SuperiorMED

A SUPERIOR APPROACH TO TREATING PAIN

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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

PATIENT SIGNATURE _____ DATE _____

PROVIDER SIGNATURE _____ DATE _____

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

| | | | | | | |
|---|---|---|---|---|---|---|
| Asthma | 0 | 1 | 2 | 3 | 4 | 5 |
| Chronic Cough | 0 | 1 | 2 | 3 | 4 | 5 |
| Wheezing | 0 | 1 | 2 | 3 | 4 | 5 |
| Shortness of Breath | 0 | 1 | 2 | 3 | 4 | 5 |
| Earache/ Ear Infection | 0 | 1 | 2 | 3 | 4 | 5 |
| Fatigue | 0 | 1 | 2 | 3 | 4 | 5 |
| Weakness | 0 | 1 | 2 | 3 | 4 | 5 |

### Neurological

| | | | | | | |
|---|---|---|---|---|---|---|
| Headaches | 0 | 1 | 2 | 3 | 4 | 5 |
| Migranes | 0 | 1 | 2 | 3 | 4 | 5 |
| Pins/Needles | 0 | 1 | 2 | 3 | 4 | 5 |
| Dizziness | 0 | 1 | 2 | 3 | 4 | 5 |
| Numbness | 0 | 1 | 2 | 3 | 4 | 5 |
| Tingling | 0 | 1 | 2 | 3 | 4 | 5 |

### Muscular/Skeletal

| | | | | | | |
|---|---|---|---|---|---|---|
| Muscle Aches | 0 | 1 | 2 | 3 | 4 | 5 |
| Fibromyalgia | 0 | 1 | 2 | 3 | 4 | 5 |
| Arthritis | 0 | 1 | 2 | 3 | 4 | 5 |
| Joint Pain | 0 | 1 | 2 | 3 | 4 | 5 |
| Low Back Pain | 0 | 1 | 2 | 3 | 4 | 5 |
| Knee Pain | 0 | 1 | 2 | 3 | 4 | 5 |
| Neck Pain | 0 | 1 | 2 | 3 | 4 | 5 |
| Wrist/Hand Pain | 0 | 1 | 2 | 3 | 4 | 5 |
| Shoulder Pain | 0 | 1 | 2 | 3 | 4 | 5 |
| Hip Pain | 0 | 1 | 2 | 3 | 4 | 5 |
| Ankle/Foot Pain | 0 | 1 | 2 | 3 | 4 | 5 |

What are some goals you wish to achieve if you were able 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.

PATIENT SIGNATURE _____ Date _____

PROVIDER SIGNATURE _____ Date _____