The Vanguard Clinic

2108 Schuetz Rd. St. Louis, MO 63146

Patient Name: _____ Date: _____

DOB: _____ Age: _____SS#/SIN: _____

Phone Number: _____Work:_____ Email: _____

Check Appropriate Box**:** □Minor □Single □Married □Divorced □Widowed □Separated

Home Address: _____

City: _____ State: _____ Zip: _____

Gender: □ Male □Female

Employer Name: _____

Spouse or Patient's Guardian: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Phone: _____

In an emergency and the patient is a minor, it is okay for us to treat in absence of parents;

_____ _____

Parent or Guardian Signature Date

Responsible Party (complete if different from above)

Name of The Person responsible for this account _____

Relationship to Patient _____

Address _____

Home Phone: _____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, provide the card:

Name of the insured_____

Relationship to patient_____Birthdate_____

Name of Employer_____ Work Phone _____

Address of Employer_____

City _____State _____ Zip _____

Insurance ID Number: _____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 **THE VANGUARD CLINIC, LLC, Rachel Wilkinson, FNP-C, Michael J Glickert, DC, Joseph Novof, DO** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Providers") 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 Providers 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 Providers 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 Providers 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 Providers 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 Providers, myself, and/or my family members as a result of services rendered by Healthcare Providers, 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 Providers is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Providers 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 Providers.* 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_____
(patient signature)

X _____ _____
(Parent or Guardian Signature, if applicable) (Print name)

Health History

Chief Complaint: _____

_____

_____

History of Chief Complaint:

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

Severity: _____ Duration: _____
(Scale of 1-10, 10 is worst pain) (When did it start? How long have you had pain?)

Timing: _____ Context: _____
(Does the pain/problem occur at specific times?) (What makes the pain/problem worse/better?)

Past Medical History

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

Measles:	YES / NO	Anemia:	YES / NO	Back Trouble:	YES / NO
Hepatitis:	YES / NO	Mumps:	YES / NO	Bladder Infection:	YES / NO
High Blood Pressure:	YES / NO	Ulcers:	YES / NO	Chicken Pox:	YES / NO
Low Blood Pressure:	YES / NO	Epilepsy:	YES / NO	Kidney Disease:	YES / NO
Whooping Cough:	YES / NO	Migraines:	YES / NO	Hemorrhoids:	YES / NO
Thyroid Issues:	YES / NO	Scarlet Fever:	YES / NO	Tuberculosis:	YES / NO
Bleeding Tendency:	YES / NO	Diphtheria:	YES / NO	Diabetes:	YES / NO
Asthma:	YES / NO	Small Pox:	YES / NO	Cancer:	YES / NO
Hives or Eczema:	YES / NO	Pneumonia:	YES / NO	Polio:	YES / NO
AIDS/HIV:	YES / NO	Glaucoma:	YES / NO	Rheumatic Fever:	YES / NO
Infectious Mono:	YES / NO	Arthritis:	YES / NO	Hernia:	YES / NO
Bronchitis:	YES / NO	Stroke:	YES / NO	Venereal Disease:	YES / NO

Mitral Valve Prolapses: YES / NO

Date of last chest x-ray? _____ Blood or Plasma Transfusion: YES / NO

Any Other Disease/Conditions: _____

_____

Previous Hospitalizations/Surgeries/Serious Illnesses

What?	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (include nonprescription/supplements/vitamins)

_____

_____

Allergies (including medication allergies): _____

_____

Doctors:

Primary Care Physician: _____

Primary Care Physician's Phone #: _____

Specialist: _____

Specialist's Phone #: _____

Patient Social History (circle):

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 work to (circle):

Fumes Dust Solvents Airborne Particles Noise

Family Medical History:

	Age	Disease	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Recent Health History Survey

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/Ear Infection	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
Itching:	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
Midback Pain	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/feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Forgetfulness	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

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

Reviewing Provider:

Signature of Provider

Date

Printed Name of Provider