Intake: 13+ years

210 Latchaw Drive
Defiance, OH 43512
Phone: 419-785-4215
Fax: 419-785-4274

Patient Name: _____ DOB: _____

Check appropriate Box**:** □ Male □ Female □ Pregnant?

Email: _____

SS #/SIN: _____ Home phone: _____ Cell Phone: _____

□Minor □Single □Married □Divorced □Widowed □Separated

Address:_____City: _____State: _____Zip: _____

Employer Name:_____

Spouse or Patient's Guardian name: _____

Spouse or Guardian's Employer: _____

Whom may we thank for referring you?_____

Emergency Contact: _____ Phone:_____

RESPONSIBLE PARTY

Name of the person responsible for this account: _____ DOB:_____

Relationship to Patient: _____ Phone: _____

Address_____City_____State_____Zip_____

Driver's License # _____

Is the person currently a patient at our office? YES or NO

Do you have Insurance? YES or NO ***If YES, please fill in ALL information below:**

	Primary Insurance	**Secondary Insurance**
Insurance Company		
Patient's Relation to Policy Holder	Self Spouse Child	Self Spouse Child
Policy Number (ID)		
Group #		
Policy Holder's Name		
Policy Holder's DOB		

Patient Signature: _____ Date:_____

Guardian Signature (if applicable:)_____Date:_____

Name:_____ DOB: _____

INTEGRATED MEDICAL GROUP

CONSENT TO TREAT

I hereby consent to the performance of evaluation and treatment from Integrated Medical Group's treatment team which may include exams, injections, and various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the medical provider and/or other licensed doctor who now or in the future work at the clinic or office listed above.

I have had an opportunity to discuss with the provider the nature and purpose of the recommended treatment and other procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of medicine there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or may be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The provider has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(*FOR MINOR PATIENTS ONLY*) In case of a medical emergency, if the patient is of school age (15+ years), I give consent to treat in my absence.

Patient Signature: _____ Date:_____

Guardian Signature (if applicable:)_____Date:_____

HIPAA AUTHORIZATION

PRIMARY CARE PROVIDER

I, _____, give permission to all Integrated Medical Group medical service providers and payers to disclose and release my private health information to:

Primary Physician:

Primary Physician Location:

By signing below, I authorize you to release my health information to the provider listed above. The health information that you may release subject to this authorization is

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions)
- ☐ Other:

FAMILY/FRIENDS

I, _____, give permission to all Integrated Medical Group medical service providers and payers to disclose and release my private health information to:

Names:	Relationship:
_____	_____
_____	_____
_____	_____

By signing below, I authorize you to release my health information to the individuals listed above. The health information that you may release subject to this authorization is

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions)
- ☐ Other:

This health information may be used to enable the persons I authorize to be made aware of my conditions and treatment or treatment options for treatment or consultation, for claims payment purposes, or related reasons. This authorization shall be effective all past, present, and future periods unless revoked. (Note: This authorization may be revoked at any time by notifying your health care providers, preferably in writing.)

Patient Signature:_____DOB:_____Date:_____

Parent/Guardian Signature (if applicable): _____ Date:_____

Name:_____DOB_____

INTEGRATED MEDICAL GROUP
ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Integrated Medical Group** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance medical plan claims, to pursue appeals on denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator.

I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Patient Signature: _____ Date:_____

Guardian Signature (if applicable:)_____Date:_____

Name:_____ DOB: _____

Health History

Chief Complaint: _____

History of Present illness:

Location: _____
(Where is the pain/problem?)

Sensation: _____
(Sharp, dull, burning, aching, throbbing, numb, tingling)

Severity: _____
(Rate the problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

When did it start: _____
(Where were you at the onset of this pain/problem?)

Other Problems: _____

_____

What makes it better:_____

What makes it worse:_____

Past Medical History

(Have you **ever** had the following? Circle "yes" or "no"/ leave blank if you are uncertain.)

Measles/Mumps	NO YES	Asthma	NO YES	Ulcer	NO YES
Chicken Pox	NO YES	Mononucleosis (Mono)	NO YES	Glaucoma	NO YES
Whooping Cough	NO YES	History of Hives	NO YES	Hernia	NO YES
Scarlet Fever	NO YES	Anemia	NO YES	Epilepsy	NO YES
Pneumonia	NO YES	Bleeding/Clotting Disorder	NO YES	Migraine	NO YES
Rheumatic Fever	NO YES	High Blood Pressure	NO YES	Thyroid Disease	NO YES
Tuberculosis	NO YES	Low Blood Pressure	NO YES	Kidney Disease	NO YES
Polio	NO YES	Stroke	NO YES	Bladder Infection	NO YES
Chronic Bronchitis	NO YES	Diabetes	NO YES	Hepatitis	NO YES
Sexually Transmitted Infection	NO YES	Cancer: _____	NO YES	Transfusion History: _____	NO YES
Other Heart Condition: _____	NO YES				

Regenerative Medicine Injection Screening

(Have you **ever** had the following? Circle "yes" or "no"/ leave blank if you are uncertain.)

Have you recently been ill or had a fever?	NO YES	Do you have low platelet count or any other platelet disorder	NO YES
Are you on antiplatelet therapy?	NO YES	Do you have anemia or low hemoglobin count	NO YES
Do you currently smoke or drink alcohol?	NO YES	NSAIDs (Ibuprofen, Advil, Naproxen, Mobic) within the last 10 days?	NO YES
Are you allergic to penicillins or sulfa drugs?	NO YES	Have you had cortisone steroid injections within the last 30 days?	NO YES

Previous Surgeries:	**When**	**Hospital, City, State**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient/Guardian Signature: _____Date:_____

Clinician Initial _____Date:_____

Name:_____ DOB: _____

Review of Symptoms

(Have you experienced any of the following in the last 1-2 months? Circle "yes" or "no"/ leave blank if you are uncertain.

Head/Eyes/Ears/Nose/Throat		**Muscular/Skeletal**		**Neurological**	
Headaches	NO YES	Neck Pain	NO YES	Feeling "foggy"	NO YES
Itchy/Watery Eyes	NO YES	Shoulder Pain	NO YES	Dizziness	NO YES
Change in Vision	NO YES	Elbow Pain	NO YES	Numbness	NO YES
Earache/Ear Infection	NO YES	Wrist/Hand Pain	NO YES	Tingling/ Pins and Needles	NO YES
Frequent Sneezing	NO YES	Low Back Pain	NO YES	**Pulmonary**	
Nasal Congestion	NO YES	Hip Pain	NO YES	Wheezing	NO YES
Chronic Cough	NO YES	Knee Pain	NO YES	Hoarseness	NO YES
Sore Throat	NO YES	Ankle/Foot Pain	NO YES	Shortness of Breath	NO YES

Patient Social History:

Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs: Never: _____ Type:_____ Frequency: _____

Family Medical History (Circle all that apply)

Father (Age:)
Arthritis Asthma Back/Disc Problems Cancer Constipation/Diarrhea Diabetes Epilepsy Headache/Migraine High BP Heart Problems Insomnia Kidney Problems Liver Problems Scoliosis Sinus Congestion Stomach Problems
Other_____

Mother (Age:)
Arthritis Asthma Back/Disc Problems Cancer Constipation/Diarrhea Diabetes Epilepsy Headache/Migraine High BP Heart Problems Insomnia Kidney Problems Liver Problems Scoliosis Sinus Congestion Stomach Problems
Other_____

Brother(s)(Ages:)
Arthritis Asthma Back/Disc Problems Cancer Constipation/Diarrhea Diabetes Epilepsy Headache/Migraine High BP Heart Problems Insomnia Kidney Problems Liver Problems Scoliosis Sinus Congestion Stomach Problems
Other_____

Sister(s)(Ages:)
Arthritis Asthma Back/Disc Problems Cancer Constipation/Diarrhea Diabetes Epilepsy Headache/Migraine High BP Heart Problems Insomnia Kidney Problems Liver Problems Scoliosis Sinus Congestion Stomach Problems
Other_____

Kids (Ages:)
Arthritis Asthma Back/Disc Problems Cancer Constipation/Diarrhea Diabetes Epilepsy Headache/Migraine High BP Heart Problems Insomnia Kidney Problems Liver Problems Scoliosis Sinus Congestion Stomach Problems
Other_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.

Patient/Guardian Signature: _____Date:_____

Clinician Initial _____Date:_____

Integrated Medical Group
210 Latchaw Dr.
Defiance, OH 43512
*Phone #419-785-4215 *Fax #419-785-4274

Medication List

Patient Name: _____DOB: _____

Allergies: _____

_____

Medication	Dosage	Frequency	Notes

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____