# PATIENT INFORMATION

**Patient Name:** ____________________________________________
(*Last*) (*First*)

Address: _________________________________________________

City: _______________________ State: _______ Zip: _____________

Home Phone (______)___________ Cell Phone (______)___________

Cell Phone Carrier: ____________________________________________

Email Address: _______________________________________________

SS# ____________________________ Sex: ☐ M ☐ F

Height: ____________ inches Weight: _____________ pounds

Birth Date: _______________________ Age: _______________

**Responsible Party:** ☐ Self ☐ Other (Parent, Guardian, Spouse)

If Other, Name: _______________________________________________

Relation to Patient: ___________________________________________

Occupation: ___________________________________________________

Employer: _____________________________________________________

Work Phone (_____)________________ # of Children ____________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race: ☐ American Indian ☐ Asian ☐ Black or African American

☐ Caucasian ☐ Pacific Islander ☐ Hispanic/Latino ☐ Other

Health Insurance: ☐ Yes ☐ No HSA/Flex Spending: ☐ Yes ☐ No

Insurance Name: _______________________________________________

Insurance ID: ________________________ Group#: ______________

Primary Care Provider or Referring Physician:

Name:_________________________________________________

Address: _____________________________________________

City: __________________________ State: _______ Zip: _________

Are you under a doctor's care at the present time? ☐ Yes ☐ No

If yes, for what? ______________________________________________

Name of Doctor:_______________________________________________

Address: _____________________________________________________

______________________________________________________________

## IN CASE OF EMERGENCY CONTACT

Name_______________________ Phone (_____)_________________

Relation to Patient: ___________________________________________

### *Who can we thank for referring you?*

☐ Internet: ☐ Friend: _____________________________

☐ Google ☐ TV: _________________________________

☐ Yelp ☐ Mailer: _____________________________

☐ ZocDoc ☐ Insurance

☐ Facebook ☐ Doctor

☐ Healthgrades ☐ Other: ______________________________

**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 River Medical Group, Bethesda Metro Physical Therapy and/or Montgomery County Chiropractic 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 for 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 or medical plan claims, to pursue appeals on any 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, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

**FINANCIAL POLICY:**
We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that patient portion of payment for all products or services will be due at the time products or services are rendered unless prior arrangements have been made. For your convenience, we accept cash, checks, credit cards and Care Credit. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs which are typically 40% of the amount owed, plus attorney's fees and court costs. I understand there are no refunds on services delivered. I understand there are no refunds on opened products. I understand there are no refunds on consumable products (food and vitamins/supplements) regardless if they have been opened or not.

**CANCELLATION, MISSED APPOINTMENTS, LATE ARRIVALS:**
ALL LATE ARRIVALS, MISSED APPOINTMENTS AND CANCELLATIONS WITHOUT 24 HOURS' NOTICE WILL BE ASSESSED A **$40 MISSED APPOINTMENT FEE.** This is in addition to any charges already paid for services. We ask that all patients arrive at least 5 minutes prior to your scheduled appointment time. Any arrival 10 minutes past your appointment time or later will be considered a missed appointment. Notice for cancellations and rescheduled appointments can be given by telephone, voicemail or email both during and outside of business hours and days.

**HEALTH INFORMATION PRIVACY PRACTICES ACT (HIPPA) NOTICE:**
I acknowledge that I have received or been given the opportunity to receive a copy of the Notice of Privacy Practices.

**By Signing Below, you agree that you have read and understand the above statements contained in the assignment of health plan benefits and rights, appointment and designation as personal and/or ERISA/PPACA representative and beneficiary, Financial Policy, Cancellation Policy, and HIPPA notice.**

Patient Printed Name: _____________________________________________

Patient Signature: ____________________________________________(SEAL)

Guardian Signature (if applicable): _____________________________(SEAL)

Signed this __________ day of ______________________, 20______.

## MEDICAL HISTORY ☐ None

*General History (Check All That Apply)*

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Transfusion
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Celiac
- ☐ Chemical Dependency
- ☐ Chest pain
- ☐ Colitis
- ☐ Constipation
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Gallbladder Disorder
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hormone Replacement Therapy
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Malaria
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Nervous Breakdown
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psoriasis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ STD
- ☐ Stroke
- ☐ Swelling feet
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Whooping Cough
- ☐ Other: ________________ ________________

Explanation: ____________________________________________________
____________________________________________________________
____________________________________________________________

**Date of Last:**
Physical Exam ______________ Spinal Exam/X-Ray ________________
MRI or CT-Scan ______________ Lab Work ______________________

## FAMILY HISTORY ☐ None

**Possible Hereditary Diseases:** ______________________________
____________________________________________________________
____________________________________________________________

## SOCIAL HISTORY

Smoking: ☐ Every Day ☐ Occasional ☐ Former Smoker ☐ Never
Alcohol: Drinks/week_________ Caffeine: Drinks/day__________

## GYNECOLOGIC HISTORY ☐ N/A

Are you currently pregnant? ☐ Yes ☐ No
Pregnancies #:________Dates:____________________________
Deliveries #________Natural delivery or C-section? ____________
Menstrual: Onset:____________Duration: _____________
Are they regular? ☐ Yes ☐ No
Pain associated? ☐ Yes ☐ No
Last menstrual period: ________________
Check all that apply to you:
☐ Amenorrhea ☐ Heavy Periods ☐ Menopause
Fibrocystic Breast ☐ Hysterectomy ☐ Uterine Fibroma

## Medications ☐ None

| *Medications:* | *Dosages:* |
|---|---|
| ______________________ | _______________ |
| ______________________ | _______________ |
| ______________________ | _______________ |
| ______________________ | _______________ |
| ______________________ | _______________ |
| ______________________ | _______________ |
| ______________________ | _______________ |

(Use back of sheet if additional space is needed.)

***Birth Control:*** ______________________________________

## ALLERGIES ☐ None

| *Medication Allergies:* | *General Allergies:* |
|---|---|
| ______________________ | _______________ |
| ______________________ | _______________ |

## HOSPITALIZATIONS ☐ None

| *Hospitalized For:* | *Date:* |
|---|---|
| ______________________ | _______________ |
| ______________________ | _______________ |

## Surgeries ☐ None

| *Surgery:* | *Date:* |
|---|---|
| ______________________ | _______________ |
| ______________________ | _______________ |

**Do you have any surgical devices in your body? (i.e. screws, pins, plates, etc) ☐ Yes ☐ No**
**If yes, where are they located?**______________________________
____________________________________________________________

## ACTIVITY LEVEL

*Select one of the following*:

- ☐ Inactive: no regular physical activity with a sit-down job
- ☐ Light Activity: no organized physical activity during leisure time
- ☐ Moderate Activity: Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- ☐ Heavy Activity: consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling or active sports at least three times per week.
- ☐ Vigorous Activity: participation in extensive physical exercise for at least 60 minutes per session, 4 or more times per week.

*Patient Name:* ______________________________________________ *Date:* ____________________

**Indicate which of the below you have experienced in the last 1-2 months:**
**Blank = Never; 1 = Rarely; 2 = Occasionally; 3 = Frequently; 4 = Constant**

| Eyes/Ears/Nose/Throat/Respiratory: | | Gastrointestinal: | | Endocrine/Hormone: | |
|---|---|---|---|---|---|
| Asthma | 1 2 3 4 | Constipation | 1 2 3 4 | Weight Loss or Gain | 1 2 3 4 |
| Stuffy Nose | 1 2 3 4 | Diarrhea | 1 2 3 4 | Inability to Lose Weight | 1 2 3 4 |
| Hay Fever | 1 2 3 4 | Reflux or Heartburn | 1 2 3 4 | Hypo/Hyper Thyroid | 1 2 3 4 |
| Sore Throat | 1 2 3 4 | Bloating | 1 2 3 4 | Change in Appetite | 1 2 3 4 |
| Chronic Cough | 1 2 3 4 | Gas | 1 2 3 4 | Fatigue or Drowsiness | 1 2 3 4 |
| Chest Congestion | 1 2 3 4 | Nausea or Vomiting | 1 2 3 4 | Poor Sleep | 1 2 3 4 |
| Frequent Sneezing | 1 2 3 4 | Chrohn's Disease | 1 2 3 4 | Decreased Endurance | 1 2 3 4 |
| Itchy/Watery Eyes | 1 2 3 4 | Stomach Pains | | Feel "Burned Out" | 1 2 3 4 |
| Drainage | 1 2 3 4 | or Cramping | 1 2 3 4 | Hot Flashes or | |
| Earache or Ear Infection | 1 2 3 4 | | | Night Sweats | 1 2 3 4 |
| Itching | 1 2 3 4 | Urinary: | | | |
| Hoarseness | 1 2 3 4 | | | Reproductive: | |
| Shortness of Breath | 1 2 3 4 | Frequency | 1 2 3 4 | | |
| Wheezing | 1 2 3 4 | Urgency | 1 2 3 4 | Pain During Sex | 1 2 3 4 |
| | | Burning or Pain | 1 2 3 4 | Low Sex Drive | 1 2 3 4 |
| Muscular/Skeletal: | | Blood in Urine | 1 2 3 4 | Erectile Dysfunction | 1 2 3 4 |
| | | Incontinence | 1 2 3 4 | | |
| Muscle Aches | 1 2 3 4 | | | Mental/Emotional: | |
| Fibromyalgia | 1 2 3 4 | Skin: | | | |
| Arthritis | 1 2 3 4 | | | Anxiety | 1 2 3 4 |
| Joint Pain | 1 2 3 4 | Rashes | 1 2 3 4 | Stress | 1 2 3 4 |
| Low Back Pain | 1 2 3 4 | Eczema | 1 2 3 4 | Depression | 1 2 3 4 |
| Neck Pain | 1 2 3 4 | Itching | 1 2 3 4 | Poor Concentration | 1 2 3 4 |
| Wrist/Hand Pain | 1 2 3 4 | Dryness | 1 2 3 4 | Foggy Thinking | 1 2 3 4 |
| Elbow Pain | 1 2 3 4 | Loss of Hair | 1 2 3 4 | Forgetfulness | 1 2 3 4 |
| Shoulder Pain | 1 2 3 4 | Excessive Sweating | 1 2 3 4 | Mood Swings, Irritability | |
| Hip Pain | 1 2 3 4 | | | or Grumpiness | 1 2 3 4 |
| Knee Pain | 1 2 3 4 | Neurological: | | | |
| Ankle/Foot Pain | 1 2 3 4 | | | Other: | |
| Pain Between | | Headaches | 1 2 3 4 | | |
| Shoulder Blades | 1 2 3 4 | Migraines | 1 2 3 4 | Fever or Chills | 1 2 3 4 |
| | | Dizziness | 1 2 3 4 | Weakness | 1 2 3 4 |
| Cardiovascular: | | Numbness | 1 2 3 4 | Hyperactivity | 1 2 3 4 |
| | | Tingling | 1 2 3 4 | Insomnia | 1 2 3 4 |
| Shortness of Breath with Activity | 1 2 3 4 | | | | |
| Difficulty Breathing When Lying Down | 1 2 3 4 | | | | |

Which conditions/symptoms bother you the most?

How long have you been bothered by these conditions?

Describe how it feels or affects you when it is at its worst?

If you could eliminate one of the above, which would it be?

What are your health goals?

*Patient Name:* ____________________ *Date:* ____________

*Patient Name*___________________________________________ *DOB* ___________________ *Date* ___________________

## History of Present Illness

***Please fill in each line as completely as possible. If you have more than one problem/condition you would like to address, please use a separate form for each complaint. For example, Headaches and Neck pain, or Back and Knee pain would be listed separately.**

**Chief complaint: In your own words, describe what is bothering you today -** ____________________________________________

________________________________________________________________________________________________

1. When did the symptoms start:____________________________________________________________________________
2. Believed to be caused by?________________________________________________________________________________
3. Can it be attributed to any of the following types of accidents? □ N/A □ Automobile □ Work □ Other__________________
   **If yes**, has it been reported to: □ Automobile Insurance □ Worker's Comp □ Lawyer □ Other _________________________
4. Quality of the symptoms (circle all that apply): Tight Stiff Dull Achy Sore Sharp Stabbing Cramps
   Burning Numbness Tingling Swelling Other:____________________
5. Does it travel to any other areas? □ **No** □ **Yes** **If yes,** Where?___________________________________________________
6. Severity of Symptoms (Scale 1-10: 1=Mild, 10= Severe): 0 1 2 3 4 5 6 7 8 9 10
7. How often are the symptoms there (circle):
   □ Daily □ 1-2times per week □ 3-4 times per week □ 5-6 times per week
   □ Less than once per week. If less than once per week, describe how often________________________
8. What percentage of time are the symptoms present? □ 100%(Constant) □ 75% □ 50% □ 25%
9. Is there a time of day where symptoms are better? □ Morning □ Afternoon □ Evening □ While Sleeping
10. Is there a time of day where symptoms are worse? □ Morning □ Afternoon □ Evening □ While Sleeping
11. What makes the symptoms worse?______________________________________________________________________________
12. What is the patient unable to do as a result of this problem?____________________________________________________________
13. What makes the symptoms better?______________________________________________________________________________
14. Is there a family history of this? □ **No** □ **Yes**
15. Taking any medication for this complaint? □ **No** □ **Yes** **If yes**: □ Over the Counter □ Prescription
    List here:____________________________________________________________________________________________
16. Taken any medication (OTC/Pres.) for this symptom in the past? □ **No** □ **Yes**
    If yes, Was there relief of symptoms? □ **No** □ **Yes** If not currently taking, why not?_______________________________
17. Any previous treatment for this or have been seen by previous Doctors for this? □ **No** □ **Yes**
    **If yes**, when and with who?______________________________________________________________________________
18. Anything else that has been tried to handle this? □ **No** □ **Yes**
    **If yes**, What has been tried? ______________________________________________________________________________
19. What was the outcome of what has been tried?___________________________________________________________________
20. Any prior injuries that could be related to this complaint, not already listed? □ **No** □ **Yes**
    **If yes**, please describe:_____________________________________________________________________________________
21. Any prior surgeries specifically related to this complaint? □ **No** □ **Yes**
    **If Yes**, Please describe: ________________________________________________________________________________

**Internal Use Only:**

**Additional Notes:** ________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

**Long Term Goals: 1**____________________________ **2**______________________________ **3**________________________________

**Provider Signature:** __________________________________________ **Date:** ___________________________________

## INFORMED CONSENT

I hereby consent and request the performance of Medical services and other healthcare services including, but not limited to, health consultations, examinations, examination tests, chiropractic, physical therapy, rehab exercises, diagnostic imaging, nutrition/diet counseling, dry needling, laser, trigger point injections, joint injections, massage and physical modalities for the purpose of treatment on me or for whom I am legally responsible, by the clinical staff of River Medical Group, Bethesda Metro Physical Therapy and/or Montgomery County Chiropractic. I have been informed that these treatments are generally considered safe methods of treatment but that as with any healthcare procedure, there may be certain complications or side effects. Side effects include soreness, bruising, redness, numbness or tingling and dizziness or fainting. Unusual risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, pneumothorax, sprains and burns. The nutritional supplements (which are from plant, animal and mineral sources) are traditionally considered safe, although possible side effects, including abdominal discomfort may occur. The clinic uses sterile disposable needles to maintain a clean and safe environment. I will notify a staff member who is caring for me if I am or become pregnant.
I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

## Release of medical records

Medical records may be released to my primary care doctor, referring doctor, imaging center, insurance carrier or any other doctor of my choosing. In the event that my current condition, or a future condition is the result of an accident (automobile, work related, or otherwise), medical records may be released to all insurance carriers and legal firms involved. By signing below, I acknowledge and agree to this release of information and understand that it can be revoked at any time, by me, by submitting a written request.

## Standard Publicity Release

This section pertains only to those patients who choose to provide our offices with a success story testimonial, either written, verbal, videotaped, or captured on camera. Your picture, written testimonial or video will only be shared with your permission and will only be available when YOU PROVIDE it to us. This release is in accordance with the Federal Trade Commission (FTC). All ownership and rights to use your success story in commercial, educational or promotional material are granted to River Medical Group, Bethesda Metro Physical Therapy and/or Montgomery County Chiropractic.

By Voluntarily Signing below, I show that I have read, or have had read to me, the above informed consent, record release and publicity release agreement. I have been told about the risks and benefits of being under care and have had an opportunity to ask questions. 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.

______________________________ ______________________________

**Printed Name of Patient** **Date**

______________________________

**Signature of Patient, Parent, or Guardian**

## Consent to Treat a Minor (if applicable)

As of this date, I have the legal right to select and authorize health care services for the minor child named above. I authorize the performance of diagnostic tests and treatments as written above. This authorization extends to all doctors, licensed practitioners and staff members.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

______________________________ ______________________________

**Printed Name of Parent/Guardian** **Date**

______________________________

**Signature of Parent/Guardian**