SuperiorMED
A SUPERIOR APPROACH TO TREATING PAIN
4306 North Sheridan Road, Peoria, IL 61614
info@superiormedpeoria.com
309.682.9000

Today's Date: _____

New Patient Paperwork

DEMOGRAPHICS

Patient Name_____ DOB _____/_____/_____ ☐ Male ☐ Female
Address _____ City _____ State _____ Zip _____
Email: _____ Phone _____ SS #/SIN _____
Check appropriate Box: ☐Single ☐Partner ☐Married ☐Divorced ☐Widowed ☐Separated
Employer Name:_____Occupation:_____
Whom may we thank for the referral? _____
Emergency Contact _____ Relation _____ Phone Number _____
In case of medical emergency, if the patient is 15+ years old it is okay to treat in my absence.

_____ _____
Parent / Guardian Signature. Date

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____++_____
Address of Employer_____ State _____ Zip_____
Insurance Company_____ Group #_____
Ins. Co. Address _____ City _____ State _____

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 SuperiorMED 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 or this document is to be considered as valid and as enforceable as the original.

Print Patient Name _____ Date _____

Patient Signature _____ Guardian Signature _____
(if applicable)

HEALTH HISTORY

Patient Name_____ DOB _____/_____/_____ Date _____

Chief Complaint _____

History of present illness:

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

Severity: *(On a scale between 1-5; how severe is the pain?)*_____

Duration: *(How long have you had this pain? When did it start?)*_____

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

Modifying Factors (What makes the pain/problem worse or better?)_____

Associated Signs/Symptoms *(What other associated problems have you been having?)*_____

_____

Are you pregnant, trying to conceive, or nursing? _____

PAST MEDICAL HISTORY

Please circle "yes" or "no" / leave blank if you are uncertain if you have ever had the following:

Measles	YES	NO	Migraine Headaches	YES	NO	Hives of Eczema	YES	NO
Chicken Pox	YES	NO	Diabetes	YES	NO	AIDS & HIV	YES	NO
Whooping Cough	YES	NO	Cancer	YES	NO	Bronchitis	YES	NO
Diphtheria	YES	NO	Polio	YES	NO	Hepatitis	YES	NO
Small Pox	YES	NO	Hernia	YES	NO	Kidney Disease	YES	NO
Pneumonia	YES	NO	Bleeding Tendency	YES	NO	Thyroid Disease	YES	NO
Arthritis	YES	NO	Back Trouble	YES	NO	Hemorrhoids	YES	NO
Stroke	YES	NO	Low Blood Sugar	YES	NO	Epilepsy	YES	NO
Anemia	YES	NO	Asthma	YES	NO			

Please list any other diseases _____

Primary Care Provider _____

Previous Hospitalizations / Surgeries / Serious Illness	When	Hospital / City / State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (include nonprescription) _____

Allergies _____

PATIENT SOCIAL HISTORY

Alcohol Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Tobacco Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Recreational Drug Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Excessive exposure at work or at home to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ Noise

CLINICIAN SIGNATURE _____ DATE REVIEWED _____

Patient Name_____ DOB _____/_____/_____ Date _____

FAMILY MEDICAL HISTORY

	Age	Disease	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____

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

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Constantly

General						**Muscular/Skeletal**					
Asthma	0	1	2	3	4	Muscle Aches	0	1	2	3	4
Muscle Aches	0	1	2	3	4	Fibromyalgia	0	1	2	3	4
Chronic Cough	0	1	2	3	4	Arthritis	0	1	2	3	4
Earache / Ear Infection	0	1	2	3	4	Joint Pain	0	1	2	3	4
Wheezing	0	1	2	3	4	Low Back Pain	0	1	2	3	4
Shortness of Breath	0	1	2	3	4	Neck Pain	0	1	2	3	4
Fatigue	0	1	2	3	4	Wrist/Hand Pain	0	1	2	3	4
Weakness, Tiredness	0	1	2	3	4	Elbow Pain	0	1	2	3	4
						Shoulder Pain	0	1	2	3	4
Neurological						Hip Pain	0	1	2	3	4
Headaches	0	1	2	3	4	Ankle/Foot Pain	0	1	2	3	4
Pins/needles (in hands or feet)	0	1	2	3	4	Pain between Shoulder blades	0	1	2	3	4
Dizziness	0	1	2	3	4						
Numbness	0	1	2	3	4						
Tingling	0	1	2	3	4						
Migraines	0	1	2	3	4						

What are some goals you wish to achieve if you were able to decrease pain?

_____

_____

What are you willing to do in order to decrease pain?

_____

_____

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 patient, parent or guardian _____ Date _____

Signature of Doctor _____ Date _____