Saks Wellness Center PC

CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE FRONT DESK

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle Initial:	S.S. #:	Date of Birth:	Sex: ❑M ❑F

Street address:	Work Phone:	Home Phone:	Primary Phone: ❑Home ❑Work ❑Cell

Address Line 2:	Cell Phone:

City:	State:	Zip Code:	Email:

Primary Care Physician:	Referred

Would you like to receive appointment reminders? Choose ONE:
❑Email ❑Text Message ❑Phone Call ❑None

Occupation:	Employer:

Employer's address:

City:	State:	Zip Code:

Spouse's Name:	Date of Birth:

We will attempt to contact your spouse first in the case of an emergency. Please list any additional contacts

Name:	Phone:

Preferred Language: ❑English ❑Spanish ❑German ❑French ❑Italian ❑Russian ❑Portuguese ❑Chinese ❑ Japanese ❑Korean ❑Vietnamese ❑Decline to Answer ❑Other _____

Please check ALL races that apply: ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Decline to Answer

Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic nor Latino ❑Declined to Answer

Preferred Communication: ❑Cell Phone ❑Home Phone ❑Work Phone ❑Mail ❑Email ❑In Person

Smoking Status: ❑Current everyday ❑Current some days ❑Former ❑Never Start Year _____ Quit Date _____

Current Medications:
1.Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
2. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
3. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
4. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
5. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____

Drug Allergies:

1. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____

2. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____

3. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____

Alcohol Use: ❑None ❑Light ❑Moderate ❑Heavy	Drug Use: ❑None ❑Light ❑Moderate ❑Heavy	Exercise: ❑None ❑Light ❑Moderate ❑Heavy

INSURANCE INFORMATION	
Primary Insurance:	Insured ID:

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. 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 to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship **Date**

ARE YO INTERESTED IN ANY OF THE FOLLOWING SERVICES WE OFFER?		
Service	**YES**	**NO**
Chiropractic Care		
Nutritional Therapy		
Massage Therapy		
Rehabilitation/Exercise Therapy		

Release of Medical Information:

Please list ALL person's we may share your medical/health information with or contact if we cannot reach you yourself

Name (First and Last)	Phone Number
1.	
2.	
3.	

FOR OFFICE USE ONLY		
HEIGHT:	WEIGHT:	BP:

A. Notifier: Saks Wellness Center

B. PatientName: **C. IdentificationNumber:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't payfor **D.**_____below, you may have topay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay forthe**D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Chiropractic Exam		$125
X-Rays		$300
Massage Therapy		$45-$75
Mechanical Traction/flexion Distraction		$20-$25
Ice/Hot		$5
Nutrition/Functional Medicine		$60-$125
Supplements		Range in price
Laser / Neuropathy / TE / BS4L Therapies		$35 and up
Neuropathy		$5000

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about yourcare.
- Ask us any questions that you may have after you finishreading.
- Choose an option below about whether to receivethe**D.**_____listedabove.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box foryou.

☐ **OPTION 1.** I wantthe**D.**_____listed above. You may ask to be paid now,but I also want Medicare billed for an official decision on payment, which is sent to me on aMedicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays ordeductibles.

☐ **OPTION2.** Iwantthe **D.**_____listed above, but do not bill Medicare.Youmayask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is notbilled**.

☐ **OPTION 3.** I don't wantthe**D.**_____listed above. I understand with thischoiceI am **not** responsible for payment, and **I cannot appeal to see if Medicare wouldpay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

FAMILY HISTORY							
Please indicate which conditions exist or have existed by marking the boxes below.							
	Self	Mother	Father	Sister	Brother	Son	Daughter
Bone Cancer	❑	❑	❑	❑	❑	❑	❑
Brain Cancer	❑	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑	❑
Esophageal Cancer	❑	❑	❑	❑	❑	❑	❑
Gastric Cancer	❑	❑	❑	❑	❑	❑	❑
Kidney Cancer	❑	❑	❑	❑	❑	❑	❑
Leukemia	❑	❑	❑	❑	❑	❑	❑
Liver Cancer	❑	❑	❑	❑	❑	❑	❑
Muscle Cancer	❑	❑	❑	❑	❑	❑	❑
Other Cancer	❑	❑	❑	❑	❑	❑	❑
Ovarian Cancer	❑	❑	❑	❑	❑	❑	❑
Pancreatic Cancer	❑	❑	❑	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑
Rectal Cancer	❑	❑	❑	❑	❑	❑	❑
Skin Cancer	❑	❑	❑	❑	❑	❑	❑
Thyroid Cancer	❑	❑	❑	❑	❑	❑	❑
Clotting Disorder	❑	❑	❑	❑	❑	❑	❑
Deep Vein Thrombosis	❑	❑	❑	❑	❑	❑	❑
Pulmonary Embolism	❑	❑	❑	❑	❑	❑	❑
Unknown Clotting Disorder	❑	❑	❑	❑	❑	❑	❑
Dementia/Alzheimer's	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Gestational Diabetes	❑	❑	❑	❑	❑	❑	❑
Impaired Fasting Glucose	❑	❑	❑	❑	❑	❑	❑
Insulin Resistance	❑	❑	❑	❑	❑	❑	❑
Maturity onset Diabetes (MODY)	❑	❑	❑	❑	❑	❑	❑
Pre-Diabetes	❑	❑	❑	❑	❑	❑	❑
Type 1 Diabetes	❑	❑	❑	❑	❑	❑	❑
Type 2 Diabetes	❑	❑	❑	❑	❑	❑	❑
Colon Polyp	❑	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑	❑
Familial adenomatous polyposis (FAP)	❑	❑	❑	❑	❑	❑	❑
Gastrointestinal Disorder	❑	❑	❑	❑	❑	❑	❑
Irritable Bowel Syndrome	❑	❑	❑	❑	❑	❑	❑
Ulcerative Colitis	❑	❑	❑	❑	❑	❑	❑
Lynch Syndrome	❑	❑	❑	❑	❑	❑	❑
Angina	❑	❑	❑	❑	❑	❑	❑
Coronary Artery Disease	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑
Unknown Heart Disease	❑	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑	❑
Cystic Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Chronic Kidney Disease (assoc. Diabetes Type 2)	❑	❑	❑	❑	❑	❑	❑
Congenital Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Kidney Nephrosis	❑	❑	❑	❑	❑	❑	❑
Nephritis	❑	❑	❑	❑	❑	❑	❑
Nephrotic Syndrome	❑	❑	❑	❑	❑	❑	❑
Other Kidney Disease	❑	❑	❑	❑	❑	❑	❑

SYMPTOMS							
	Self	Mother	Father	Sister	Brother	Son	Daughter
Unknown Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑
COPD	❑	❑	❑	❑	❑	❑	❑
Chronic Bronchitis	❑	❑	❑	❑	❑	❑	❑
Chronic Lower Respiratory Disease	❑	❑	❑	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	❑	❑	❑
Influenza	❑	❑	❑	❑	❑	❑	❑
Pneumonia	❑	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑	❑
ADHD	❑	❑	❑	❑	❑	❑	❑
Autism	❑	❑	❑	❑	❑	❑	❑
Bipolar Disorder	❑	❑	❑	❑	❑	❑	❑
Dementia	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑
Eating Disorder	❑	❑	❑	❑	❑	❑	❑
Mental Disorder	❑	❑	❑	❑	❑	❑	❑
OCD	❑	❑	❑	❑	❑	❑	❑
Panic Disorder	❑	❑	❑	❑	❑	❑	❑
Personality Disorder	❑	❑	❑	❑	❑	❑	❑
PTSD	❑	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑	❑
Social Phobia	❑	❑	❑	❑	❑	❑	❑
Septicemia	❑	❑	❑	❑	❑	❑	❑
Stroke/Brain Attack	❑	❑	❑	❑	❑	❑	❑
Sudden Infant Death Syndrome	❑	❑	❑	❑	❑	❑	❑

PATIENT HISTORY

Please describe your past accidents:

1.Accident: _____ ❑Job ❑Auto ❑Other Date: _____
2.Accident: _____ ❑Job ❑Auto ❑Other Date: _____
3.Accident: _____ ❑Job ❑Auto ❑Other Date: _____

Please describe your past surgeries:

1. Surgery: _____ Date: _____
2. Surgery: _____ Date: _____
3. Surgery: _____ Date: _____

Do you have any implants? ❑Yes ❑No If yes, please describe _____

Do you have any gunshot wounds? ❑Yes ❑No

Are you currently pregnant? ❑Yes ❑No If yes, please list your due date: _____

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

AIDS	❑	Allergies	❑	Anemia	❑	Arthritis	❑
Asthma	❑	Back Pain	❑	Bladder Trouble	❑	Bone Fracture	❑
Cancer	❑	Chest Pain	❑	Concussion	❑	Constipation	❑
Convulsions	❑	Depression	❑	Diarrhea	❑	Dislocated Joints	❑
Epilepsy	❑	Fibromyalgia	❑	German Measles	❑	Headache	❑
Heart Trouble	❑	Hepatitis	❑	Herniated Disc	❑	High Blood Pressure	❑
High Cholesterol	❑	HIV/ARC	❑	Kidney Disorder	❑	Loss of Bowel Control	❑
Lung Disease	❑	Menstrual Cramps	❑	Migraine Headaches	❑	Multiple Sclerosis	❑
Muscular Dystrophy	❑	Neck Pain	❑	Nervousness	❑	Numbness	❑
Osteoporosis	❑	Parkinson's disease	❑	Pinched Nerve	❑	Polio	❑
Poor circulation	❑	Reproductive disorder	❑	Rheumatic Fever	❑	Rheumatism	❑
Rheumatoid Arthritis	❑	Scarlet Fever	❑	Scoliosis	❑	Serious Injury	❑
Sinus Trouble	❑	Stroke	❑	Thyroid Problems	❑	Tuberculosis	❑
Tumors or Growths	❑	Ulcers	❑	Venereal Disease	❑	_____	❑

Please fill out a *SEPARATE* page for *EACH* symptom you are experiencing in order of severity

WRITE YOUR WORSE SYMPTOM OR AREA OF IRRITATION ON THIS PAGE

SYMPTOM 1

Symptom:

Area of irritation:_____ **Doctor's notes:**_____

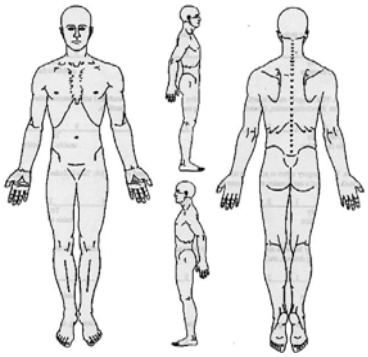
Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom:

Pain Quality:	**Pain Frequency:**	**Pain Radiates Into:**	**Pain Cause:**	**Pain Duration:**
❑Aching ❑Burning ❑Cramping ❑Numbness ❑Sharp ❑Shooting ❑Stiffness ❑Tingling	❑Constant ❑Frequent ❑Intermittent ❑Occasional	❑Arm ❑Leg ❑Shoulder ❑Buttock ***And*** ❑Right Side ❑Left Side ❑Both Sides	❑A Fall ❑Auto Accident ❑Lifting Injury ❑Unknown ❑Gradual Onset	When did symptom first occur? _____ **Doctor's Notes:** _____

Pain Pattern:	**Pain Aggravated By:**		**Pain Relieved By:**	**Prior Intervention:**
❑Worse in Morning ❑Worse in Afternoon ❑Worse in Evening ❑Worse when Sleeping	❑Bending ❑Coughing/Sneezing ❑Getting up from chair ❑Walking ❑Lifting	❑Twisting ❑Lying down ❑Standing ❑Sitting	❑Stretching ❑Rest ❑Lying Down ❑Standing ❑Ice ❑Knees Bent	❑OTC Medicines ❑Prescription medicine ❑Massage ❑ Surgery ❑Chiropractic Care

Please Mark Applicable Area for this Condition:



SYMPTOM 2

Symptom:

Area of irritation:_____ **Doctor's notes:**_____

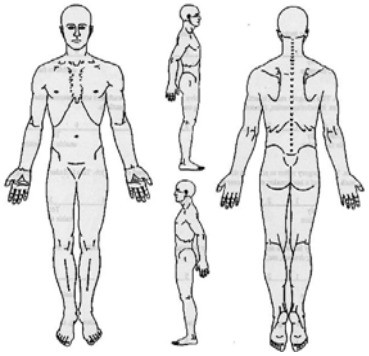
Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom:

Pain Quality:	**Pain Frequency:**	**Pain Radiates Into:**	**Pain Cause:**	**Pain Duration:**
❑Aching ❑Burning ❑Cramping ❑Numbness ❑Sharp ❑Shooting ❑Stiffness ❑Tingling	❑Constant ❑Frequent ❑Intermittent ❑Occasional	❑Arm ❑Leg ❑Shoulder ❑Buttock ***And*** ❑Right Side ❑Left Side ❑Both Sides	❑A Fall ❑Auto Accident ❑Lifting Injury ❑Unknown ❑Gradual Onset	When did symptom first occur? _____ **Doctor's Notes:** _____

Pain Pattern:	**Pain Aggravated By:**		**Pain Relieved By:**	**Prior Intervention:**
❑Worse in Morning ❑Worse in Afternoon ❑Worse in Evening ❑Worse when Sleeping	❑Bending ❑Coughing/Sneezing ❑Getting up from chair ❑Walking ❑Lifting	❑Twisting ❑Lying down ❑Standing ❑Sitting	❑Stretching ❑Rest ❑Lying Down ❑Standing ❑Ice ❑Knees Bent	❑OTC Medicines ❑Prescription medicine ❑Massage ❑ Surgery ❑Chiropractic Care

Please Mark Applicable Area for this Condition:



SYMPTOM 3

Symptom:

Area of irritation:_____ **Doctor's notes:**_____

Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom:

Pain Quality:	**Pain Frequency:**	**Pain Radiates Into:**	**Pain Cause:**	**Pain Duration:**
❑Aching ❑Burning ❑Cramping ❑Numbness ❑Sharp ❑Shooting ❑Stiffness ❑Tingling	❑Constant ❑Frequent ❑Intermittent ❑Occasional	❑Arm ❑Leg ❑Shoulder ❑Buttock ***And*** ❑Right Side ❑Left Side ❑Both Sides	❑A Fall ❑Auto Accident ❑Lifting Injury ❑Unknown ❑Gradual Onset	When did symptom first occur? _____ **Doctor's Notes:** _____

Pain Pattern:	**Pain Aggravated By:**		**Pain Relieved By:**	**Prior Intervention:**
❑Worse in Morning ❑Worse in Afternoon ❑Worse in Evening ❑Worse when Sleeping	❑Bending ❑Coughing/Sneezing ❑Getting up from chair ❑Walking ❑Lifting	❑Twisting ❑Lying down ❑Standing ❑Sitting	❑Stretching ❑Rest ❑Lying Down ❑Standing ❑Ice ❑Knees Bent	❑OTC Medicines ❑Prescription medicine ❑Massage ❑ Surgery ❑Chiropractic Care

Please Mark Applicable Area for this Condition: