LEADING EDGE MEDICAL

Patient Name_____ Date: _____
Email: _____ DOB_____ □ Male □Female
Home phone_____Cell Phone _____
□Single □Married □Divorced □Widowed □Separated SS#_____

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_____
Emergency Phone#_____
In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.*
*Parent/Gaurdian Signature _____Date_____

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_____

City_____State _____ Zip_____

Insurance Company_____

ID#_____Group #_____

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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 Leading Edge Medical PC 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) X_____

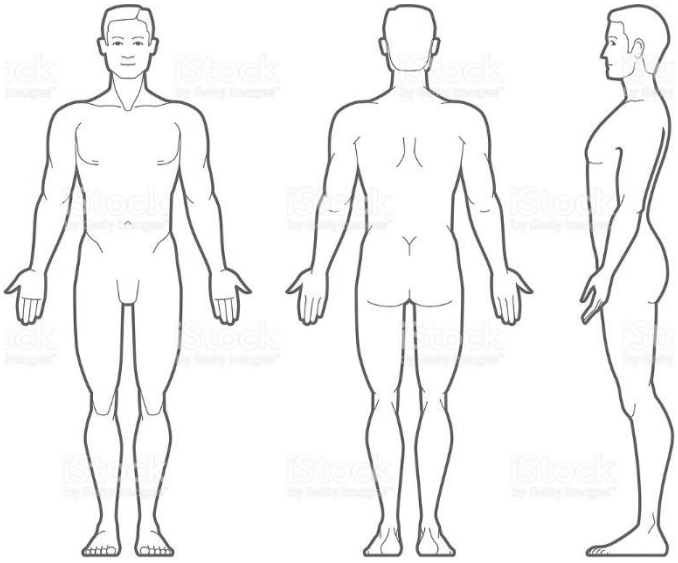
(signature of Guardian if applicable) (please print patient name)

Provider Initials_____Date Reviewed_____

LEADING EDGE MEDICAL

Health History

Mark/Circle all areas of Complaint



Chief Complaint: _____

History of Present illness:

Location: _____ Quality: _____
(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

Severity: _____Duration: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being (How long have you had this pain/ problem? the most severe?) When did it start?)

Timing: _____Context: _____
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated Symptom 1_____

Location: _____ Quality: _____

Timing: _____Context: _____

Associated Symptom 2_____

Location: _____Quality: _____

Timing: _____Context: _____

Associated Symptom 3_____

Location: _____ Quality: _____

Timing: _____Context: _____

Associated Symptom 4_____

Location: _____Quality: _____

Timing: _____Context: _____

Past Medical History

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

Measles	NO	YES	Chicken Pox	NO	YES	Scarlet Fever	NO	YES
Anemia.	NO	YES	Epilepsy	NO	YES	Tuberculosis	NO	YES
Back Trouble	NO	YES	Low Blood Press.	NO	YES	Date of Last Chest X-Ray_____		
Hepatitis	NO	YES	Kidney Disease	NO	YES	Bleeding Tendency	NO	YES
Mumps	NO	YES	Whooping Cough	NO	YES	Diphtheria	NO	YES
Bladder Infection	NO	YES	Migraine Headaches	NO	YES	Diabetes	NO	YES
High Blood Pressure	NO	YES	Hemorrhoids	NO	YES	Asthma	NO	YES
Ulcer	NO	YES	Thyroid Disease	NO	YES	AIDS & HIV	NO	YES
Any Other Disease	NO	YES	Small pox	NO	YES	Glaucoma	NO	YES
Small pox	NO	YES	Cancer	NO	YES	Infectious Mono	NO	YES
Cancer	NO	YES	Eczema	NO	YES	Arthritis	NO	YES
Eczema	NO	YES	Rheumatic Fever	NO	YES	Venereal Disease	NO	YES
Pneumonia	NO	YES	Hernia	NO	YES	Mitral Valve Prolepses	NO	YES
Polio	NO	YES	Bronchitis	NO	YES			

Provider Initials_____Date Reviewed_____

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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? NO YES

if yes what type: _____

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: _____

Allergies_____

_____

_____

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 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
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	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
Needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5	Forgetfulness	1 2 3 4 5
Feeling foggy	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, _____

Provider Initials_____Date Reviewed_____