FAMILY WELLNESS PHYSICIANS

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: _____/_____/_____

PATIENT NAME: _____ _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (_____) _____-_____ YES NO

WORK PHONE #: (_____) _____-_____ YES NO

CELL PHONE #: (_____) _____-_____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____ RACE _____ ETHNICITY _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (_____) _____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (_____)_____-_____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR CLINICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ PHONE #: (_____) _____-_____

INSURANCE INFORMATION

ARE YOU ELIGIBLE FOR MEDICARE AND/OR MEDICAID? _____

PRIMARY INSURANCE COMPANY NAME :**(IF AUTO ACCIDENT, THIS IS YOUR PRIMARY)**

_____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (_____) _____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CLAIM/CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (_____) _____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

HAVE YOU HAD A FLU SHOT?_____ IF YES, WHEN_____ HAVE YOU HAD A PNEUMONIA VACCINE? _____IF YES, WHEN_____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ☐ CHEW ___ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES, IF YES, TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ ____ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTH
☐ OTHER _____

WHAT IS YOUR HEIGHT? _____ **WEIGHT?** _____ **BLOOD PRESSURE?** _____/_____

ARE YOU INTERESTED IN LOSING 3-5 LBS. A WEEK IN A HEALTHY AND NATURAL WAY? YES_____ NO_____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGAN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPED OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES ☐ NO
WERE THESE SYMPTOMS **RELATED TO AN AUTO ACCIDENT**? YES OR NO IF YES, DATE OF ACCIDENT? _____
AUTO INSURANCE CARRIER: _____ **CLAIM #** _____ POLICY # _____
ADJUSTOR'S NAME (IF KNOWN) _____ PHONE # _____
WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO **IF YES, WAS IT REPORTED TO YOUR EMPLOYER?** YES OR NO

DID YOU RETAIN AN ATTORNEY? YES OR NO, IF YES, NAME, ADDRESS AND TELEPHONE NUMBER OF ATTORNEY:

_____

_____

_____

_____

WOMEN PATIENTS: ARE YOU PREGNANT? _____ NO _____ YES, IF YES, HOW FAR ALONG? _____

_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVID INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____ _____
SIGNATURE DATE

February 2013

PATIENT NAME: _____

DATE OF BIRTH: ___/___/____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

WHAT IS YOUR REACTION TO EACH ALLERGY LISTED?

_____

HAVE YOU HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

OTHER CONDITIONS: _____

CURRENT PROBLEM

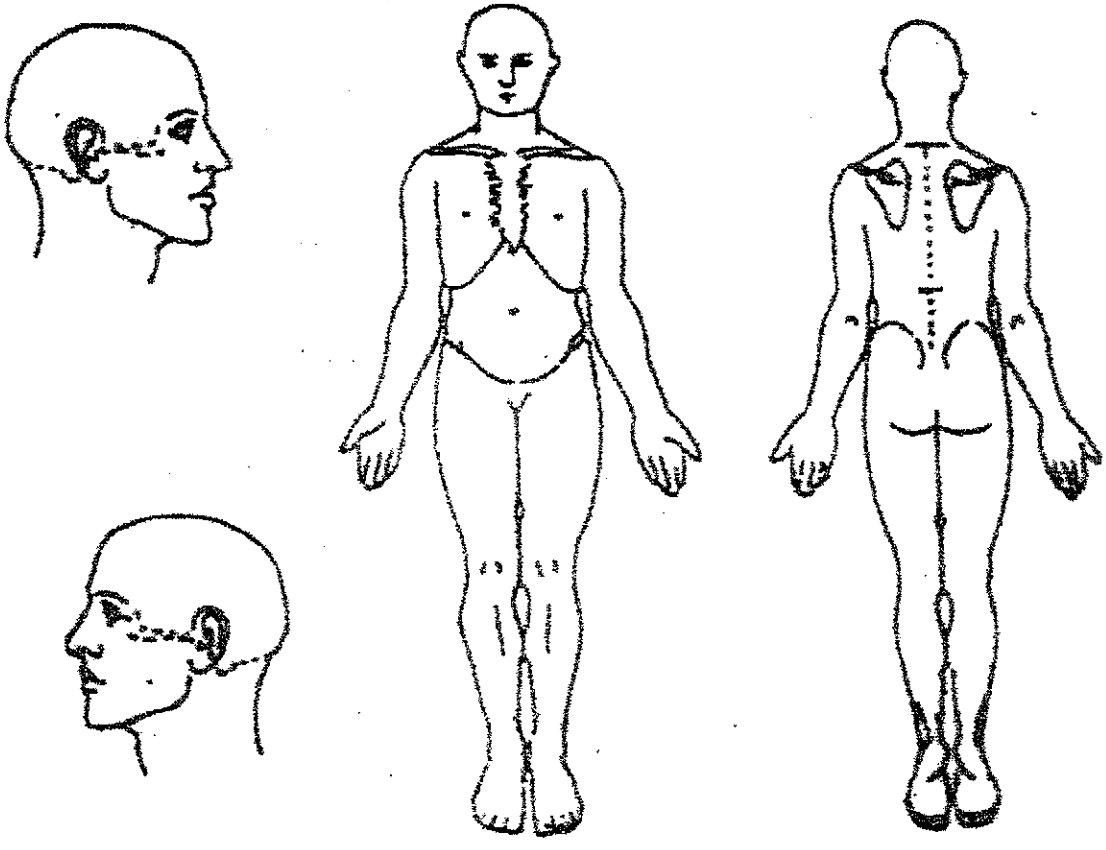
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HAVE YOU HAD THIS CONDITION IN THE PAST? _____ IF YES, WHEN? _____

DID YOU SEEK TREATMENT BY A DOCTOR FOR THIS CONDITION? _____ IF SO, BY WHOM? _____

HAVE YOU HAD X-RAYS/DIAGNOSTIC IMAGES TAKEN FOR THIS CONDITION? _____ IF YES, _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Other / Employed Full-Time Student Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO / PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. b.	a. b.

IDEAL PROTEIN HEALTH WEIGHT MANAGEMENT PROGRAM

Your BMI (Body Mass Index) is: _____

The US Government, via the Affordable Care Act, requests that all healthcare providers to measure the BMI (Body Mass Index, a ratio of weight to height) of all patients at every visit and inform those with a BMI above 24 of the increased health risks they face. Though it is not an all-inclusive measure of overall health, BMI can b a strong indicator of the likelihood that you will develop the potential issues listed below. Losing weight and making simple lifestyle changes can be an effective way to alleviate these risks and their associated symptoms. If your provider has recommended that you lose weight and/or make these changes, please stop by the front desk on your way out for some additional information on the program we offer our at-risk patients here at the clinic.

1. **Are you concerned about your weight's effect on your health or life?** _____
2. **Body weight is a sensitive subject for many people. Is it alright if we discuss your weight today?** _____
3. **How comfortable are you about working on your weight? (Circle the number below).**

Not at all — Very Comfortable

0 1 2 3 4 5 6 7 8 9 10

As weight increases, the chances of having diseases and health problems also increases. Overweight and Obesity increases the likelihood of conditions that are very harmful, such as....

- Heart Disease, including heart attack and stroke
- High Blood Pressure (BP)
- Elevated Blood Sugar*
- Type 2 Diabetes*
- Pre-Diabetes*
- High HgbA1c (a measure of blood sugar average over the past few months)*
- Gestational Diabetes*
- Infertility
- Sleep Apnea
- Fatty Liver and other Liver Diseases
- Gallbladder Disease
- Some types of Cancer: Breast, Thyroid, Colon, Esophagus, Uterus, Prostate, Kidney, & Liver
- High Blood Triglycerides; High LDL cholesterol; Low HDL cholesterol
- Osteoarthritis
- Higher health care costs
- Early Death

*Diabetes Type 2 risk increases as the weight goes up.

Men: Overweight (BMI 25-29.9) the chances are 240% higher compared to normal weight men
Men: Obese (BMI over 30) the chances are 670% higher compared to normal weight men
Women: Overweight (BMI 25-29.9) the chances are 390% higher compared to normal weight women
Women: Obese (BMI over 30) the chances are 1240% higher compared to normal weight women

Would you like a recommended plan to improve things for you? _____

If you are interested, see Front Desk Person for information on our recommended plan.

We understand this is an important decision and support your desire to improve your health.

2013. AHA/ACA/TOS Guidelines for the Management of Overweight and Obesity in Adults
Oct 2011. AHRQ Publication No. 11-05159-EF-1. Screening for and Management of Obesity and Overweight in Adults.

Family Wellness Physicians

Chiropractic/ Acupuncture
Richard Pellegrino, D.C.
1133 S. Military Trail
Deerfield Beach, FL 33442
Phone: 954-571-9555
Fax: 954-571-9692

Consent to Treat

I understand that if I am accepted as a patient of Family Wellness Physicians, I am authorizing Dr. Richard Pellegrino to proceed with any examinations and treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request.

Patient Signature _____

Date _____

Parental or Guardian Signature authorizing case of a minor:

_____

Signed: _____

Witnessed: _____

Patient Consent for Use and Disclosure of Protected Health Information

Richard Pellegrino D.C., INC

I hereby give consent for Richard Pellegrino, D.C., Inc., (hereinafter referred to as the "practice") use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The practices Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Richard Pellegrino, our privacy officer, at the following address:
1133 S. Military Trail, Deerfield Beach, FL 33442

With this consent, the practice may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent, the practice may email my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the practices use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, the practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Printed Patients Name or Legal Guardian

_____
Date

Family Wellness Physicians

Richard Pellegrino DC INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and CONSENT FORM

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in our Notice of Privacy Practices, updated effective September 23, 2013. We are permitted to review our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Authorization of PHI Disclosure The information described above may be disclosed to the following recipients:

Name of Person #1: _____ Relationship to You:

Name of Person #2: _____ Relationship to You:

I understand that Family Wellness Physicians will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations: If the medical information to be disclosed will result from treatment for research purposes, Family Wellness Physicians will not provide the treatment if I am unwilling to sign this authorization form. If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Family Wellness Physicians will not provide the treatment if I am unwilling to sign this authorization form.

By signing below, I am acknowledging that I have received a copy of Family Wellness Physicians Notice of Privacy Practices. I am also giving Family Wellness Physicians consent to disclose my protected health information to the person(s) listed above until such time a new Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form is completed by me. I also understand and agree to the terms of this authorization.

Patient Name: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

Signature: _____ Date: _____