



2237 North Commerce Parkway, Ste 2
 Weston, FL 33326
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 www.westonmedicalhealth.com

The Next Generation in Healthcare

CONFIDENTIAL PATIENT INFORMATION

Full Legal Name: _____ / _____ / _____
Nombre legal (Last Name) (First Name) (Middle Initial)

Preferred Name: _____ Age: _____ Date of Birth: _____ S.S.#: _____
Edad Fecha de Nacimiento # de Seguro Social

Address: _____ / _____ / _____ / _____
Direccion Postal (street# / PO Box) (city) (state) (Zip code)

Telephone # () _____ () _____ / () _____
Telefonico (home) (work) (cell phone or other)

E-mail address: _____ Gender: female _____ male _____
Correo Electronico Sexo Mujer Hombre

Are you (check one): Single _____ Married _____ Other _____ Partner's Name: _____
Estado Legal Soltero(a) Casado(a) Otro Nombre de Pareja

Occupation: _____ (circle) Full time / Part time / Student / Retired
Ocupacion

Employer / School: _____
Empleador/Escuela:

Address: _____ / _____ / _____ / _____
Direccion de tal (Street / PO Box) (City) (State) (Zip code)

Name of Primary Care Physician: _____ Contact Number: _____
Nombre de su doctor primario

How were you referred to our office? _____

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).
 May the doctor send you educational/promotional materials such as newsletters via e-mail? Yes No

INSURANCE INFORMATION **INFORMACION DE SEGURO MEDICO**

Insurance Information – Please provide Insurance Card and State Driver's License:

Group Insurance: Insurance Co: _____ Member ID: _____
Compañía de seguro Medico Numero de Identificacion

Insured Full Legal Name: _____ Date of Birth: ____/____/____
Nombre legal del Asegurado Fecha de Nacimiento de tal

Insured's Address: _____ / _____ / _____ / _____ / () _____
(Street/PO Box) (City) (State) (Zip Code) (Phone)

MVA: Date of MVA: _____ State MVA occurred: _____ Claim number: _____
(Motor Vehicle Accident/Fecha del accidente) Estado donde ocurrio Numero de Demanda

Insurance Co: _____ Claim submitted Y N Adjuster: _____ Phone: () _____
Compañía de Seguro de Automóvil Demanda Reportado? Nombre de persona asignado al caso

Attorney's Name: _____ Phone: () _____ PIP Coverage: _____
Nombre de Abogado Numero Telefonico

Do you have any secondary or additional insurance plans? Yes No Name: _____
Tiene usted algun seguro adicional or secundario?

Medicare Insurance Only

Select to indicate you do not have an HMO Plan Select to indicate if you are receiving in home care

By signing below, I certify that the above information is correct and true to the best of my knowledge.

Signature of Patient/Responsible Party _____ Today's Date _____

Reverse Side

ASSIGNMENT OF BENEFITS

I, the above/below-named patient, by signing below, hereby irrevocably assign to WESTON MEDICAL HEALTH CENTER, any and all of my rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined by Florida law, for any services and charges provided by WESTON MEDICAL HEALTH CENTER. It is the intent of the undersigned that this assignment is irrevocable and shall apply to any and all causes of action, lawsuits, claims, counter-claims, and demands.

I understand that in the event it becomes necessary to collect monies owed through an attorney, I will be responsible for all costs including, but not limited to, attorney's fees and court costs. I also understand that this assignment of benefits gives WESTON MEDICAL HEALTH CENTER the right to file a lawsuit against my insurance company, or the applicable insurance company.

By signing below, I certify I have read this assignment of benefits and I understand all of the terms and conditions. I acknowledge that all of my questions concerning this assignment of benefits have been fully explained to me by Weston Medical Health Center.

____ Initials

STATEMENT OF CONFIDENTIALITY

I authorize payment of insurance benefits directly to the doctor or doctor's office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

____ Initials

I Authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to processing my claims.

____ Initials

PRIVACY PRACTICE NOTIFICATION

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

- A full copy of the patient's Bill of Rights is available upon request

____ Initials

PATIENT RESPONSIBILITY

All co-pays are due at time of service.

Insurance companies provide providers **non guaranteed** information upon verification of benefits and may reimburse differently upon claim payment. You are responsible for deductibles, adjustments or unpaid balances made by your insurance.

If your insurance company/plan overrides the assignment of benefits and makes claim payments directly to you, you are responsible to pay Weston Medical Health Center upon receipt. A payment arrangement for these services after an insurer has paid you is not acceptable. A copy of the Explanation of Benefits must accompany the check(s) so we may record your account properly.

I authorize Weston Medical Health Center to retain my credit card on file for recurring billing, co pays, deductibles and unpaid balances.

- A full copy of the financial policy is available upon request

____ Initials

By signing below, I certify that the information I furnish is true and correct. I know that it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature of Patient/Responsible Party _____ **Today's Date** _____

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CURRENT HEALTH CONDITION

Name: _____
Nombre

Date: _____
Fecha

What is your chief Complaint? _____
¿Lo que le trae a la oficina hoy?

Date of onset/injury: _____
¿Fecha que empeso sus sintomas?

Have you received treatment for injury?
¿Ha recibido tratamiento para la herida? Yes No

Have you had an auto accident, slip or fall in the past two years? Yes No

If Yes, please indicate what type: Auto Work Personal Injury Home

Have you been fitted for a custom BACK brace within the last 3 years? Yes No

Have you been fitted for a custom KNEE brace within the last 5 years? Yes No

What kind of pain?

Where is the pain?

What type of pain?

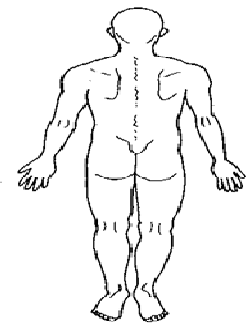
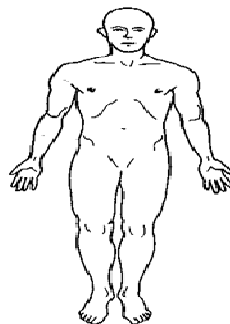
	Left	Right	<input type="checkbox"/> Ache/Dull	<input type="checkbox"/> Burning	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Sharp Throbbing
Arms:							
Legs:							
Knees:							
Hips:							
Shoulders:							
Elbows:							
Wrists:							
Feet:							
Head:							
Neck:							
Back:							

On a scale of 1 to 10, with 1 being light pain and 10 being very severe, how severe is your pain most of the time and how frequent is your pain?



Frequency (0-100%) _____ %

Indicate where you have pain or other symptoms



Increase Pain: Sit Stand Walk Climb Bend Squat
 Up Stairs Down Stairs Movement Lay Down Touch

Decrease pain: Sit Stand Walk Climb Bend Squat
 Up Stairs Down Stairs Movement Lay Down Touch

Signature of Patient/Responsible Party _____ **Today's Date** _____



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CONFIDENTIAL HEALTH HISTORY

I Am Pregnant [] Yes [] No [] Not Sure

I use: [] tobacco _____ packs/day or stopped _____ (Date)
[] alcohol type and amount _____ Per day/Per Week

REVIEW OF SYSTEM — PLEASE CHECK ANY THAT APPLY:

GENERAL

- [] Tire easily/Fatigue
[] Recent weight gain or loss
[] Night sweats

HEAD/EAR/NOSE/THROAT

- [] Glaucoma
[] Cataracts
[] A mass in my neck
[] Frequent nosebleeds
[] Ringing in my ear
[] Hearing loss

HEM / ENDOCRINE

- [] Diabetes
[] Thyroid disease
[] Anemia
[] HIV
[] Bruise easily
[] Had blood clots

SKIN DISORDER

- [] Skin disorder

RESPIRATORY

- [] Shortness of breath;
[] At night [] Laying flat [] or with Walking
[] Frequent wheezing
[] Asthma
[] Cough

CARDIOVASCULAR

- [] Chest pain/tightness:
[] Exertional [] Nonexertional
How long? _____ Months

MENTAL HEALTH:

- [] Anxious
[] Depressed
[] Difficulty sleeping

NEUROLOGICAL

- [] Weakness of arms, legs
[] Numbness and tingling of arms, legs
[] Dizziness
[] Headaches
[] Seizures
[] Faint frequently
[] Tremors

GI / GU

- [] Belly pain
[] Bleeding ulcers
[] Heartburn regularly
[] Trouble swallowing
[] Frequent nausea or vomiting
[] Diarrhea
[] Constipation
[] Hepatitis
[] Kidney disease
[] Incontinence of the bowel or bladder

MUSCULOSKELETAL

- [] Joints are stiff
[] Joints hurt
[] Joints are swollen
[] Muscles hurt
[] Muscles are weak
[] Gout
[] Rheumatoid Arthritis

CONFIDENTIAL HEALTH HISTORY

Name: _____

Date: _____

If you previously had any of the following procedures, please list the date and place they were performed.

Procedure	Date(s)	Place Performed
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

Please mark any condition that you now have or have recovered from in the recent past.

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Menstrual Dysfunction | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Urinary, Genital Problems | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Angina | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Alcohol or Drug Problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Gall Stones | |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Sexual Dysfunction | | |

Current medications. Please list all medications you are taking. (Prescription and over the counter)		Hospitalization and Surgery
Name of medication and Strength	# of doses / day	Please list all surgery and any periods of hospitalization (give dates)
Are you allergic to any medications?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Please list:

Family history: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had?:

Condition	If so, who?	Condition	If so, who?
Heart Disease		Diabetes	
Hypertension		Epilepsy	
Stroke		Bleeding Disorders	
Cancer		Kidney Disease	

Do you require special care of have any concerns that might affect your treatment or recovery? NO YES
(If yes, please describe.)

Thank you for assisting us in gathering the information our medical providers need to help determine a personal treatment plan for you. To certify that the information is correct as given to us by you, please affix your signature in the area provided below.

Signature of Patient/Responsible Party _____ Today's Date _____

