Max Center for Health

240 North Liberty Street | Powell, OH | 43065

Date: _____ Patient Name_____ SS#/SIN_____

DOB_____ Phone Number_____ Email _____

☐ *Male* ☐ *Female* *Check appropriate Box:* ☐*Minor* ☐*Single* ☐*Married* ☐*Divorced* ☐*Widowed* ☐*Separated*

Patient's Address _____City _____ State_____ Zip_____

Responsible Party

Responsible Party _____ Relationship to Patient_____

Address_____

Home Phone _____

E-Mail _____

Cell Phone_____

Driver's License # _____

Date of Birth:_____

Health History

Chief Complaint:

_____

Additional Concerns:

_____

_____

History of Present illness:

Location: _____ **Quality:** _____
(Where is the pain/problem?) (Describe pain. Example: dull, sharp, etc..)

Severity: _____ **Duration:** _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?) (How long have you had this pain/ problem? When did it start?)

Timing: _____ **Context:** _____
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ **Modifying Factors** _____

_____ _____

(What other associated problems have you been having?) (What makes the pain/problem worse or better? Have you had previous episodes?)

Medical History

(Do you currently have or have had in the past any of the following: (click "yes" or "no"/ leave blank if you are uncertain.)

COPD	Y	N	Varicose Veins	Y	N	Blood/Plasma Transfusion	Y N	Bleeding Disorders	Y N
Asthma	Y	N	Epilepsy/Seizures	Y	N	A-fib/Arrythmia	Y N	Keloid Scars	Y N
Dysphagia	Y	N	Migraines	Y	N	Gout	Y N	HIV/AIDS	Y N
Stroke	Y	N	Diabetes	Y	N	Clotting Disorder	Y N	Taking/taken Accutane	Y N
Osteomyelitis	Y	N	Cancer	Y	N	Pacemaker/metal implants	Y N	Trigeminal Neuralgia	Y N
Lupus	Y	N	Methemoglobinemia	Y	N	Tattoo/dental work within the past 2 weeks	Y N	Cellulitis	Y N
Rheumatoid Arthritis	Y	N	Liver disease/hepatitis	Y	N	Ulcer	Y N	Cold Sores	Y N
Autoimmune Disorder	Y	N	Hernia	Y	N	High Cholesterol	Y N	Copper IUD	Y N
Neuromuscular Disorder	Y	N	Diastasis Recti	Y	N	Anxiety/Depression	Y N	Kidney Disease	Y N
G6PD Deficiency	Y	N	High Blood Pressure	Y	N	Acne	Y N	Thyroid/hormone Disorder	Y N
Heart Attack	Y	N	Low Blood Pressure	Y	N	Arthritis	Y N	Recipient of a transplant	Y N
Use of Retin-A products	Y	N	Eye drooping/hooding	Y	N	Anemia	Y N	Any Other Disease	Y N

If YES to any of the above, please explain: _____

_____

Allergies: (Sulfa, Lidocaine, Cow's Milk Protein, Visine, human Albumin, etc.)_____

_____

Previous reactions to Procedures/Anaphylaxis: _____

Medications: (include nonprescription and supplements)

_____

_____

Previous Hospitalizations/Surgeries/Cosmetic Procedures When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Women only:

Are you currently pregnant or breastfeeding?_____

Patient Social History:

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Excessive Exposure at home/work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Check which of the below you have experienced in the last 1-2 months

Neurological

Headaches _____
Migraines _____
Dizziness _____
Numbness _____
Tingling _____
Pins/needles in hands or fee _____

General

Fatigue _____
Malaise _____
Weakness, tiredness _____
Lightheadedness _____
Diarrhea _____
Constipation _____

Eyes/Ears/Nose/Throat/Respiratory

Asthma _____
Stuffy Nose _____
Hay Fever _____
Sore throat _____
Chronic Cough _____
Chest Congestion _____
Frequent Sneezing _____
Itchy/Watery Eyes _____
Drainage _____
Earache or Ear Infection _____
Itching _____
Hoarseness _____
Shortness of Breath _____

Muscular/Skeletal General

Muscle Aches _____
Fibromyalgia _____
Arthritis _____
Joint Pain _____
Low Back Pain _____
Neck Pain _____
Wrist/Hand Pain _____
Elbow Pain _____
Shoulder Pain _____
Hip Pain _____
Knee Pain _____
Ankle/Foot Pain _____
Pain b/t shoulder blades _____

Wheezing _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Max Center for Health as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____ X_____

Date Signature of the Patient, Parent or Guardian