Name: _____ Date: _____ ◯ Male ◯ Female

SSN: _____ DOB: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work 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+, it is ok to treat in my absence.
☐ Yes ☐ No Parent or Guardian: _____ Date: _____

Person responsible for this account: _____ Relationship to Patient: _____
Address: _____ Cell Phone: _____

Email: _____ Driver's License #: _____ Date of Birth: _____

Is the person currently a patient at our office? ◯ Yes ◯ No

Do you have medical insurance? ◯ Yes ◯ No If yes, complete the following:

Name of the insured: _____ Relationship to patient: _____
DOB: _____ SSN: _____ Name of Employer: _____ Work Phone: _____
Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Insurance ID #: _____
Insurance 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 Sunshine Medical Centers 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 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 _____ (signature of patient)

X _____ (Please print patient name) x _____(signature of Guardian if applicable)

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ Date: _____
Chief Compliant: _____

History of Present Illness:

Location of Problem: _____
(Where is the pain/problem?)

What activities have you given up or changed due to this problem?
_____

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the worst)

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

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

What have you tried in the past to handle this problem?
_____
(Heat, ice, over the counter medications, prescription medications, rest, exercise, physical therapy, chiropractic, massage)

What other areas of your body are affected by this problem?
_____
_____
(Ex. ankle problems due to knee problem)

What activities increase symptoms / makes problem worse?
_____
_____
(What makes the pain/problem worse or better? Going up and down stairs etc.)

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
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	Kidney Disease	NO	YES
Whooping Cough	NO	YES	Migraines	NO	YES	Hemorrhoids	NO	YES	Thyroid Disease	NO	YES
Scarlet Fever	NO	YES	Tuberculosis	NO	YES	Date of last Chest X-ray	NO	YES	Bleeding Tendency	NO	YES
Diphtheria	NO	YES	Diabetes	NO	YES	Asthma	NO	YES	Mitral Valve Prolapse	NO	YES
Small Pox	NO	YES	Cancer	NO	YES	Hives / Eczema	NO	YES	Any other Disease	NO	YES
Pneumonia	NO	YES	Polio	NO	YES	AIDS or HIV	NO	YES	(Please List):		
Rheumatic Fever	NO	YES	Glaucoma	NO	YES	Infectious Mono	NO	YES	_____		
Arthritis	NO	YES	Hernia	NO	YES	Bronchitis	NO	YES	_____		
Venereal Disease	NO	YES	Blood Transfusion	NO	YES	Stroke	NO	YES	_____		

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

_____
_____
_____

Medications: (include non-prescription)

_____
_____
_____

Primary Care Physician: _____
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? _____
Do you have a sulfa allergy? NO◯ YES◯
Allergies/Medication Allergies: _____
_____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:** _____
Name: _____ DOB: _____ Date: _____

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: ◯ Rarely: ◯ Moderate: ◯ Daily: ◯
Excessive Exposure at home or at work to: Fumes: ☐ Dust ☐ Solvents: ☐ Airborne Particles: ☐ Noise: ☐

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

Muscular / Skeletal:		**Neurological:**		**General:**	
Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5	Weakness	1 2 3 4 5
Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Low Back Pain	1 2 3 4 5	Tingling in hands or feet	1 2 3 4 5	Irritability	1 2 3 4 5
Neck Pain	1 2 3 4 5	Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
Wrist / Hand Pain	1 2 3 4 5	Burning in hands or feet	1 2 3 4 5	Diarrhea	1 2 3 4 5
Elbow Pain	1 2 3 4 5	Hypersensitivity	1 2 3 4 5	Feeling Foggy	1 2 3 4 5
Shoulder Pain	1 2 3 4 5	Difficulty with balance	1 2 3 4 5	Forgetfulness	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 between shoulder blades	1 2 3 4 5				

Do you have a Living Will? ◯NO ◯YES Do you have a DNR (Do Not Resuscitate) ◯NO ◯YES
IF YES, PLEASE PROVIDE THE OFFICE WITH A COPY FOR YOUR FILE.

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

_____ _____
Signature of person holding POA for patient Date

_____ _____ _____
Doctor's Review Signature of Doctor Date