APG
ASSOCIATED PHYSICIANS GROUP
PAIN MANAGEMENT & PHYSICAL THERAPY CENTER

Phone: 1-888-363-8333

Today's Date_____

Name_____DOB_____

Male Female Soc Sec #_____

Mailing Address_____

City, State, Zip_____Home Phone_____

Cell Phone_____Work Phone_____

APG provides the option of electronic statements. Please check the appropriate box & provide your email. GO GREEN

Allow electronic statements: ☐No ☐Yes Email_____

Employer_____Occupation_____

Address, City, State_____Is it ok to call you at work? ☐ Yes ☐ No

How did you hear about us? ☐Phone Book ☐Newspaper ☐Seminar ☐Internet

☐Referral ☐Other_____

If you were referred, by whom? _____

Do you currently have a chiropractic physician? ☐No ☐Yes If Yes, who?_____

Do you have a primary care physician? Y N whom?_____

Emergency Contact _____ Relationship _____ Phone _____

Can we speak to a family member or spouse about your medical care: ☐ Yes ☐No

Authorized person _____ Relationship_____

	Primary Insurance	Secondary Insurance
Insurance Company		
Claims Address		
City, State, Zip		
Policy/ID #		
Group #		
Insured Name		
Relation		
Insured SS #		
Insured DOB		
Insured Employer		

Is your visit as a result of Worker's Compensation Injury or Automobile Accident? Y N

Name of Insurance Company: _____
Claim Number: _____ Adjustor Name: _____
Adjustor Contact Phone #: _____ Date of Injury: _____

_____ _____

SIGNATURE DATE

Welcome to Associated Physicians Group

The following document will serve as a summary of your health history during your initial visit to the APG. Please complete all sections; sign and date all pages. If you need assistance in filling out these forms, please call our office at 1-888-363-8333.

Name_____Date_____

Medical History

Medical Conditions: *please list all major illnesses/conditions you have been diagnosed with.*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgeries: *please list all surgeries & the month/year they were performed*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History

Do you smoke? ☐Y ☐N Packs/Day_____ If quit, how long _____ how much prior _____

Do you drink Alcohol? ☐Y ☐N Drinks/Day_____

Do you consume caffeine?☐Y ☐N What kind & how much _____

Do you use recreational drugs? ☐Y ☐N Which _____

Average Hours of sleep _____

Exercise (specific activities & frequency) _____

Have you recently traveled to any foreign countries? ☐Y ☐N If Yes, where? _____

Are you a victim of physical or sexual abuse? ☐Y ☐N

Are you currently involved in or planning a claim/lawsuit for:

Workman's Comp ☐Y ☐N Personal Injury/Insurance ☐Y ☐N Disability ☐Y ☐N

If Yes to any, do you have an attorney ☐Y ☐N if yes, whom_____

_____

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Name _____ **Date** _____

Current Medications: *(Please list all medications you are currently taking, prescription & over the counter)*

Name of medication & strength	# of doses per day

Allergies:

Medications:_____**Food:**_____ **Check all that apply:** ☐**Latex** ☐**IV Contrast Dye**

☐**Betadine/Iodine** ☐**Adhesive Tape**

Family History: *(Anyone in your immediate family: mother, father, siblings, children)*

*Heart Disease who*_____
*Hypertension who*_____
*Stroke who*_____
*Cancer who*_____
*Diabetes who*_____
Gastrointestinal Disease who _____
Lung Disease who _____
_____

*Epilepsy who*_____
*Glaucoma who*_____
*Bleeding Disorders who*_____
*Kidney Disease who*_____
*Thyroid Disease who*_____
Liver Disease who _____
Other who _____
_____

<u>Women Only:</u>

Can you become pregnant: ☐Y ☐N If not why: _____ Are you now pregnant? ☐Y ☐N

Date of last period_____Normal ☐Y ☐N

Date of last Mammogram _____ Date of last Pap Smear_____Normal ☐Y ☐N

_____
SIGNATURE DATE

Welcome to Associated Physicians Group

Name _____ **Date** _____

REVIEW OF SYSTEMS: (CHECK ANY SYMPTOMS YOU HAVE HAD *RECENTLY* OR *FREQUENTLY IN THE PAST*

CONSTITUTIONAL	☐fever ☐weight loss ☐unusual fatigue ☐night sweats ☐poor appetite
HEAD/EYES	☐headaches ☐blurry vision ☐eye pain ☐eye discharge ☐double vision ☐loss of vision
EAR/NOSE/THROAT	☐ear discharge ☐hearing loss ☐ringing in ears ☐loss of taste ☐loss of smell ☐runny nose ☐nasal congestion ☐frequent nose bleeds ☐sore throat
CARDIOVASCULAR	☐chest pain/pressure ☐shortness of breath ☐palpitations ☐inability to lie flat ☐passing out ☐varicose veins ☐leg cramps *with exercise* ☐ankle/leg swelling
PULMONARY	☐cough ☐bloody cough ☐increased sputum volume ☐green sputum ☐blue extremities
GASTROINTESTINAL	☐difficulty/pain with swallowing ☐heartburn ☐bowel changes ☐constipation ☐diarrhea ☐black or bloody stools ☐abdominal pain or bloating ☐excessive gas ☐frequent nausea ☐fecal incontinence
WOMEN'S HEALTH	☐breast lumps ☐nipple discharge ☐asymmetry of breasts ☐vaginal discharge ☐vaginal spotting/bleeding (other than normal menstruation) ☐difficult periods ☐vaginal sores/lesions ☐pain with intercourse ☐decreased libido ☐hot flashes
MEN'S HEALTH	☐difficulty getting/maintaining erections ☐penile sores/lesions ☐decreased libido ☐penile discharge ☐testicular mass ☐testicular pain ☐difficulty starting/maintaining urine stream
URINARY TRACT	☐frequent and/or excessive urination ☐painful urination ☐urinary incontinence ☐blood in urine ☐cloudy or dark urine ☐flank pain
MUSCULOSKELETAL	☐painful joints ☐swollen joints ☐difficulty with range of motion ☐muscle pain ☐fluid on joints
SKIN	☐sores ☐rash ☐lumps/bumps ☐skin tags ☐suspicious moles ☐lesions ☐pallor
NEUROLOGY	☐numbness ☐muscle weakness ☐tingling ☐difficulty walking ☐poor memory ☐poor coordination ☐confusion ☐seizures ☐tremors ☐paralysis
ENDOCRINE	☐excessive thirst ☐excessive hunger ☐cold intolerance ☐heat intolerance ☐swollen glands
PSYCHIATRIC	☐anxiety ☐depression ☐suicidal thoughts ☐homicidal thoughts ☐apathy
OTHER	

SIGNATURE DATE

APG Internal Medicine

Name _____ **DOB** _____ **Date** _____

IMMUNIZATION HISTORY:

VACCINE	**DATE**
DPT (diphtheria/pertussis/tetanus)	
Polio	
MMR (measles/mumps/rubella)	
TD (tetanus booster)	
HPV (gardasil)	
Pneumonia	
Meninigitis	
Hepatitis B	
Influenza	
Varicella (chicken pox)	
Zostavax (shingles)	

PREVENTION:

	DATE	NORMAL?
BONE DENSITY		☐YES ☐NO
COLONOSCOPY OR SIGMOIDOSCOPY		☐YES ☐NO
MEN: DIGITAL PROSTATE EXAM		☐YES ☐NO
MEN: PSA (PROSTATE BLOOD TEST)		☐YES ☐NO
WOMEN: PAP OR PELVIC EXAM		☐YES ☐NO
WOMEN: MAMMOGRAM		☐YES ☐NO
LAST MENSTRUAL CYCLE		☐YES ☐NO

RECENT BLOOD TEST (WHAT & WHEN): _____

_____

RECENT STRESS TEST/OTHER CARDIAC TESTING (DESCRIBE TEST & RESULTS): _____

_____

OTHER RECENT TESTING: _____

_____

_____

SIGNATURE DATE

Cancellation Policy: Due to the high demand for appointments and in order to be respectful of the medical needs of all of our patients, it is necessary that a 24-hour notice of cancellation be provided for any appointment that a patient is unable to attend. In the event the patient does not provide 24-hour notice, they will be charged a **$25 cancellation fee**. This will be billed directly to the patient and is not reimbursable by their insurance company. This fee will need to be paid before the patient will be seen for their next scheduled appointment.
If a patient fails to provide sufficient notification of cancellation for more than 2 appointments, we reserve the right to dismiss the patient from our care.

Driver Contract: Patients are instructed not to drive for 24 hours following spinal injections and certain other muscle, nerve or joint injections as there is a risk of numbness, weakness, light-headedness or other complication that may impair the patient's ability to drive or operate machinery safely and may lead to undue risk of accident, injury or death. This can occur at any time during the immediate 24 hours after an injection and is unpredictable, regardless of past experience with other injections, procedures or at other clinics.
By signing below, I indicate that I have been adequately informed of these risks and of my physician's requirement that I appear with a driver at the time of my procedure, for my own safety. My signature also indicates the understanding that, should I present without a driver, refuse to provide a driver, or choose to drive during the 24 hours following my procedure despite my physician's recommendations, that my procedure may be rescheduled or cancelled and that I may even be discharged from the practice on a case-by-case basis.

Privacy Policy (HIPAA): I have received or have been offered a copy and understand this practices Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duty in respect to my information. I understand that this practice reserves the right to change the terms of it's Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practice upon request.

Assignment of Benefits: I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient Name: _____ Date: _____

Patient or Representative Signature: _____

Relationship: _____