MEDICAL HISTORY

Office Use Only
☐ Medical History Completed
Completed By:
Date Completed:

Patient Name: _____ **DOB:**_____

REASON FOR VISIT: _____

PAST MEDICAL HISTORY: Have you had any of the following conditions?

❑ Diabetes	❑ Environmental Allergies	❑ Brain or Nerve Disease	❑ Arthritis
❑ Thyroid Disorder	❑ Blood Clots or Phlebitis	❑ Liver Disease	❑ Ulcers
❑ Tuberculosis	❑ Anxiety	❑ Hepatitis	❑ Abnormal Skin Test
❑ High Blood Pressure	❑ Depression	❑ Heart Disease/Problems	❑ Migraine
❑ Cholesterol Problems	❑ Mental Illness	❑ Sexually Transmitted Disease	❑ Seizures
❑ Lung Disease	❑ Kidney Disease	❑ Acid Reflux or Hiatal Hernia	❑ Asthma
❑ Osteoporosis	❑ Kidney Stones	❑ Cancer:_____	❑ Other:_____

LIST ALL CURRENT MEDICATIONS & DOSES (Including birth control, pain meds, sleeping med, non-prescription and vitamins)

Medication Name	Medication Strength	Medication Dose

LIST ALL MEDICATION ALLERGIES (Including reaction):_____

LIST ALL HOSPITALIZATIONS FOR MAJOR ILLNESSES OR SURGERIES:

Date	Hospitalization and/or Operation

Date	Severe Accidents and/or Injuries

FAMILY HISTORY: Age at Death / Reason

Mother _____ / _____ Father _____ / _____ Sibling _____ / _____ Sibling _____ / _____

(Below, please circle any that apply to your family members. Mother = M, Father = F, Sibling = S)

M/F/S - Thyroid Disease	M/F/S - Diabetes	M/F/S - Osteoporosis	M/F/S - Blood Clots	M/F/S - Cancer	M/F/S - Ulcers
M/F/S - High Blood Pressure	M/F/S - Stroke	M/F/S - Mental Illness	M/F/S - Heart Attack	M/F/S - TB	M/F/S - Alcoholism

SOCIAL HISTORY:

Alcohol use:	# of drinks per day:	What age did you start drinking?	Year Quit:
Tobacco use:	Type:	# Per day: What age did you start?	Year Quit:
Coffee use:	# of drinks per day:	Energy Drink use: # of drinks per day:	History of Drug abuse: Yes / No

Flu Vaccine	Y N	Date:		Typical breakfast:
Tetanus Booster	Y N	Date:		Typical lunch:
Pneumonia	Y N	Date:		Typical dinner:
Hepatitis B	Y N	Date:		Typical snacks:
Last Colonoscopy	Date:		Result	How often do you exercise?
				What is your workout?

_____

Patient or Authorized Representative Signature **Date**

REVIEW OF SYSTEMS

Patient Name: _____ **DOB:**_____

REVIEW OF SYMPTOMS: (Please check each item "yes" or "no" as they relate to your current health)

CONSTITUTIONAL:	Yes	No
Weight Loss/Gain	❑	❑
Fatigue	❑	❑
Fever	❑	❑
EYES:		
Glasses/Contacts	❑	❑
Eye Pain	❑	❑
Double Vision	❑	❑
Cataracts	❑	❑
EAR, NOSE, THROAT:		
Difficulty hearing	❑	❑
Ringing in ears	❑	❑
Vertigo	❑	❑
Sinus trouble	❑	❑
Nasal stuffiness	❑	❑
Frequent sore throat	❑	❑
CARDIOVASCULAR:		
Chest pain	❑	❑
Rapid Heart Rate	❑	❑
Palpitations	❑	❑
Elevated Blood Pressure	❑	❑
Dizziness	❑	❑
Varicose Veins	❑	❑
ENDOCRINE:		
Hair Loss	❑	❑
PMS	❑	❑
Irritability/Mood Swings	❑	❑
Hot flashes/ Night Sweats	❑	❑
Insomnia	❑	❑
Fatigue	❑	❑
Weight Gain	❑	❑
Impaired Memory	❑	❑

RESPIRATORY:	Yes	No
Cough	❑	❑
Coughing blood	❑	❑
Wheezing	❑	❑
Chills	❑	❑
Shortness of breath	❑	❑
Sputum Production	❑	❑
GASTROINTESTINAL		
Heartburn/Reflux	❑	❑
Nausea/Vomiting	❑	❑
Constipation	❑	❑
Change in BM's	❑	❑
Diarrhea	❑	❑
Jaundice	❑	❑
Abdominal Pain	❑	❑
Black or bloody BM	❑	❑
Difficulty Swallowing	❑	❑
GENITOURINARY:	❑	❑
Blood in Urine	❑	❑
Pain / Burning Sensation	❑	❑
Trouble Urinating	❑	❑
Flank Pain	❑	❑
Frequency / Urgency		
Incontinence	❑	❑
Rash or Lesion	❑	❑
Discharge	❑	❑
Itching or Odor	❑	❑
PSYCHIATRIC:		
Mood Swings	❑	❑
Anxiety and/or Depression	❑	❑
Difficulty Sleeping	❑	❑
Suicidal Thoughts	❑	❑
SEXUAL HEALTH		
Loss of Sexual Desire	❑	❑
Loss of Sexual Sensation	❑	❑
Pain with Intercourse	❑	❑
Inability to Achieve Orgasm	❑	❑
Impotence	❑	❑

HEMATOLOGY/LYMPH:	Yes	No
Bruise easily	❑	❑
Gums bleed easily	❑	❑
Enlarged glands	❑	❑
MUSCULOSKELETAL:		
Joint Pain/Swelling	❑	❑
Stiffness	❑	❑
Muscle Pain	❑	❑
Back Pain	❑	❑
SKIN:		
Acne	❑	❑
Rash/Sores	❑	❑
Lesions	❑	❑
Itching/Burning	❑	❑
NEUROLOGICAL:		
Loss of Strength	❑	❑
Numbness	❑	❑
Headaches	❑	❑
Tremors	❑	❑
Memory Loss	❑	❑

FEMALES ONLY:

Last Mammogram/results:_____	_____	
Last Pap/Results:	_____	_____
Age at onset of periods:_____		
Last menstrual period: _____		
Menses Cycle Regular?	❑	❑
Last DEXA Scan/Results: _____	_____	
Are you on Replacement Hormones?	❑	❑
Current Birth Control?_____		
Number of Child Births? _____		
Are you currently pregnant?	❑	❑
Are you trying to become pregnant?	❑	❑
Heavy Periods	❑	❑
Painful Cramps	❑	❑
Vaginal Discharge/Itching	❑	❑
Vaginal Dryness	❑	❑
Nipple Discharge	❑	❑
Cysts in Breasts	❑	❑

_____

Patient or Authorized Representative Signature **Date**

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Date Completed:

PATIENT REGISTRATION

Patient Information (Please Complete ALL Sections):

Patient Legal Name	Preferred First Name	Date of Birth
Address	City, State, Zip	
Primary Phone	May we leave a confidential message at this #? ☐ YES ☐ NO	Email
Assigned Sex at Birth: ☐ Male ☐ Female	Gender Identity/Preferred Pronoun (He/She/They/Other):	Social Security Number:
Pharmacy:	Job/Occupation:	How did you hear about us?
Marital Status:	Emergency Contact Name:	Emergency Contact Phone:
Authorized Representative:	Relationship to Patient:	Authorized Representative Phone:

Insurance Information (Please Complete ALL Sections):

Primary Health Insurance	Policy #	Group #	
Policy Holder Name	Policy Holder Date of Birth	Sex	Relationship to Patient
Secondary Health Insurance	Policy #	Group #	
Policy Holder Name	Policy Holder Date of Birth	Sex	Relationship to Patient
Guarantor's Name (Person responsible for payment)	Address:	DOB:	Phone:

I am receiving treatment as a result of an accident: ☐ Yes ☐ No
If Yes, was it a: ☐ Motor Vehicle Accident ☐ Work Related Accident ☐ Other

Please review and *initial next to each* policy listed below.

_____ **INFORMED CONSENT:** I understand that health care providers cannot guarantee results of treatment. I know that each person reacts in a different way to treatments and procedures. Therefore, the results cannot be certain. I acknowledge that no guarantee of the outcome of the care I have requested has been made. I have ample opportunity to ask questions, and my questions have been answered to my satisfaction. Chiropractic Care, Physical Therapy, Osteopathy, Massage Therapy, Nutrition Therapy: Though chiropractic, physical therapy, osteopathy, massage therapy and nutrition therapy treatments are usually beneficial and rarely cause any problems, I understand that, like many other forms of health care, there are some risks. These can include, but are not limited to; fractures, disc injuries, cerebral-vascular accidents, dislocations and sprain/strains. These complications are extremely rare occurrences.

_____ **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:**
I acknowledge, that at my request, Complete Care will provide me with a Copy of Complete Care's Notice of Privacy Practices.
I understand that Complete Care will use and disclose health information about me. I understand that my health information may include information both created and received by Complete Care, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information. I understand and agree that Complete Care may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

_____ **ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT** I hereby give lifetime authorization for payment of insurance benefits to Complete Care for any services rendered. I will provide a copy of my current insurance card and I understand I am financially responsible for all charges whether or not they are covered by insurance. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered. I hereby authorize Complete Care to release all information necessary to secure payment of benefits. I understand that it is my responsibility to know my insurance policy coverage and benefits and will notify Complete Care of any insurance changes in a timely manner. I understand that my insurance company may have additional stipulations that may affect my coverage and that I am responsible for any amounts not covered. Services rendered may be considered non-covered by my insurance and/or may be subject to deductible in addition to a copay. I understand that I have the right to refuse any service before they are rendered if I think they are non-covered services or not payable by my insurance.

FINANCIAL POLICIES

Patient Name: _____ **DOB:**_____

_____**COPAYMENTS:** I understand that all copays are due at check-in, prior to seeing my provider.

_____ **PRIVATE PAY PRIMARY CARE (SELF PAY):** I understand that if I will be responsible for all charges related to services provided to me by Complete Integrative Care and Complete Care Laboratories. A DEPOSIT of $230 will be collected at check in, prior to each appointment. The $230 deposit will be applied toward my balance for services rendered. I understand that I will receive a bill for the remaining balance for services rendered that day.

_____**ACCOUNT BALANCES:** I understand that if I have a balance on my account I will receive a monthly statement until the account is paid in full. Bills are due and payable upon receipt of this monthly statement. Complete Care will bill my insurance for me if I provide the appropriate billing information. I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter is mailed.

_____**MANAGED CARE (MEDICAID):** I understand that my insurance coverage is based on funding levels. There are some diagnoses and/or services that are considered non-covered and my insurance will not pay for any additional visits for these conditions or services.

_____**MEDICARE:** Complete Care is a participating provider with Medicare. Medicare will pay 80% of what they allow, minus your annual deductible. If this has not been met, you will be responsible for the deductible and the 20% of allowable charges. By signing this agreement, you authorize any holder of medical or other information regarding the patient names above to release such information to the Social Security Administration effective from this date.

_____**ANCILLARY SERVICES:** I understand that it is my responsibility to know from whom my insurance company requires me to obtain any labs, x-rays, or any other ancillary services and I will let my providers medical staff know so that they may schedule these services accordingly. If my provider orders any tests, imaging or services not processed here at Complete Care, they will be sent to an outside provider. If you have labs processed at more than one facility, you could receive a statement from both Complete Care and the outside laboratory with any out-of-pocket expense as well as two EOB's (explanation of benefits) from your insurance company. If you have questions regarding charges from one of these services, you will need to contact the outside entity directly.

_____**CANCELLATION AND NO SHOW POLICY:** I understand that if I fail to notify Complete Care of a cancelation or reschedule at least 1 business day before my scheduled appointment, for any reason, it will be recorded as a "same day" cancellation. If I have more than 3 same-day cancellations per 12-month period I understand that I may be dismissed from care.

_____**RETURNED CHECKS:** I understand that personal checks returned for non-sufficient funds may be charges a fee of $25. Balances must be handled by cash, credit card, or money order.

_____**ON-CALL PROVIDER SERVICES:** Please note that after hours call is available for all primary care urgent needs. **Please be advised prescription refills will not be addressed after hours and that no opioids or benzodiazepines will be prescribed for urgent needs. Please also be advised that if you choose to utilize our after-hours call service and receive care via the phone by the medical provider, there will be a $50.00 fee billed to your account.** Thank you for your understanding.

By signing this Financial Policy Notice and Notice of Privacy practices, you, the guarantor, acknowledge that you have read, understand and accept the above policies.

_____

Printed Name of Patient or Authorized Representative

_____ _____

Signature of Patient or Authorized Representative **Date**

AUTHORIZATION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth

Complete Care has my permission to discuss the information I have marked below with the following people:

- ❑ Name:_____
  Phone:_____
  Relationship to Patient:_____

- ❑ Name:_____
  Phone:_____
  Relationship to Patient:_____

- ❑ Name:_____
  Phone:_____
  Relationship to Patient:_____

The following information may be verbally shared with the people listed above:

(This form does not authorize releasing copies of my records.)

- ☐ Scheduling/Appointment Times and Dates
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plans
- ☐ Lab/Imaging/other test results
- ☐ Billing and Payment Information
- ☐ Other: _____

☐ Information is not to be released to anyone.

I understand that I have the right to revoke my permission at any time, and that these permissions remain in effect until the time I revoke in writing.

_____

Printed Name of Patient or Authorized Representative

_____ _____

Signature of Patient or Authorized Representative **Date**