



Patient Information

Name: _____
Last First MI

Mailing Address: _____ City: _____, State: _____, Zip: _____

Phone# (H) _____ (M) _____

Date of Birth: ____/____/____ Male Female SS#: _____

Marital Status: Single Married Minor

Employer: _____ Email Address: _____

May we call you at work? Yes No Can we leave a voicemail/message? Yes No

May we text you to confirm/reschedule appointments? Yes No to inform you of services offered? Yes No

How did you hear about us: _____

Emergency contact: Name: _____ Relation: _____

Phone: (H) _____ (W) _____

HEALTH HISTORY

Who is your main doctor or health care provider: _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of strength | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Bowel/Bladder |
| <input type="checkbox"/> Mid Back Pain. | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Night Pain | Changes |
| <input type="checkbox"/> Low Back Pain. | (Please Circle Areas) | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Sudden Weight | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Pins/Needles in: | <input type="checkbox"/> Light Bothers | Loss | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Leg/Knee Pain | Arms,Hands, Fingers | <input type="checkbox"/> Eyes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Headaches | Legs, Feet | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Arms Numb | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Tension | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Asthma | Due to Pain | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Shortness of Breath | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatoid |
| <input type="checkbox"/> Alcoholism | _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | Arthritis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | Fever |
| <input type="checkbox"/> Anorexia | Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid |
| Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | Problems |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | | |

- Tumors/Growths Ulcers Venereal Disease Other; _____
- Typhoid Fever Vaginal Infections Whooping Cough _____

Form ND

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

PLEASE LIST ALL ALLERGIES: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Did anybody in your family have any of the following conditions? Please check the box and tell us who it was.

- Heart Disease _____ Diabetes _____ Stroke _____
- Cancer _____ Arthritis _____ Other _____

Do you exercise? Frequently Moderately Occasionally None

At work do you mostly: Sit Stand Do Light Lifting Do Heavy Labor

What is your daily/weekly intake of the following?

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

PAST, FAMILY & SOCIAL HISTORY (PFSH)

Past History

Allergies: _____

Medications: _____

Illnesses: _____

Operations: _____

Do you have any surgical devices in your body? (i.e. screws, pins, plates, etc?)

If yes, what are they , and where are they located _____

Family History of Diseases:

Social History

Smoker Y N Comments _____

Alcohol Y N Comments _____

Illicit Drugs Y N Comments _____

Employment Y N Comments _____

Financial Information

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

Name of person whose is the policy holder of this insurance: _____ SS#: _____

Relationship to patient (if other than self): _____ DOB: _____ Phone: _____

ID # _____ Group # _____ member services phone number _____

Assignment, Consent of Care and Release

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make it known to the doctor.

PATIENT SIGNATURE (X) _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

I was given the opportunity to receive and review the office's Patient Notice of Privacy Practices policy.

PATIENT SIGNATURE (X) _____ DATE _____

**AUTHORIZATION FOR CARE
ASSIGNMENT OF INSURANCE BENEFITS**

This is an agreement between the undersigned patient and Advanta Total Health LLC (hereinafter referred to as Advanta).

Initial the Following:

_____ **I hereby authorize Advanta to treat my condition, as the clinician deems appropriate including the use of diagnostic testing and prescribed treatment modalities.** Original x-rays taken at Advanta will remain the property of Advanta, being on file where they may be seen at any time while a patient of this office. Should I require copies of the films, I also agree to pay for the cost of duplication. Advanta will not be held responsible for any pre-existing medically diagnosed conditions.

_____ **I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.** Furthermore, I understand that Advanta 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 Advanta will be credited to my account on receipt. 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 that my fees for professional services rendered to me by Advanta will be immediately due and payable. Balances over 90 days will be transferred to an outside collection firm.

_____ **I understand that I am responsible to pay all collection and/or attorney fees for any debts including a 35% collection fee and court costs involved in collecting said balances.**

_____ **I agree to accept responsibility for whatever is not covered or accepted by the insurance company; this will include any part of my deductible, which has not been met, co-pays or disallowed services.**

_____ **I authorize and direct my insurance company, and/or my attorney, to pay directly to Advanta such sums as may be due and owing Advanta for services rendered me,** both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I understand that if my treatment is the result of a personal injury, that Advanta may have to provide additional documentation, depositions, and testimony. Because of this, I agree to pay Advanta the full amount of all services at their usual and customary fees notwithstanding any agreements Advanta may have with any other insurance companies/Health Maintenance Organizations, Preferred Provider Organizations, Point of Service carriers or healthcare entities or carriers of any kind. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks received for payment of my doctor bill.

_____ **I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.** I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collections efforts, including but not limited to all reasonable court costs and all attorney fees. I grant Advanta my permission to contact me in regards to my appointments and leave messages on my home, cell, or office.

_____ **I understand that, if I am accepted for care by Advanta, I will be responsible for attending all my appointments.** AND that, if necessary, I will call Advanta to reschedule my appointment a minimum of 24 hours in advance. If I fail to do this, I further understand Advanta may charge me a \$50 missed appointment charge.

Patient Name (Printed)

Person Authorizing Care if other than Patient

Signature

_____/_____/_____
Date

Witness

_____/_____/_____
Date

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I, _____, have had the opportunity to review a copy of
Advanta Total Health's Notice of Privacy Practices.

Signature of Patient/Parent/Guardian Date

Relationship to Patient

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____
Date Initials

I hereby grant permission to Advanta Total Health to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm an appointment, to notify me that test results are available, to notify me that a form or prescription is ready for pick-up, or to conduct any other relevant business that is deemed necessary.
Personal or detailed information will not be left on an answering machine or voice mail.

Signature of Patient/Parent/Guardian

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____
Date Initials