1st Choice Health & Wellness Center

Patient Record

Date: _____

Who referred you to us?

_____

2441 State Street, #10 New Albany, Indiana 47150 (812) 945-4500

Name (first, middle initial, last): _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female Height: _____ Weight: _____

Marital status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced Spouse's name: _____

# of Children: _Name(s) _____

Social Security number: ____/____/____ Home phone: ( ) _____ Cell phone: ( ) _____

Email: _____ What is the best way to reach you? ❑ Home ❑ Cell ❑ Work ❑ E-mail

Employer: _____ Job title: _____ Work phone: ( ) _____ Ext____

• ***Insurance information - (Please also bring your insurance card(s) so we can put a copy in your file. Thanks!)***

Primary insurance company: _____ Insurance ID #: _____ Group #: _____

Name of subscriber: _____ Subscribers Date of Birth: _____

Relationship to patient: _____ Name of subscribers employer: _____ Phone #: _____

Secondary insurance: _____ Insurance ID #: _____

• ***Emergency contact information - In case of emergency, who should we contact?***

Name (first, middle initial, last): _____ Relationship: _____

Phone number: ( ) _____ Cell phone: ( ) _____

• ***Medical background information -***

What is your primary care doctor's name & address? _____

Have you had medical problems with: ❑ Heart ❑ Lungs ❑ Kidneys ❑ Gastro-Intestinal ❑ Genital/Urinary

❑ Nervous system (seizures, depression) ❑ Endocrine (diarrhea) ❑ Skeletal

For women only - Are you now (or do you think you might be) pregnant? ❑ Yes ❑ No ❑ Maybe

List all medications you are currently taking and the reason you are taking them: _____

_____

_____

_____

List all medical allergies: _____

List all major surgeries and the approximate dates you've had them during your lifetime: _____

_____

Do you smoke? ❑ Yes ❑ No Do you drink alcohol?: ❑ None ❑ Socially / occasionally ❑ Daily

• ***Your current condition***

What is your major symptom/problem? _____ Date began?: _____

What is the cause of your complaint?: ❑ Auto Accident ❑ Work injury ❑ Other Accident ❑ Illness ❑ Congenital ❑ Unknown Please describe how this onset of your primary complaint started: _____

_____

_____

Rate your pain - how do you feel today?

On a scale from 0 to 10, with 0 representing no pain and 10 representing the most severe pain you can imagine, please circle the appropriate number on each scale.

How do you rate your pain today? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)
Since your pain started, how do you rate your least pain level? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)
Since your pain started, how do you rate your worst pain level? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe) If this complaint was made worse by an auto accident, work or personal injury, what was your level of pain prior to the accident? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

If your primary complaint is a pain complaint, does it radiate? ❑ Yes ❑ No
If "Yes", it radiates where? _____

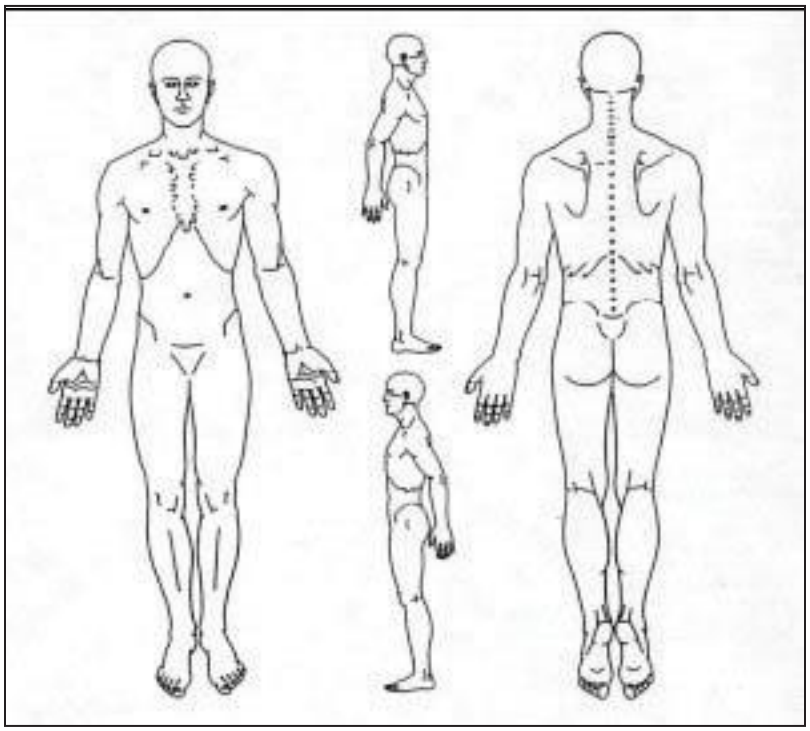
Is this your first episode of this pain complaint? ❑ Yes ❑ No

Have you had more than four episodes? ❑ Yes ❑ No

Is your primary complaint: ❑ Improving ❑ Getting worse ❑ About the same ❑ Intermittent
If your complaint is Auto, Work or Other-Accident related, when was the accident?_____/_____/_____

Please mark all areas of pain:

Patient information & authorization



I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to this office will be credited to my account upon receipt. I permit this office to endorse co- issued remittances for the convenience of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me are immediately due and payable unless other arrangements have been made.

I authorize 1st Choice Health & Wellness Center to release any information regarding my treatment to any insurance company in effort to receive re-imbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____ _____
Patient's signature Date

_____ _____
Spouse's or Guardian's signature Date