Advanced Medical and Chiropractic Services

GENERAL INFORMATION

Today's Date	Prefix ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Miss	First Name	Middle Name	Last Name

Street Address (No POB)	City	State	Zip

Social Security No.	Marital Status ☐Married ☐Single ☐Divorced ☐Widowed	Date of Birth	AGE	Spouse's Name (if applicable)

Gender ☐Male ☐Female	Home Phone	Work Phone w/Ext.	Cell Phone	Pager	Other Phone

Preferred Contact Number ☐Home Phone ☐Work Phone ☐Cell Phone ☐Pager ☐Other Number

Is it okay to leave phone messages? ☐YES ☐NO	**Email Address** (By providing your email address, you agree to accept our marketing emails. We do not share emails addresses w/ other companies)

REASON FOR VISIT AND PATIENT STATUS

Reason for Today's Visit:	Patient Status: ☐ New Patient ☐Existing Patient

EMERGENCY CONTACT INFORMATION

First Name	Last Name	Relationship	Home Phone	Work/Cell Phone

WHO ARE YOU HERE TO SEE?

☐ *Dhanani, Nadya (BHMS) ☐ Greenberg, Mike (DC) ☐ Tan, Carlos (MD)	☐ Looper, Amber PA		☐ Other:_______________ *This provider does not diagnose and/or treat diseases. For all diseases and/or treatments, please see one of our Licensed Medical Doctors.

EMPLOYMENT

Employment Status ☐Full Time ☐Part Time ☐Full Time Student ☐Part Time Student ☐Retired ☐Other

Occupation	Company Name	Manager's Name

Employer Street Address (NO POB)	City	State	Zip

ADDITIONAL PERSONAL INFORMATION

Ethnicity ☐African-American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other_______________________

Date of Current Illness/Accident	Were You Injured on the Job? ☐Yes ☐No

PRIMARY CARE PHYSICIAN

Primary Care Physician Name	Primary Care Physician's City & State

WERE YOU REFERRED BY ONE OF THE FOLLOWING?

☐ **Patient** ☐ **Physician** ☐ **Primary Care Physician** ☐ **Attorney** ☐ **Other**_______________________

If so, please complete the information below so we can thank them.

Company or Practice Name	First, Middle Last Name	Gender ☐Male ☐Female

Street Address (NO POB)	City	State	Zip

Phone Number:	Fax Number:

PRIMARY INSURANCE COMPANY INFORMATION

Name of Insurance Company	Contact Name (if applicable)

Claims Address	City	State	Zip

Customer Service Number	Effective Date	Co-Pay

Insurance Plan Name	Plan Type (HMO, PPO, POS, etc)	Patient's Policy Number	Group OR FECA No.

GUARANTOR/POLICY HOLDER INFORMATION

Please complete the information below if you are not the primary insurance policy holder.

Policy Holder's First Name	Policy Holder's Middle Name	Policy Holder's Last Name

Policy Holder's Street Address (NO PO Box)	City	State	Zip

Policy Holder's Employer	Policy Holder's Date of Birth	Policy Holder's Social Security No.

Policy Holder's Phone Number	Relationship to Policy Holder	Policy Holder's Gender ☐Male ☐Female

ATTORNEY INFORMATION

You may be asked to sign an attorney/patient lien.

Attorney Name	Attorney Phone	Attorney Fax

Attorney Address	City	State	Zip

Do you need auto/medical insurance filed also? ☐Yes ☐No

INSURANCE DISCLAIMER

Any insurance benefits our office discusses with you are based on verbal conversations with your insurance carrier(s). We do not guarantee the accuracy of this information, nor do we determine eligibility, medical necessity, or the existence of a pre-existing condition. Please contact your Insurance carrier(s) for more information.

FINANCIAL AGREEMENT

1. All information is accurate to the best of my knowledge.
2. I authorize the release of all medical records necessary to insure payment to Advandced Medical and Chiropractic Services (AMNCS).
3. I assign all benefits payable to AMNCS and agree to give fifteen days written notice should I decide to void that agreement.
4. All accounts are due and payable on the date of service unless prior arrangements have been made. There will be a $28.00 fee assessed for returned check fees.
5. As a courtesy, my insurance may be filed. Regardless of coverage, all accounts are due and payable within 60 days.
6. If AMNCS agrees to accept an attorney lien, I understand that regular monthly payments are due from date of service until the case is settled. I also understand Payment in full is due within 30 days of the date of settlement.
7. AMNCS reserves the right to modify this agreement with ten days written notification.
8. Interest in the amount of 1.5% monthly may be charged to any account with a balance greater than 60 days.
9. I authorize the Physicians to use images of me for identification purposed and/or images captured during the course of treatment for educational/instructional purposes.
10. In the event that my account is delinquent, I understand and agree that I will be responsible for attorney fees (15%), court costs, or any related fees. In addition, I understand and agree that should my account be turned over to a collection agency that I will be responsible for any collection fees (30%).

Signature of Patient or Guarantor	Today's Date

INTERNAL USE ONLY

☐Driver's Lic Copy	☐Insurance Copy	☐Photo Taken	☐ Auto Insurance (if applicable)	Your Initials

All providers listed are Independent Contractors. The worker is not under the control of the employer for the performance of work.

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PATIENT ACKNOWLEDGEMENT AND CONSENT

I have been given a copy of AMNCS' Notice of Privacy Practices. I consent to the uses and disclosure of my health information as outlined in the Notice of Privacy Practices.

______________________________ ____________________
Signature of Patient or Representative Date

____
Printed Name of Patient

____
Printed Name of Representative

Please describe the Representative's authority to act on behalf of the Patient **(initial one).**

( ) The representative is the parent of the patient, who is a minor.

( ) The representative is the guardian of the patient, who has been adjudicated incompetent.

( ) The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to AMNCS.

( ) I authorize/give my consent to the person(s) below to discuss my PHI. I understand that I may revoke this authorization at any time by giving written notice to AMNCS:

1. ______________________________ ____________________
(Name) (Relationship)

2. ______________________________ ____________________
(Name) (Relationship)

3. ______________________________ ____________________
(Name) (Relationship)

FOR OFFICE USE ONLY

If acknowledgement of receipt of the Notice of Privacy is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and reason you could not obtain it.

____

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Advanced Medical and Chiropractic Services

Amber Looper, PA-C

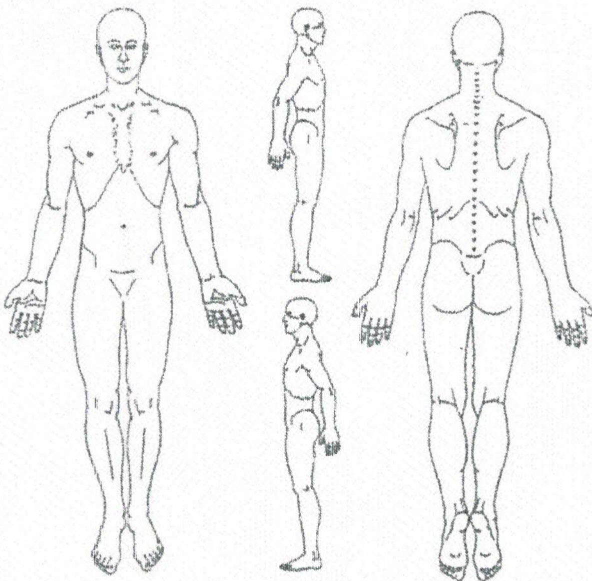
Patient Pain Symptoms Questionnaire and Assessment Form

Patient's Name ______________________________ **Birthdate:** ________________

Current Complaint: ____

When did your symptoms first begin? ____

Is this condition getting progressively worse? _______________________________________



Using the diagram, indicate any areas you are feeling pain by marking a

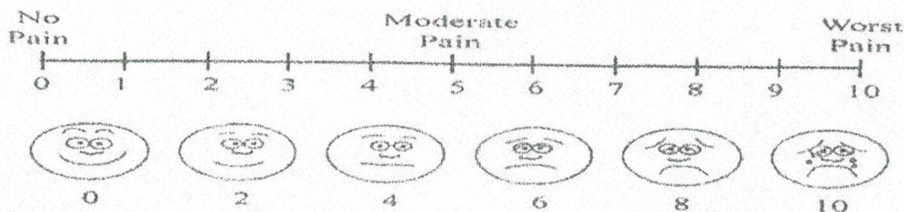
PPP=Pain **NNN=Numbness** **TTT=Tingling**
BBB= Burning **CCC=Cramping** **XXX=Other**

Please indicate any other symptoms that you have experienced:

___Dizziness ___Memory Loss ___Numb Feet/Toes
___Irritability ___Ears Ringing ___Back Pain
___Difficulty Sleeping ___Fatigue ___Jaw Problems
___Chest Pain ___Arm/Shoulder Pain ___Leg Pain
___Back Stiffness ___Blurred Vision ___Tension
___Numb Hand/Fingers ___Low Back Pain
___Neck Stiffness ___Shortness of Breath ___Nausea
___Buzzing in Ear ___Neck Pain ___Upset Stomach

___Other: ________________________________

On a scale of 1-10, with 10 being the worst possible pain, what is your level of pain?



The pain is (check all that apply):

☐ Constant ☐ Intermittent ☐ Worse in Morning ☐ Worse in Afternoon ☐ Worse at Night

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Type of pain (check all that apply):

☐ Sharp/stabbing ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Stinging
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Tender ☐ Other ______

The onset of the pain occurred:

☐ Zero to 72 hours ☐ 4 – 5 days ☐ 1 week ☐ 2 – 3 weeks ☐ 1 month ☐ 2 - months

The pain is (check all that apply):

☐ Better with heat
☐ Better with ice
☐ Better with movement
☐ Better while sitting
☐ Better while standing
☐ Better while lying down

☐ Worse with heat
☐ Worse with ice
☐ Worse with movement
☐ Worse while sitting
☐ Worse while standing
☐ Worse while lying down

Does it interfere with your

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Do you exercise? **Y / N**

If yes, how many days a week do you exercise? __________ How long? __________

What type of exercise(s)? ______________________________

Have you ever seen a pain management specialist? **Y / N**

If yes, what treatments are you currently receiving on a regular basis? (Acupuncture, physical therapy, medication, etc.) ______________________________

I certify that the above information I have provided is to the best of my knowledge accurate and true.

Patient Signature ______________________________ Date __________

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other ____________

Name and phone number of other doctor(s) who have treated you for your current condition ____________

Date of Last: Physical Exam ____________ Spinal X-Ray ____________
Spinal Exam ____________ Chest X-Ray ____________
Dental X-Ray ____________ MRI, CT-Scan, Bone Scan ____________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐	☐	Fractures	☐	☐	Mumps	☐	☐
Alcoholism	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐
Allergy Shots	☐	☐	Goiter	☐	☐	Pacemaker	☐	☐
Anemia	☐	☐	Gonorrhea	☐	☐	Parkinson's Disease	☐	☐
Anorexia	☐	☐	Gout	☐	☐	Pinched Nerve	☐	☐
Appendicitis	☐	☐	Heart Disease	☐	☐	Pneumonia	☐	☐
Arthritis	☐	☐	Hepatitis	☐	☐	Polio	☐	☐
Bleeding Disorders	☐	☐	Hernia	☐	☐	Prostate Problem	☐	☐
Breast Lump	☐	☐	Herniated Disk	☐	☐	Prosthesis	☐	☐
Bronchitis	☐	☐	Herpes	☐	☐	Psychiatric Care	☐	☐
Bulimia	☐	☐	High Blood Pressure	☐	☐	Rheumatoid Arthritis	☐	☐
Cancer	☐	☐	High Cholesterol	☐	☐	Rheumatic Fever	☐	☐
Cataracts	☐	☐	Kidney Disease	☐	☐	Scarlet Fever	☐	☐
Chemical Dependency	☐	☐	Liver Disease	☐	☐	Sexually Transmitted Disease	☐	☐
Chicken Pox	☐	☐	Measles	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Migraine Headaches	☐	☐	Suicide Attempt	☐	☐
Emphysema	☐	☐	Miscarriage	☐	☐	Thyroid Problems	☐	☐
Epilepsy	☐	☐	Mononucleosis	☐	☐	Tonsilitis	☐	☐
			Multiple Sclerosis	☐	☐			

Condition	Yes	No
Tuberculosis	☐	☐
Tumors, Growths	☐	☐
Typhoid Fever	☐	☐
Ulcers	☐	☐
Vaginal Infections	☐	☐
Whooping Cough	☐	☐

Other ____________

EXERCISE
☐ None ☐ Moderate
☐ Daily ☐ Heavy

WORK ACTIVITY
☐ Sitting ☐ Light Labor
☐ Standing ☐ Heavy Labor

HABITS
☐ Smoking Packs/Day ______ ☐ Coffee/Caffeine Drinks Cups/Day ______
☐ Alcohol Drinks/Week ______ ☐ High Stress Level Reason ______

Are you pregnant? ☐ Yes ☐ No Due Date ____________

Injuries / Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
Pharmacy Name ______		
Pharmacy Phone ______		