WELCOME NEW PATIENT TO:

Form ND

Advanta Total Health

Patient Information

Name: _____
Last First MI

Mailing Address: _____ City: _____, State: _____, Zip: _____

Phone# (H)_____ (M) _____

Date of Birth: ____/____/____ ☐ Male ☐ Female SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Minor

Employer: _____ Email Address: _____

May we call you at work? ☐ Yes ☐ No Can we leave a voicemail/message? ☐ Yes ☐ No

May we text you to confirm/reschedule appointments? ☐ Yes ☐ No to inform you of services offered? ☐ Yes ☐ No

How did you hear about us: _____

Emergency contact: Name: _____ Relation: _____

Phone: (H)_____ (W)_____

HEALTH HISTORY

Who is your main doctor or health care provider: _____

Please check to indicate if you are currently experiencing any of the following conditions:

- ❑ Neck Pain
- ❑ Mid Back Pain.
- ❑ Low Back Pain.
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Arms Numb
- ❑ Asthma
- ❑ Loss of strength (Please Circle Areas)
- ❑ Pins/Needles in: Arms,Hands, Fingers Legs, Feet
- ❑ Fatigue
- ❑ Trouble Sleeping Due to Pain
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer _____
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Defibrillator
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Seizures
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis

❑ Tumors/Growths ❑ Ulcers ❑ Venereal Disease ❑ Other;_____
❑ Typhoid Fever ❑ Vaginal Infections ❑ Whooping Cough _

Form ND

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain_____

Please list any medications you are currently taking:_____

_____

Please list any surgeries and/or hospitalizations you have had (type & date):_____

_____

PLEASE LIST ALL ALLERGIES:_____

Please list any supplements you are currently taking (vitamins/herbs/minerals):_____

Did anybody in your family have any of the following conditions? Please check the box and tell us who it was.

❑ Heart Disease_____ ❑ Diabetes_____ ❑ Stroke_____
❑ Cancer_____ ❑ Arthritis_____ ❑ Other _____

Do you exercise? ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

At work do you mostly: ☐ Sit ☐ Stand ☐ Do Light Lifting ☐ Do Heavy Labor

What is your daily/weekly intake of the following?

Caffeine_____ cups/day Alcohol_____ drinks/week Cigarettes_____ packs/day

PAST, FAMILY & SOCIAL HISTORY (PFSH)

Past History
Allergies: _____

Medications: _____

Illnesses: _____

Operations: _____

Do you have any surgical devices in your body? (i.e. screws, pins, plates, etc?)

If yes, what are they , and where are they located _____

_____

Family History *of Diseases*:

_____

Social History

Smoker Y N Comments _____

Alcohol Y N Comments _____

Illicit Drugs Y N Comments _____

Employment Y N Comments _____

Financial Information

Do you have health insurance? ☐ Yes ☐ No Name of Carrier:_____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier:_____

Name of person whose is the policy holder of this insurance:_____ SS#: _____

Relationship to patient (if other than self):_____ DOB: _____ Phone:_____

ID #_____ Group #_____member services phone number _____

Assignment, Consent of Care and Release

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make it known to the doctor.

PATIENT SIGNATURE (X)_____ DATE_____

SIGNATURE OF PARENT/GUARDIAN_____ DATE_____

I was given the opportunity to receive and review the office's Patient Notice of Privacy Practices policy.

PATIENT SIGNATURE (X)_____ DATE_____

Form ND

AUTHORIZATION FOR CARE
ASSIGNMENT OF INSURANCE BENEFITS

This is an agreement between the undersigned patient and Advanta Total Health LLC (hereinafter referred to as Advanta).

Initial the Following:

_____ **I hereby authorize Advanta to treat my condition, as the clinician deems appropriate including the use of diagnostic testing and prescribed treatment modalities.** Original x-rays taken at Advanta will remain the property of Advanta, being on file where they may be seen at any time while a patient of this office. Should I require copies of the films, I also agree to pay for the cost of duplication. Advanta will not be held responsible for any pre-existing medically diagnosed conditions.

_____ **I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself**. Furthermore, I understand that Advanta will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Advanta will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care that my fees for professional services rendered to me by Advanta will be immediately due and payable. Balances over 90 days will be transferred to an outside collection firm.

_____ **I understand that I am responsible to pay all collection and/or attorney fees for any debts including a 35% collection fee and court costs involved in collecting said balances.**

_____ ***I agree to accept responsibility for whatever is not covered or accepted by the insurance company; this will include any part of my deductible, which has not been met, co-pays or disallowed services.***

_____ **I authorize and direct my insurance company, and/or my attorney, *to pay directly to Advanta* such sums as may be due and owing Advanta for services rendered me**, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I understand that if my treatment is the result of a personal injury, that Advanta may have to provide additional documentation, depositions, and testimony. Because of this, I agree to pay Advanta the full amount of all services at their usual and customary fees notwithstanding any agreements Advanta may have with any other insurance companies/Health Maintenance Organizations, Preferred Provider Organizations, Point of Service carriers or healthcare entities or carriers of any kind. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks received for payment of my doctor bill.

_____ **I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.** I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collections efforts, including but not limited to all reasonable court costs and all attorney fees. I grant Advanta my permission to contact me in regards to my appointments and leave messages on my home, cell, or office.

_____ **I understand that, if I am accepted for care by Advanta, I will be responsible for attending all my appointments.** AND that, if necessary, I will call Advanta to reschedule my appointment a minimum of 24 hours in advance. If I fail to do this, I further understand Advanta may charge me a $50 missed appointment charge.

_____ _____
Patient Name (Printed) Person Authorizing Care if other than Patient

_____ _____/_____/_____
Signature Date

_____ _____/_____/_____
Witness Date

ADVANTA TOTAL HEALTH

Form ND

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I, _____, have had the opportunity to review a copy of Advanta Total Health's Notice of Privacy Practices.

_____ _____
Signature of Patient/Parent/Guardian **Date**

_____
Relationship to Patient

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____ _____
Date **Initials**

I hereby grant permission to Advanta Total Health to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm an appointment, to notify me that test results are available, to notify me that a form or prescription if ready for pick-up, or to conduct any other relevant business that is deemed necessary.
Personal or detailed information will not be left on an answering machine or voice mail.

_____
Signature of Patient/Parent/Guardian

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____ _____
Date **Initials**