid
Macular Degeneration
Vision Change
Contacts/Glasses
Hearing Deficit/ Loss

Nervous System
Anxiety
Depression
Convulsion/Epilepsy
Fainting
Memory Loss
Migraines
Muscle Weakness
Muscle Dystrophy
Muscular Sclerosis
Stroke
Neuropathy
Parkinson's Disease
Other_____

Respiratory
Asthma
Emphysema/COPD
Bronchitis
Pneumonia
Aspiration
Tracheotomy
Tuberculosis
Coughing Blood
Shortness of breath
Wheezing
Pulmonary Embolus

Social History:

1. Do you currently smoke or chew tobacco? Yes No
   How many packs per day?_____ How many years?_____
   If NO, have you in the past?_____ How many years?_____

2. Do you drink alcohol? Yes No How many glasses/drinks per day?_____

3. Do you drink caffeine? Yes No How many glasses/drinks per day?_____

4. Do you use any illicit or recreational drugs (i.e marijuana, cocaine, heroin, etc.)? Yes No
   If yes, which drugs?_____ If not, have you in the past years? Yes No
   If yes, which drugs?_____

Surgical History:

Please list any surgeries AND years:

_____
_____
_____
_____
_____
_____

Family Health History ie: High blood pressure, diabetes, cancer etc.

Mother:_____
Father:_____
Siblings:_____
Children:_____
Maternal Grandparents:_____
Paternal Grandparents:_____

Authorization of Medical Information:

Please read the following questions carefully and sign at the bottom of this page.
You have the right to review our privacy practices at any time.
Please refer to our HIPAA notice located at the front desk.

( ) I have read and understand the HIPAA notice.
( ) I decline reading the HIPAA notice but am fully aware that this information is always available to me.

Please **CHECK** any boxes where we may leave a message if necessary:

( ) HOME ( ) ANSWERING ( ) WORK ( ) CELL PHONE

May we discuss your medical information with members of your family of friends?
( ) YES ( ) NO

If **YES** Please list the name of the person or persons and their relationship to the patient.

Name: _____

Relationship to patient: _____

Phone Number: _____

Please list ANY information from your medical record you would NOT us to disclose:

_____

_____

_____

Patient name (print) _____ Date _____

Signature of Patient/Legal Guardian _____

Photography and or video consent

I hereby grant Innovation Medical Group, the irrevocable right and permission to use photographs and/or video recordings of me on company and other websites or YouTube channels, and in publications, promotional flyers, educational materials, derivative works, Marketing purposes or for any other similar purpose without compensation to me.

I understand and agree that such photographs and/or video recordings of me may be placed on the Internet. I also understand and agree that I may be identified by name and/or title in printed, Internet, or broadcast information that might accompany the photographs and/or video recordings of me. I waive the right to approve the final product. I agree that all such portraits, pictures, photographs, video recordings of me. I waive the right to approve the final product. I agree that all such portraits, pictures, photographs, video and audio recordings, and any reproductions thereof, and all plates, negatives, recordings tape and digital files are and shall remain the property of the Company.

I hereby release, acquit, and forever discharge the company, its current and former managers, officers, and employees of the company and its affiliates of any kind from any and all claims, demands, rights, promises, damages, and liabilities arising out of or in connection with the use or distribution of said photographs and/or video recordings, including but not limited to any claims for invasion of privacy, appropriation of likeness, or defamation.

I hereby warrant that I am eighteen (18) years old or more and competent to contract in my own name or, if I am less than eighteen years old, that my parent or guardian has signed this release form below. This release is binding on me and my heirs, assigns, and personal representatives.

( ) Accept ( ) Declined

Printed Name:

Signature of patient: Date:

If an individual photographed/recorded is under eighteen (18) years old, the following sections must be completed: I have read and I understand this document. I understand and agree that it is binding on me, my child (named above), our heirs, assigns and personal representatives. I acknowledge that I am eighteen (18) years old or more and that I am the parent or guardian of the child named above.

Signature of Parent/Guardian of Individual

Parent/Guardian of Individual printed name:

Date:

Financial Agreement
1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is furnished.
You are responsible for copays, deductibles, non-covered services, co-insurance and items considered "not medically necessary"
by your insurance company.
For unpaid claims over 45 days, it is your responsibility to follow up with you insurance and the balance due is considered due and
payable.
2. It is your responsibility to notify our front desk staff of any insurance or address changes.
3. You will be responsible for any charges that occur if we are not notified.
Patient Authorization
I hereby authorize Providers to administer such medication or procedures as are necessary on the basis of findings in my case. I authorize the holder
of medical or other information to release to my insurance carrier, governmental agency, or its intermediary, any information needed for this or a related

insurance claim. I request that payment of authorized benefits by made to **Innovation Medical Group** I agree to pay any charges incurred by me to
Innovation Medical Group. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my
signature on all insurance submissions.
_____I authorize **Innovation Medical Group** to submit insurance claims using my signature on file below
_____I authorize the release of any medical information necessary in order to process this assignment on this claim.
_____I authorize payment of medical benefits to be paid directly to **Innovation Medical Group** for services described on the claim form.
ALL CO-PAYS AND/OR CO-INSURANCE ARE DUE AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.
Print Name
Signature Date