APEX HEALTH
SPINE & SPORT
3014 Bashor Rd., Goshen IN 46526 P: (574) 533-2531 F: (574) 533-7788

Date: _____

Confidential Patient Information

Patients Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: ____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Address of Insured (if different than above): _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider? (Y / N)
Person to contact in case of emergency (Name and Phone): _____
Have you had any X-rays / MRI's / CT's taken in the last 2 years? Y N If so, Where? _____
_____

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 at clinic's request, and convey directly to **Apex Health Spine & Sport** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such provider and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the provider and clinic to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. 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 provider and clinic to the full extent permissible under the law and under 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 provider 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 provider and clinic in any attempts by such provider 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 provider and clinic against such insurers and/or employee health care plan in my name but at such provider 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.

_____ _____
Signature of Insured / Guardian Date

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Patient Name: _____ Date: _____

PATIENT HISTORY FORM

PAST MEDICAL HISTORY

Please list previous surgeries and dates. _____

_____

Please list previous fractures. _____

Please list all other health conditions (cancer, diabetes, high blood pressure, etc.) for which you have been diagnosed.

_____

_____

Do you smoke? ○ No ○ Previous Smoker, date of cessation: _____ ○ Current Smoker: _____ pks per day

Do you exercise regularly? ○ No ○ Yes. How many times per week and what type? _____

Do you have any allergies? _____

REVIEW OF SYSTEMS: Are you *currently* experiencing any of the following symptoms/conditions? (Please circle)

Y	N	Fever/Chills	Y	N	Blood Clots/Blood Thinner	Y	N	Joint Swelling
Y	N	Headaches	Y	N	Chest Pain	Y	N	Depression
Y	N	Dizziness/Lightheaded	Y	N	Shortness of Breath	Y	N	Skin Discoloring / Rash
Y	N	Double Vision	Y	N	Abdominal Pain	Y	N	Weakness/Fatigue
Y	N	Blurry Vision (New Onset)	Y	N	Nausea	Y	N	Bowel/Bladder Changes
Y	N	Persistent Cough	Y	N	Arthritis	Y	N	Numbness/Tingling

HOW CAN WE HELP YOU TODAY?

PRIMARY COMPLAINT: _____ Date symptoms began: _____

How did it begin? _____

Please list any previous treatments for this condition. _____

What makes it worse? _____ What makes it better? _____

SECONDARY COMPLAINT: _____ Date symptoms began: _____

How did it begin? _____

Please list any previous treatments for this condition. _____

What makes it worse? _____ What make it better? _____