ADVANTAGE HEALTH AND WELLNESS CENTER
510 Pasadena Ave S., St. Petersburg, FL 33707 7730 Starkey Road Seminole, FL 33777 P: 727-343-3959 F: 727-343-3125

PATIENT INFORMATION FORM

Please answer all the questions completely. If you do not understand a question or are unsure of the information, please ask for assistance. **All bold questions are mandatory**.

Please provide your insurance cards for us to copy to ensure proper billing.

Name: (First)________________________, (Middle) ______________, (Last)___________________________

Address: _____________________________________, **City:** ___________________, **State:**___, **Zip:** ______

Phone: Home: ( )______________ , Work: ( )_____________, **Soc. Sec. #** : ______ - _____ - ______

E-mail address: ____, Age: ______, **Sex:** M / F

Birth Date: ____ /____ /______ **Marital Status:** □ Single □ Married □ Widowed □ Divorced □Separated

Preferred Language: __________, **Race:** ____________, (Decline to Provide), **Ethnicity:** __________ (Decline to Provide)

Spouse Name: __________________, Ages of Children: ________, **Employer**:__________________________

Occupation: ____, Employer Phone # ( ) ____________

Emergency Contact: ______________________, Relation: _____________, **Phone #** ( ) ____________

How did you learn about us? ____

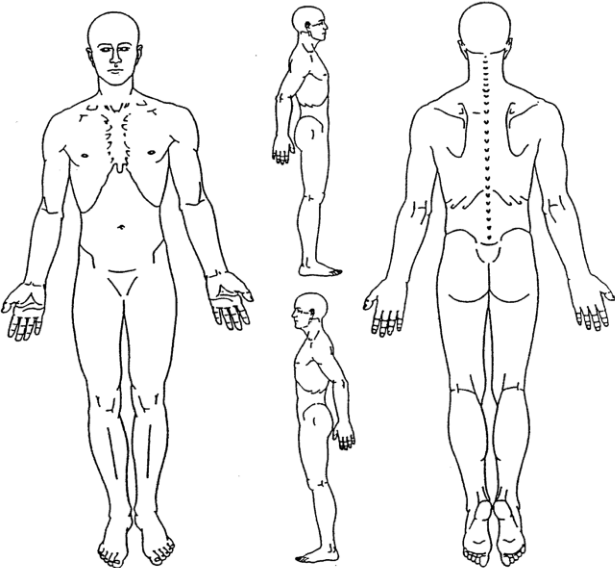
Reason for treatment today: □ Illness, □ Accident: □ Auto, □ Work, □ Other: ______________________

If related to an accident, have you reported it to your Auto Insurance or Employer? □ YES □ NO

Do you have health insurance? □ YES, □ NO Company: ____

Full Name of Policy Holder: ___________________________, **Policy Holder's Date of Birth** ____/____/____

Please mark the location of the pain or condition on the diagram. Describe the pain(s) in the column, use words such as: ache, burning, numb, radiating pain, sharp, shooting, stabbing, throbbing, tightness, tingling, etc.



CHIEF COMPLAINT: (Please describe the type and location of your pain)

____

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First date of injury / symptoms: ____________________

How did this condition develop? ____

When did you first notice this problem? ____

Have you ever had the same or similar condition? If yes, when and describe: ____________________________

____

Indicate any other healthcare providers who you've seen for this injury or condition, and the date of treatment.

Name: __________________________, Office: ________________________, Date of Last Visit: ___/___/___

Name: __________________________, Office: ________________________, Date of Last Visit: ___/___/___

Name: __________________________, Office: ________________________, Date of Last Visit: ___/___/___

Are you currently working? □ YES, □ NO Current job title and duties: ________________________________

____

Do you have difficulty doing your job now? □ YES, □ NO Explain: _________________________________

____

Have you lost time from work as a result of your condition? □ YES, □ NO How much? ________________

Check any difficulties you are currently experiencing:

□ Anxiety
□ Balancing
□ Bathing
□ Bending
□ Caring for children
□ Caring for pets
□ Cleaning
□ Concentration
□ Cooking
□ Coughing
□ Dressing
□ Driving
□ Eating
□ Exercise / Sports
□ General mobility
□ Going down stairs
□ Going up stairs
□ Hearing
□ Hobbies
□ Holding onto objects
□ Housework
□ Jogging/running
□ Kneeling
□ Lifting
□ Long-term memory
□ Lying down
□ Making decisions
□ Memory
□ Personal hygiene
□ Pushing/pulling with hands
□ Reaching
□ Reading
□ Riding in a car
□ School work
□ Sexual activity
□ Shopping
□ Short-term memory
□ Sitting
□ Sleeping
□ Speaking
□ Standing
□ Sneezing
□ Twisting
□ Typing
□ Using the phone
□ Using the toilet
□ Vision
□ Walking
□ Work / Job
□ Yard work
□ Yawning
□ Other: __________

Are you currently taking any medications or drugs? □ YES, □ NO List all: __________________________

____

Are you allergic to any medications or drugs? □ YES, □ NO List all, and reaction: ___________________

____

Do you use tobacco products? □ YES, □ NO If yes: □ Cigarettes □ Chew tobacco □ E-Cigarettes

Smoking status: □ Never smoker □ Former smoker □ Some day smoker □ Everyday smoker □ Decline

Do you drink alcohol? □ YES, □ NO If yes: Amount: ____, □ Daily □ Weekly □ Socially □ Rarely

Do you drink coffee? □ YES, □ NO If yes: Amount: ____, □ Daily □ Weekly □ Socially □ Rarely

Do you drink pop? □ YES, □ NO If yes: Amount: ____, □ Daily □ Weekly □ Socially □ Rarely

Have you had any previous illnesses or conditions? □ YES, □ NO Please List: ________________________

____

List type and date of any past surgeries or fractures: ____

MEDICAL HISTORY: Have you ever suffered from:

□ High Blood Pressure □ Arthritis □ Heart Disease □ Cancer: _____________

□ Dizziness □ Numbness □ Diabetes □ Anemia

□ Headaches □ Neuritis □ Asthma □ Digestive Disorders

□ Backaches □ Nervousness □ Hernia □ Significant Weight Change

□ OTHER: ____ □ None of the Above

WOMEN ONLY: Are you pregnant or is there any possibility you may? □ YES, □ NO, □ UNCERTAIN

<u>Please list any diseases or cause of death for the following family members:</u>

FAMILY HISTORY	Mother	Father	Sibling(s)	Children
DISEASE				
IF DECEASED, CAUSE OF DEATH				

Do you have a **Primary Care Doctor**? Dr.______________________________ Phone: ____________________

May we request and / or send information to the above-mentioned healthcare providers in order to make them aware of your progress and keep your records updated? □ YES, □NO

Is there anything else you wish to talk to the doctor about that is not mentioned on this form? □ YES, □ NO
<u>PLEASE REMEMBER TO BRING UP YOUR CONCERN WHEN YOU ARE WITH THE DOCTOR</u>.

I have read all the questions thoroughly and to the best of my knowledge and memory at this time, the information I have given is accurate and complete. If accepted as a patient, I hereby give the doctor permission to perform on myself (or minor child for whom I declare I am the parent or legal guardian) such general procedures, as they may deem necessary in the diagnosis and/or treatment of my (their) condition.

____ ______________________

Patient Signature Date

Fees are payable at the time of service, unless other arrangements are made in advance.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

________________________________ ___________________

Patient Name (please print) Date

____

Parent, Guardian, or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release your Protected Health Information.

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

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INFORMED CONSENT

I hereby authorize Dr. Mark Wieland, Dr. Thomas Hughes, Dr. Frank Reinhardt, and/or such assistant(s) as may be selected by him to treat me for my current complaints and physical conditions. Dr. Wieland, Dr. Hughes, or Dr. Reinhardt has explained to me the findings of the examination as well as the possible procedures necessary to treat my condition(s). The possible treatment procedures may include chiropractic spinal manipulation, electric muscle stimulation, ultrasound, moist heat, application of cold packs, traction, various forms of soft tissue manipulation by the doctor or a licensed massage therapist, exercise rehabilitation therapy, biomechanical and postural recommendations and lifestyle alteration.

The possible adverse effects during and after the application of therapy, including thermal irritation to the skin from moist heat application or cold packs, pain, or soreness from therapy such as joint manipulation, massage, and exercise therapy are reviewed. Additional complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns..

The very rare risk (1.46 per million) of possible vertebrobasilar accident (stroke) associated with cervical manipulation is reported, as is the rare possibility of major impairment (.639 per million) as a result of spinal manipulation*. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me

The possible and anticipated benefits of treatment can be pain reduction and improvement in ability to perform activities of daily living and/or occupational activities that are now restricted due to my current physical condition related to my current medial problems. Diagnostic procedures of x-rays (if necessary) and the associated risks and benefits are also explained to me.

The possible results of not seeking care and potential natural resolution of the condition(s) have been explained to me. The subject of referral to another branch of the healing arts for treatment or a second opinion is discussed. The possibility of failure of these procedures to relieve pain and/or resolve my condition(s) is discussed and no guarantee to resolve the condition(s) has been made to me by the doctor or his staff.

___ I have been told my current estimated active treatment plan will take approximately: ___ weeks / months and/or consist of approximately ___ treatments.

___ I have been told my current treatment plan is supportive or palliative in nature and will be on an as needed basis. This schedule can change substantially dependent upon my response to treatment or changes in my diagnosis.

I acknowledge that I have read this document in its entirety and that I fully understand it. I acknowledge that I was given ample time to review the document and an opportunity to ask the doctor or his staff any questions I may have concerning its contents. I am also instructed to ask any questions concerning my condition(s), tests or treatment at any time in the future if such questions should arise.

By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

______________________________ ________________________________ ________________

Patient Name Patient Signature Date

____

Witness

* Rand Study, 1996

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ASSIGNMENT OF BENEFITS

Having been accepted as a patient at Advantage Health & Wellness Center, (hereafter called THE OFFICE), I understand and agree to the following conditions of acceptance:

1. CONSENT TO TREATMENT: I give THE OFFICE permission to perform on myself (or minor child for whom I declare I am the parent or legal guardian) such general procedures, as they may deem necessary in the diagnosis and/or treatment of my (their) condition. My signature below verifies my full understanding of this consent and, upon my request, any possible risks regarding chiropractic treatment will be explained to me. I acknowledge THE OFFICE has made no guarantee or assurance as to any results I may obtain from services received.

2. NOTIFICATION OF CHANGES: I will notify THE OFFICE of changes in my health status, home, work telephone numbers, mailing address, insurance benefits, attorney representing me in a personal injury law suit, and any information I have given on the patient intake forms.

3. RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and obtain reimbursement, I authorize THE OFFICE to furnish, upon written request authorized by me, any information in my medical record including photographs or computer images to any and all persons or organization which are or may be liable for all or any portion of my medical charges at THE OFFICE. I authorize THE OFFICE to release any information pertinent to my case to any insurance company or their representative involved in this case.

4. FILING INSURANCE CLAIMS: As a courtesy and at my request for THE OFFICE to accept delayed payment for my care, THE OFFICE will submit insurance claim forms for payment of my medical benefits. I authorize THE OFFICE to submit claims for each service rendered and charge usual, reasonable, and customary charges in this area for each service.

5. I hereby instruct and direct my insurance company: (__________________________) to pay by check made out to: Advantage Health & Wellness Center and mailed to 510 Pasadena Ave So., St. Petersburg, FL 33707 under my current personal injury protection/medical payments insurance policy as payment towards the total charges rendered by Advantage Health & Wellness Center. This is a direct assignment of benefits and rights under this policy. This assignment includes my right to file any and all legal claims against my insurance company if it fails to make timely, reasonable, or proper payments to Advantage Health & Wellness Center. A photocopy of this assignment is to be considered as effective and as valid as the original. I also authorize the release of any information pertinent to my claim to any appropriate insurance company or attorney.

6. ATTORNEY LIEN: In the event I receive medical payment benefits, no-fault benefits, health and accident benefits, workers compensation benefits, or other reimbursement from any settlement, judgment, or verdict on my behalf, I hereby authorize and direct my attorney to FIRST PAY THE OFFICE directly the amount due for services rendered before any other disbursements are made from any funds received by the attorney's office on my behalf. This attorney lien is binding on any and all attorneys involved in my case prior to and subsequent to the date of this agreement with THE OFFICE. I may only revoke this lien by a certified letter received at THE OFFICE. I also give power of attorney to THE OFFICE to endorse/sign my name on any check received in my name for services rendered and owing THE OFFICE.

7. GUARANTEE OF PAYMENT: I understand and agree I am personally responsible for all services received at THE OFFICE, and promise to pay regardless of my health insurance benefits and/or possible future payment from any judgment or verdict on my behalf. I understand if my account at this office is past 60 days overdue, it may be subject to a 1.5% per month (18% per year) finance charge. If the defaulted amount is referred to a collection agency and/or for legal action, I agree to pay for reasonable court costs and other costs of collection.

MY SIGNATURE BELOW VERIFIES I HAVE READ AND UNDERSTAND THE ABOVE CONDITIONS OF ACCEPTANCE AS A PATIENT AT THE OFFICE, AND I AGREE TO THESE CONDITIONS.

A photocopy of this agreement shall be considered as effective and valid as the original.

______________________________	______________________________	________________
Patient Name	**Patient Signature**	**Date**

____

Witness