

Discovery Medical Center
502 Pratt Avenue NE Huntsville, Alabama 35801

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 _____

E-Mail _____ Cell Phone _____

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 _____

**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 Discovery Medical Center, Dr. Michel Farah, MD, Dr. Kathy Cornelius Dr. Sam McGough, DC, 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 of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X _____ (SEAL)
(patient signature)

X _____
(signature of Guardian if applicable)

X _____
(please print patient name)

Health History

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint:

History of Present illness:

Location: _____

Quality:

(Where is the pain/problem?)
activity, etc..)

(Example: normal vs abnormal color,

Severity: _____

Duration:

(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

(How long have you had this pain/ problem? When did it start?)

Timing: _____

Context:

(Does the pain/problem occur at a specific time?)
problem?)

(Where were you at the onset of this pain/

Associated Signs/Symptoms _____

Modifying Factors

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

(What makes the pain/problem worse or better? Have
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		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
Disease.....	NO	YES						Kidney
Whooping Cough... Disease.....	NO	YES	Migraine Headaches.	NO	YES	Hemorrhoids.....	NO	YES
	NO	YES						Thyroid
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
Disease.....	NO	YES						Any Other
Small pox.....	NO	YES	Cancer.....	NO	YES	Hives of Eczema.....	NO	YES
Pneumonia.....	NO	YES	Polio.....	NO	YES	AIDS & HIV.....	NO	YES
Rheumatic Fever... Disease.....	NO	YES	Glaucoma.....	NO	YES	Infectious Mono.....	NO	YES
	NO	YES						(Please List):
Arthritis.....	NO	YES	Hernia.....	NO	YES	Bronchitis.....	NO	YES
Venereal Disease... Disease.....	NO	YES	Blood or Plasma			Mitral Valve Prolepses....	NO	YES
			Transfusion.....	NO	YES	Stroke.....	NO	YES

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