advocare

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Information

Patient Last Name: _____

First Name: _____ MI _____

Other Name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Addr1: _____

Addr2: _____

City, State, Zip: _____

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email ☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home)

Driver's License # (DL#) _____ State(ST) _____

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Other _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Race: (please choose one of the following):
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Asian
☐ Patient Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Home Phone: (_____) _____

Alt Phone: (_____) _____

Home E-Mail: _____

Cell Phone: (_____) _____

Employer: _____

Address: _____

City, State, Zip: _____

Work Phone: (_____) _____

INSURANCE INFORMATION (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

SECONDARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Primary Care Phys.: _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Refer. Phys. (if different): _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Pharmacy Name, Address & Phone #: _____

Guarantor Information

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____

Addr1: _____

Addr2: _____

City, State, Zip: _____

Employer: _____

Address: _____

Work Phone: (_____) _____

Driver's License # (DL#) _____ State(ST) _____

Patient's Relationship to Guarantor: _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Phone: (_____) _____

Cell Phone: (_____) _____

City, State, Zip: _____

Guarantor E-Mail: _____

Emerg. Cont.: _____

Home Phone: (_____) _____

Alt Phone: (_____) _____

Patient's Relationship to Emerg. Cont.: _____

Cell Phone: (_____) _____

How did you hear about our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing ☐ Newspaper/Magazine ☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other

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Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Child/Dependent Registration Form

Today's Date: _____

Please complete this form and **sign page 3** in order to ensure proper billing of your services. **Please print.**

Patient Information

Patient Last Name: _____ Social Security Number: _____

First Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Other Name/AKA: _____ Home Phone: (_____) _____

Addr1: _____ Alt Phone: (_____) _____

Addr2: _____ Cell Phone: (_____) _____

City, State, Zip: _____ Email Address: _____

Preferred Method of Contact:
☐ Alt Phone Number ☐ Email ☐ Letter
☐ Phone Call (Cell) ☐ Phone Call (Home)

Ethnicity: **(Data is used for statistical reporting.)**
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Employment Status:
☐ Employed Full Time ☐ Employed Part Time
☐ Student

Race: **(Data is used for statistical reporting.)**
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Patient Declined

Employer: _____ Language: ☐ English ☐ Spanish ☐ Other _____

Insurance Information (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: _____ Telephone #: (_____) _____

Address: _____ Child's ID: _____

Subscriber's Name: _____ Group/Plan#: _____ Effective Date: _____

Subscriber's DOB: _____ Sex: ☐ M ☐ F Subscriber SS#: _____ Relationship to Patient: _____

Subscriber's Employer: _____ PCP listed on Card: _____

SECONDARY CARRIER: _____ Telephone #: (_____) _____

Address: _____ Child's ID: _____

Subscriber's Name: _____ Group/Plan#: _____ Effective Date: _____

Subscriber's DOB: _____ Sex: ☐ M ☐ F Subscriber SS#: _____ Relationship to Patient: _____

Subscriber's Employer: _____ PCP listed on Card: _____

Primary Care Phys: _____ Refer. Phys (if different): _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Telephone #: (_____) _____ Telephone #: (_____) _____

Pharmacy Name, Address & Phone #: _____

Guarantor Information (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____ Patient's Relationship to Guarantor: _____

Addr1: _____ Social Security Number: _____

Addr2: _____ Date of Birth: _____ Sex: ☐ M ☐ F

City, State, Zip: _____ Home Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____

Address: _____ Cell Phone: (_____) _____

City, State, Zip: _____ Email Address: _____

Driver's License #: _____ State _____

Other Parent or Guardian

Parent/Guardian: _____ Patient's Relationship to Guardian: _____

Addr1: _____ Social Security Number: _____

Addr2: _____ Date of Birth: _____ Sex: ☐ M ☐ F

City, State, Zip: _____ Home Phone: (_____) _____

Employer: _____ Cell Phone: (_____) _____

Address: _____ City, State, Zip: _____

Work Phone: (_____) _____ Driver's License #: _____ State _____

Emergency Contact Information (Someone living outside the primary household)

Last Name, First Name: _____ Patient's Relationship to Contact: _____

Addr1: _____ Home Phone: (_____) _____

Addr2: _____ Work Phone: (_____) _____

City, State, Zip: _____ Cell Phone: (_____) _____

List All Children/Siblings

Child #1 Last Name _____ First Name _____ Date of Birth _____

Child #2 Last Name _____ First Name _____ Date of Birth _____

Child #3 Last Name _____ First Name _____ Date of Birth _____

Child #4 Last Name _____ First Name _____ Date of Birth _____

How did you hear about our practice?

☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing ☐ Newspaper/Magazine
☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other

advocare™

HIPAA Acknowledgement
Notice of Privacy Practices

Printed Name of Patient _____

Patient Date of Birth _____

I acknowledge receipt of Advocare's Notice of Privacy Practices.

Signature of Patient/Legal Representative

_____ Date: _____

****

Office Use:

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: _____

Signature of Advocare Representative: _____

Printed Name: _____ Date: _____

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IDX Account #:_____

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Advocare Payment Policy and Notice of Privacy Practices for more information)

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Vaccine Registry (if applicable)

Please be advised that our office submits confidential data of children and adult vaccinations to your States Immunization Registry per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record of patient's immunization history.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

_____ X_____

Patient Name (Please Print) Patient Signature

_____

Guarantor/Parent/ Guardian completing this form (Please Print) Date

X_____

Guarantor/Parent/ Guardian Signature Date

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐Y ☐N	Has treatment been authorized by the V.A.?	☐Y ☐N
Do you or your spouse have other insurance?	☐Y ☐N	Are you covered under the Black Lung Program?	☐Y ☐N
Are you disabled or have end stage renal disease?	☐Y ☐N	Is there Medigap coverage secondary to Medicare?	☐Y ☐N
Is illness/injury the result of an auto accident?	☐Y ☐N	Is there insurance coverage primary to Medicare?	☐Y ☐N
Did illness/injury occur at work?	☐Y ☐N	Is there employer supplemental coverage secondary to Medicare?	☐Y ☐N

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ X_____

Patient Name (Please Print) Patient Signature

_____

Guarantor/Parent/ Guardian completing this form (Please Print) Date

X_____

Guarantor/Parent/ Guardian Signature Date

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Patient's Name: _____ Date: _____

Date when you first started having pain? _____

Referring Physician _____ _____

Was there a particular episode or incident that started your pain? (work, car accident, etc.)

_____

Describe the episode or incident:

_____

Describe your symptoms:

Body Part: _____ When is pain worse? _____

Other symptoms: _____

What makes the pain worse? For example: cough/sneeze? Time of day? Bending forward or backward?

_____

Does anything make your pain better? _____

What treatment have you had so far? Medication, physical therapy, chiro, injections, surgery, etc.

_____

Do you have any loss of sensation? ____ Yes ____ No If yes, where? _____

Do you have any loss of strength? ____ Yes ____ No If yes, where? _____

Any bowel or bladder dysfunction? _____

Any other symptoms? _____

Past & current medical condition? For example: high blood pressure, thyroid, cholesterol, diabetes, etc.?

_____

Previous surgery? _____

Any allergies to medications? _____

Current medications? _____

_____

Are you currently working? ____ Yes ____ No ____ Light duty If no, date of disability_____

Any prior injuries to this site? ____ Yes ____ No If yes, date of injury _____

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Circle the number that best describes your current pain with 10 being the most painful:

Back/Leg:	0	1	2	3	4	5	6	7	8	9	10
Neck/Arm:	0	1	2	3	4	5	6	7	8	9	10

Mark the drawing using the symbols that best describe your pain:

Numbness: ===== Ache: ^^^^^ Pins & Needles: OOOOO

Stabbing: ///// Burning: XXXXX Cramping: #####