



WELCOME TO OUR OFFICE

Included you will find the forms required for your first visit at our office.

Please complete the forms in their entirety, prior to your appointment, using a BLACK ink pen. DO NOT DATE any forms. We will complete the date when you arrive for your appointment. If the appointment is for a minor, all forms must be completed by a parent or guardian and must include the patient's name and the parent's or guardian's signature on each form. If you are a guardian, it is important that you bring the court ordered paperwork with you for the minor's first visit.

We have included specific instructions for each form in your packet to assist you in completing this necessary information.

REMEMBER to bring your completed forms, driver's license and insurance card(s) with you to your appointment. We look forward to your visit in our office and helping you with your health concerns.

If you have any questions regarding the completion of these forms, please contact our office and we will be happy to assist you.

ENTRANCE APPLICATION

This form provides us with your personal information required to complete your registration as a new patient in our office. Please be sure to fill out the form as complete as possible.

FINANCIAL AGREEMENT

This form informs you of your financial responsibility for your treatment in our office and gives us permission to file your insurance and receive benefit payments directly from your insurance company. Please sign this form in all three places. DO NOT DATE.



Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member. Thank you and welcome to HealthSource!

Patient Information

First Name: _____ Middle _____ Last _____ Gender: __M__ F
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Social Security Number: _____
Email Address: _____ Birthdate: _____ Age: _____
Marital Status: __S__ M __W__ D Job Title: _____ Work Phone: _____
Spouse Name: _____ Birthdate: _____ Social Security Number: _____
Children: Names and Ages: _____

Insurance Information

Name of person on the insurance card: _____ DOB: _____
Name of employer: _____
Employer phone number: _____ City: _____
Person responsible for this account: _____

Additional Information

In case of emergency, whom should we contact? _____
Relation to patient: _____ Phone Number: _____
Family Physician: _____
May we send your Family Physician updates on your progress? _____ Yes _____ No
What is your primary complaint? _____

Is this worker's compensation? _____ Is this personal injury? _____

Office use only Account Number Date



Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT'S / GUARDIAN'S SIGNATURE

INSURED'S SIGNATURE

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to HealthSource all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

PATIENT'S / GUARDIAN'S SIGNATURE

DATE

HS HealthSource®

NAME: _____ DATE: _____ PHYSICIAN: _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|--|--|
| <input type="checkbox"/> changes in appetite | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> pain at night |
| <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> headaches | <input type="checkbox"/> weakness/fatigue |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> weight loss/gain |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|--|---|
| <input type="checkbox"/> anemia | <input type="checkbox"/> heart disease | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> asthma | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> cancer (type) _____ | <input type="checkbox"/> kidney/liver problems | <input type="checkbox"/> stomach ulcers |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> lung problems | <input type="checkbox"/> stroke |
| <input type="checkbox"/> depression | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> pacemaker inserted | <input type="checkbox"/> HIV | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> other _____ | | |

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Do you smoke? YES NO _____ pack/day

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list current medications (QUANTITY & FREQUENCY):

1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? YES NO

ALLERGIES: _____

Are you latex sensitive? YES NO

PLEASE LIST PAST SURGERIES:

1. _____ Year _____ 2. _____ Year _____
3. _____ Year _____ 4. _____ Year _____
5. _____ Year _____ 6. _____ Year _____

HEIGHT _____

WEIGHT _____

FOR DIABETIC PATIENTS only: SHOE SIZE AND WIDTH _____

Hammer toes Blister/callus Bunions Corns

Xerosis (dry, rough, cracking) Ingrown Nails

Patient Signature: _____

Date: _____

(office use only) PT Initials _____ Date _____