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: _____

First Name: _____

Other Name/AKA: _____

Addr1: _____

Addr2: _____

City, State, Zip: _____

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

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

Employer: _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Phone: (_____) _____

Alt Phone: (_____) _____

Cell Phone: (_____) _____

Email Address: _____

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

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

Language: ☐ English ☐ Spanish ☐ Other _____

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

PRIMARY CARRIER: _____

Address: _____

Subscriber's Name: _____

Subscriber's DOB: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

Child's ID: _____

Group/Plan#: _____ Effective Date: _____

Subscriber SS#: _____ Relationship to Patient: _____

PCP listed on Card: _____

SECONDARY CARRIER: _____

Address: _____

Subscriber's Name: _____

Subscriber's DOB: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

Child's ID: _____

Group/Plan#: _____ Effective Date: _____

Subscriber SS#: _____ Relationship to Patient: _____

PCP listed on Card: _____

Primary Care Phys: _____

Address: _____

City, State, Zip: _____

Telephone #: (_____) _____

Refer. Phys (if different): _____

Address: _____

City, State, Zip: _____

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

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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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Date of Evaluation ___/___/___

Name (first/middle initial/last): _____ Age: ____ DOB: _____

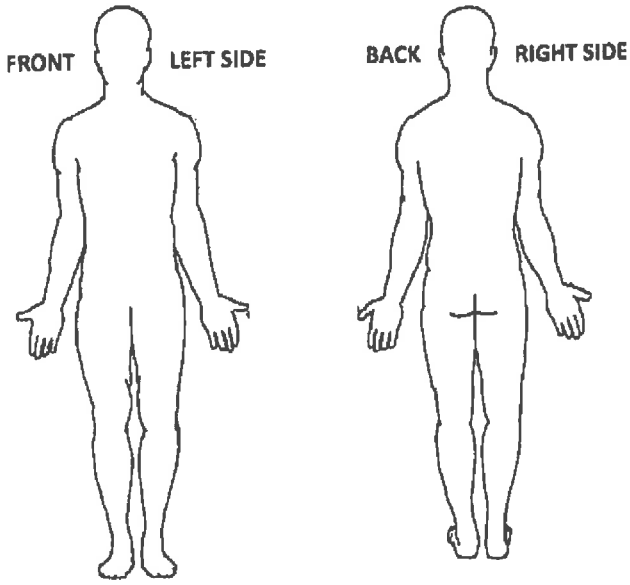
Referring Physician: _____ Family Physician: _____

Occupation: _____ Work related? ___ Yes ___ No Auto related? ___ Yes, State ____ ___ No

Leisure Activities _____

How did you hear about us? ___ Physician ___ Family ___ Friend ___ Radio ___ Advertisement ___ Other: _____

1. What problems or concerns would you like addressed? Please explain: _____
   _____
2. When did your problem develop? Please list exact date: ___/___/___
3. How did your problem begin? _____
4. Since your problem began, is it: ___ Improving ____ Staying the same ____ Worsening
5. Please note on the diagram where you're experiencing pain (using the appropriate letters):



T = Tingling
D = Dull
S = Sharp
N = Numbness
B = Burning
R = Radiating
A = Ache

6. Is your pain:
____ Constant ____ Intermittent

7. Express your pain on a scale of 0-10 (10 being extreme):
____ At present ____ At best ____ At worst

8. Are there any activities or positions that significantly **worsen** your symptoms?
____ Sitting ____ Standing ____ Walking ____ Lifting ____ Lying down ____ Ice ____ Heat ____ Bending
____ Bowel or bladder movements ____ Other: _____

9. Are there any activities or positions that significantly **improve** your symptoms?
____ Sitting ____ Standing ____ Walking ____ Lifting ____ Lying down ____ Ice ____ Heat ____ Bending
____ Pain medications ____ Other: _____

10. What part of the day do you feel best? _____ Worst? _____

11. Is sleep disturbed due to your pain? ____ Yes ____ No

12. Are you currently receiving the following treatment with another provider?
____ Physical therapy ____ Chiropractic ____ Massage ____ Home healthcare services ____ Skilled nursing facility services

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13. Have you had prior treatment(s) for this condition?

____ Physical therapy ____ Chiropractic ____ Injections ____ Massage ____ Surgery ____ Acupuncture ___ Other :_____

14. Recent diagnostic tests? ____ X-ray ____ CT Scan ____ MRI ____ EMG ____ Bone Scan ____Other:_____

15. Please list all medications you are currently taking: _____

_____

_____

16. Have you ever had any of the following? (Please check all that apply)

	Anxiety Disorder		Depression		Heart problems/heart attack		Nausea
	Smoking: __Past __Present		Strokes		Sweating		Ulcers
	Arthritis		Diabetes		Hernia		Osteoporosis
	Bladder problems		Dizziness		High blood pressure		Pacemaker
	Blood clots		Easy bleeding		HIV/AIDS		Pregnancy: __Past __Present
	Bowel problems		Emphysema		Kidney problems		Rheumatoid
	Broken bones		Fatigue		Liver/gallbladder		Ringing in ears
	Cancer		Fever		Major trauma		Seizures
	Chills		Head injury		Metal implants		Skin problems
	Circulatory problems		Headaches		Vomiting		Weakness
	Weight gain		Weight loss				

Please explain any checked items above and add others not listed: _____

_____

_____

_____

_____

17. Past surgical history: _____

_____

_____