

**Superior Healthcare Physical Medicine**

4306 N Sheridan Rd, Peoria, IL 61614

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_

SS #/SIN \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Patient's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse or Patient's Guardian name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

\_\_\_\_\_  
Parent or Guardian Date

**Responsible Party**

Name of The Person responsible for this account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is the person currently a patient at our office?  Yes  No

**Do you have any Medical insurance?**  Yes  No if yes, complete the following:

Name of the insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or local # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS  
AS WELL AS AN**

**APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Superior Healthcare Physical Medicine** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

X \_\_\_\_\_ (SEAL)  
(patient signature)

X \_\_\_\_\_ (SEAL)  
(signature of Guardian if applicable)

X \_\_\_\_\_  
(please print patient name)

# Health History

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

## History of Present illness:

**Location:** \_\_\_\_\_  
(Where is the pain/problem?)

**Quality:** \_\_\_\_\_  
(Example: normal vs abnormal color, activity, etc..)

**Severity:** \_\_\_\_\_  
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

**Duration:** \_\_\_\_\_  
(How long have you had this pain/ problem?  
When did it start?)

**Timing:** \_\_\_\_\_  
(Does the pain/problem occur at a specific time?)

**Context:** \_\_\_\_\_  
(Where were you at the onset of this pain/problem?)

**Associated Signs/Symptoms** \_\_\_\_\_

**Modifying Factors** \_\_\_\_\_

(What other associated problems have you been having?)

(What makes the pain/problem worse or better? Have you had previous episodes?)

## Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles.....	NO	YES	Anemia.....	NO	YES	Back Trouble.....	NO	YES	Hepatitis.....	NO	YES
Mumps.....	NO	YES	Bladder Infection.....	NO	YES	High Blood Pressure.....	NO	YES	Ulcer.....	NO	YES
Chicken Pox.....	NO	YES	Epilepsy.....	NO	YES	Low Blood Pressure.....	NO	YES	Kidney Disease.....	NO	YES
Whooping Cough...	NO	YES	Migraine Headaches.	NO	YES	Hemorrhoids.....	NO	YES	Thyroid Disease.....	NO	YES
Scarlet Fever.....	NO	YES	Tuberculosis.....	NO	YES	Date of Last Chest X-Ray	_____	_____	Bleeding Tendency.....	NO	YES
Diphtheria.....	NO	YES	Diabetes.....	NO	YES	Asthma.....	NO	YES	Any Other Disease.....	NO	YES
Small pox.....	NO	YES	Cancer.....	NO	YES	Hives of Eczema.....	NO	YES	(Please List):	_____	_____
Pneumonia.....	NO	YES	Polio.....	NO	YES	AIDS & HIV.....	NO	YES	_____	_____	_____
Rheumatic Fever...	NO	YES	Glaucoma.....	NO	YES	Infectious Mono.....	NO	YES	_____	_____	_____
Arthritis.....	NO	YES	Hernia.....	NO	YES	Bronchitis.....	NO	YES	_____	_____	_____
Veneral Disease...	NO	YES	Blood or Plasma	_____	_____	Mitral Valve Prolapses...	NO	YES	_____	_____	_____
			Transfusion.....	NO	YES	Stroke.....	NO	YES	_____	_____	_____

**Primary Care Provider:** \_\_\_\_\_

**Previous Hospitalizations/Surgeries/Serious Illnesses**      **When?**      **Hospital, City, State**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication:** (include nonprescription)

\_\_\_\_\_

Have you ever taken Fen-Phen/Redux?      NO      YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: \_\_\_\_\_

**Allergies** \_\_\_\_\_

## Patient Social History:

Marital Status      Single: \_\_\_\_\_      Married: \_\_\_\_\_      Separated: \_\_\_\_\_      Divorced: \_\_\_\_\_      Widowed: \_\_\_\_\_

Use of Alcohol      Never: \_\_\_\_\_      Rarely: \_\_\_\_\_      Moderate: \_\_\_\_\_      Daily: \_\_\_\_\_

Use of Tobacco      Never: \_\_\_\_\_      Rarely: \_\_\_\_\_      Moderate: \_\_\_\_\_      Daily: \_\_\_\_\_

Use of Drugs      Never: \_\_\_\_\_      Type/Frequency: \_\_\_\_\_

Excessive Exposure

At home or at work to:      Fumes: \_\_\_\_\_      Dust: \_\_\_\_\_      Solvents: \_\_\_\_\_      Airborne Particles: \_\_\_\_\_      Noise: \_\_\_\_\_

**CLINICIAN SIGNATURE:** \_\_\_\_\_ **DATE REVIEWED:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date: \_\_\_\_\_

**Family Medical History:**

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

**Eyes/Ears/Nose/Throat/Respiratory**

**Muscular/Skeletal**

Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5
Wheezing	1 2 3 4 5		

**Neurological**

**General**

Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
		Diarrhea	1 2 3 4 5
		Feeling foggy	1 2 3 4 5
		Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

\_\_\_\_\_  
Signature of the Patient, Parent or Guardian

\_\_\_\_\_  
Date

Doctor's Review

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date