Advanced Alternative Healthcare, LLC
3829 S Jefferson Ave
Springfield, MO 65807
417.890.5585 Office 417.877.0970 Fax

New Patient Registration Form

Today's Date: _____ Referred by: _____

Patient Information Sex: M F Marital Status: S M D W

Legal Name: _____
First Middle Initial Last

Home Address:_____
Street Apt # City State Zip

Phone #: Home:_____ Cell:_____ Work:_____

Date of Birth:_____ Social Security #:_____

Emergency Contact: _____ Phone #:_____

Pharmacy Name: _____ Phone #: _____

Employer Name: _____ Phone #:_____

Occupation: _____ How Long: _____

Email Address (optional):_____

May we **email** you: To Confirm Appointments: Yes No AAH Newsletters: Yes No

Responsible Party/Insured Information: If any of the information is the same as above, please indicate by writing 'same' in appropriate section. If Advanced Alternative Healthcare, LLC will be filing insurance, **this information must be the Primary Insured's Information**.

Relationship to patient: Self Spouse Parent Other:_____

Legal Name: _____
First Middle Initial Last

Home Address:_____
Street Apt # City State Zip

Phone #: Home:_____ Cell:_____ Work:_____

Date of Birth:_____ Social Security #:_____

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Patient Name:_____

Authorization, Consent, and Financial Obligation

1. **Release of Information**: I authorize the disclosure of any or all information in my medical record to:
   a. Any person, corporation, or agency responsible for all or part of services who may be responsible for determining the necessity, appropriateness, payment, or other matters related to treatment or services;
   b. This includes but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Center for Medicare and Medicaid Services or its intermediaries or carriers, or other carriers.
2. **Assignment of Benefits**: I assign to Advanced Alternative Healthcare, LLC the benefits due me for services rendered, under my policy(s), managed care plan, HMO, or the Center for Medicare and Medicaid Services or its intermediaries or carriers.
3. **Medicare Patients**: I authorize Advanced Alternative Healthcare, LLC to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.
4. **Financial Obligation**: I agree that I am financially responsible for payment of all amounts for services provided by Advanced Alternative Healthcare, LLC. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between Advanced Alternative Healthcare, LLC and my insurer, or if prohibited by applicable state or federal laws or regulations. I understand that I am financially responsible for non-covered services or deductibles, co-pay, or co-insurance as defined in my policy or plan. I agree that this Authorization shall be governed by and construed in accordance with the laws of the State of Missouri. I further understand that in the event of litigation pertaining to this Authorization, including, but not limited to, collection of amounts due for services rendered (together with collection costs, interest, court costs, attorney's fees and expenses) the exclusive forum, venue, and place of jurisdiction shall be in the Circuit Court of Greene County, Missouri. I understand I will be responsible for all costs of collection, including reasonable attorney's fee, court costs and interest on all sums due at the annual rate of 15% without necessity of demand and whether or not suit is actually filed. I also agree that Advanced Alternative Healthcare, LLC shall recover all prior discounts, adjustments and/or write-offs on patient's account in any collection action.

- **Guarantor's Responsibility**: I have read and understand the financial obligation above and agree to the terms as stated.
- **Consent for Treatment**: As a patient of Advanced Alternative Healthcare, LLC, I agree, request, and authorize my physician to administer such treatment as is necessary. Treatment may include such services, care, procedures, and/or medical, osteopathic, or acupuncture treatments, as the physician deems reasonable and necessary.
- **Authorization for Disclosure**: I give express permission to discuss with the individual(s) I have listed below the following information [check the appropriate box(es)]:

  ☐Any aspect of my health care ☐Health information only ☐Financial information only
- I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____

X Signature:_____ **Date**:_____

Acknowledgment of Receipt of Notice of Privacy Practices: The Notice of Privacy Practices of Advanced Alternative Healthcare, LLC sets forth the ways in which my personal health information may be used or disclosed by Advanced Alternative Healthcare, LLC, and outlines my rights with respect to such information. I acknowledge that on today's date:

☐ I received a copy of the Notice of Privacy Practices ☐ I declined a copy of the Notice of Privacy Practices

X Signature:_____ **Date**:_____

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NEW PATIENT INTAKE FORM

Name:_____ **Date:**_____
Date of Birth: _____ **Age:**____ **Sex:** M F

To help us establish you with our practice, please provide us with your complete health history

Main Problems or Reasons for Appointment:
(Please rank in terms of importance to you)
1._____
2._____
3._____
*Note: we may not be able to address every problem during this visit

When did these problems begin?
_____
_____
_____

Since these problems began, have they:
Worsened Improved Stayed the same

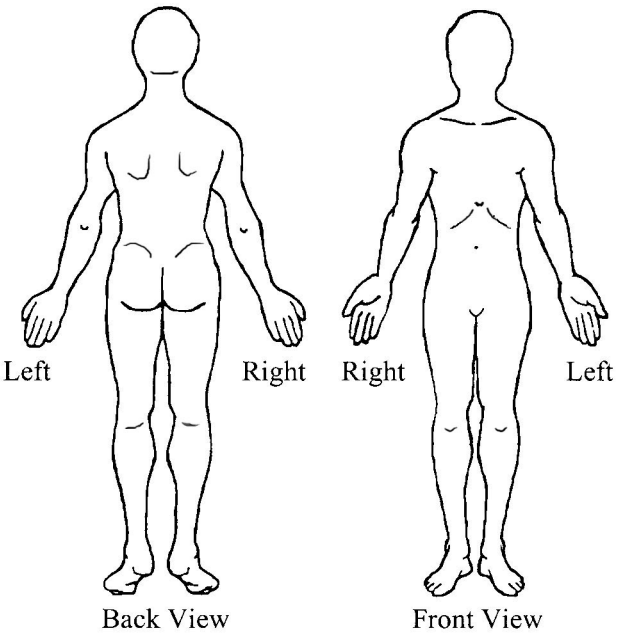
Is there anything that improves the problem or pain?
_____
_____
_____

Is there anything that worsens the problem or pain?
_____
_____
_____

Are there other symptoms you experience with these problems? _____
_____
_____

Locate your pain on the figures below, using the symbols given below.

Ache ▲▲▲ Numbness ==== Pins/Needles ○○○ Burning xxxx Stabbing //// Other ●●●



Please rate your pain on the scale below with
W=Worst pain level, **B**=Best pain level, **C**=Current pain level
"0" = No Pain and "10" = Worst possible pain

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

Past & Current Medical Problems:

Diagnosis	Month/Year First Diagnosed

Past Surgeries, Procedures & Hospitalizations:

Reason/Procedure	Month/Year

Doctor's Notes: _____
_____
_____
_____
_____

Patient Name:_____

Current Medications: (Include regular meds, herbs, vitamins, other supplements) Name of Med. Strength(mg) How many/day Reason for taking	Allergies: (Include Medications, Food, Chemical, and Environmental)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Trauma History: (Include accidents, falls, broken bones, or loss of consciousness)

What Happened Date Age Were you hospitalized

_____

_____

_____

_____

_____

_____

Social History:

Education level:_____ Marital status (circle): Single Married Divorced Widowed

Number of children/dependents:_____ Ages/Sex:_____

Employer:_____ Type of Work:_____

Are you currently on disability: Yes No If so, why:_____How long:_____

Tobacco Use: Yes No How much/day:_____ How long:_____ I want to quit: Yes No

Alcohol Use: Yes No How much/day:_____ How long:_____ I want to quit: Yes No

Coffee Use: Yes No How much/day:_____ How long:_____ I want to quit: Yes No

Caffeine Use: Yes No How much/day:_____ How long:_____ I want to quit: Yes No

Do you follow a particular diet? Yes No What type:_____ How long:_____

Do you exercise regularly? Yes No What type:_____ How often:_____

Family History (Indicate any significant illness or disease that runs in your family)

Illness/Disease Relationship to you Living Age or Age at death

_____

_____

_____

Patient Name:_____

Review of Systems

Please mark any symptoms you have experienced in the **last month**.
If not marked it is considered negative or non-pertinent.

Constitutional
- ❑ Appetite, excessive
- ❑ Appetite, poor
- ❑ Chills
- ❑ Fatigue
- ❑ Fevers
- ❑ Insomnia

Head
- ❑ Dizziness
- ❑ Grinding Teeth
- ❑ Headache
- ❑ Jaw Pain or Click
- ❑ Tooth Pain

Eyes
- ❑ Blurred Vision
- ❑ Floaters or Spots
- ❑ Vision Change
- ❑ Vision Loss

ENT
- ❑ Ear Pain
- ❑ Hearing Loss
- ❑ Ringing or Buzzing
- ❑ Nosebleed
- ❑ Sinus Pain
- ❑ Sinus Congestion
- ❑ Sinus Infection
- ❑ Change in Taste
- ❑ Dry Mouth
- ❑ Sore Throat
- ❑ Trouble Swallowing

Cardiovascular
- ❑ Blood Clots
- ❑ Chest Pain
- ❑ Short of Breath with Activities
- ❑ Irregular Heartbeat
- ❑ Lightheaded
- ❑ Swelling Feet

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cough
- ❑ Frequent Colds
- ❑ Pneumonia
- ❑ Short of Breath
- ❑ Wheezing

Gastrointestinal
- ❑ Bleeding
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn/Reflux
- ❑ Indigestion
- ❑ Nausea
- ❑ Ulcer
- ❑ Vomiting
- ❑ Bloody or Dark Stools
- ❑ Loss of Bowel Control

Musculoskeletal
- ❑ Broken Bones
- ❑ Difficulty Standing
- ❑ Difficulty Sitting
- ❑ Difficulty Walking
- ❑ Joint Stiffness
- ❑ Joint Swelling
- ❑ Morning Stiffness
- ❑ Muscle Cramps
- ❑ Muscle Weakness
- ❑ Numb Hands/Fingers
- ❑ Numb Feet/Toes

Neuro/Psych
- ❑ Anxiety
- ❑ Depression
- ❑ Difficulty Falling Asleep
- ❑ Difficulty Staying Asleep
- ❑ Fainting
- ❑ Head Injury
- ❑ Loss of Consciousness
- ❑ Loss of Sensation
- ❑ Poor Balance
- ❑ Poor Coordination
- ❑ Seizures
- ❑ Tingling Sensation
- ❑ Tremor or Shakes

Skin
- ❑ Dry
- ❑ Itchy
- ❑ Rashes

Genitourinary
-Urination that is:
- ❑ Bloody
- ❑ Burning
- ❑ Frequent
- ❑ Painful

- ❑ Kidney Stones
- ❑ Loss of Urinary Control
- ❑ Wake Up to Urinate

Reproductive
- ❑ Infertility
- ❑ Pain with Sex
- ❑ Erection Problems
- ❑ Pelvic Pain
- ❑ Painful Periods
- ❑ Hot Flashes

___# of Pregnancies
___# of Live Births
___Age Periods Began
___Age Menopause Began

Immune/Endocrine
- ❑ Anemia
- ❑ Easy Bruising
- ❑ Frequent Infections
- ❑ High / Low Blood Sugar
- ❑ Low thyroid
- ❑ High thyroid
- ❑ Hot Flashes
- ❑ Swollen Lymph Nodes
- ❑ Weight Gain or Loss

Tests/Studies

Please indicate where and when (month/year) you had any of the following tests done for the appropriate region.

Anatomy **Procedure**	**X-ray**	**MRI**	**CT Scan**	**Bone Scan**	**EMG**
Head/Brain					
Cervical					
Thoracic (Mid Back)					
Lumbar (Low Back)					
Chest					
Upper Extremity					
Lower Extremity					
Abdomen					
Pelvis					
Other					

YOUR PRIMARY CARE DOCTOR'S NAME: _____

Doctor's Phone #_____

MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR? Yes No

This history record has been designed to facilitate our patient's continuity of care at Advanced Alternative Healthcare, LLC. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

_____ _____

Patient/Guardian signature who filled out the history **Date**

_____ _____

ER Douglas, DO **Date**