Keystone Health & Wellness Center, Inc.
7955 E. Arapahoe Ct. Suite 2400, Centennial, CO 80112

Patient Name________________________________ Date: _____________________ Email: ________________

SS #/SIN__________________ DOB__________ ☐ Male ☐Female Home phone___________ Cell Phone _________

Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Address ____City _________ State_____ Zip_____________

Employer Name: ____

Spouse or Patient's Guardian name____________________ Spouse's Employer_________________________________

Whom may we thank for referring you? ____

Person to contact in case of an emergency_______________________________ Phone___________________________

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____ ____________________________

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account ______________________Relationship to Patient ___________________

Address ____Home Phone __________________________

E-Mail ____Cell Phone ____________________________

Driver's License # ________________________ Date of Birth: ____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured____ Relationship to patient______________________

Birthdate_________________ SS#/SIN______________________ Name of Employer_______________ Work Phone _________

Address of Employer____________________________________ State ___________ Zip___________________________

Insurance Company___________________________ Group #________________ Union or local # _________________________

Ins. Co. Address __________________________________ City _______________ State ________ Zip______________________

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 **Keystone Health & Wellness Center, Inc.** 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.

Signed this ______ day of ________________, 20 ____.   X__________________________ (SEAL)
(patient signature)

X____________________________(SEAL)   X____________________________
(signature of Guardian if applicable)   (please print patient name)

Health History

Patient Name: __________________________DOB: _________________Date: ____________

Chief Complaint: ____

History of Present illness:

Location: ________________________________
(Where is the pain/problem?)

Quality: __________________________________
(Example: normal vs abnormal color, activity, etc..)

Severity: ________________________________
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration: _________________________________
(How long have you had this pain/ problem? When did it start?)

Timing: ________________________________
(Does the pain/problem occur at a specific time?)

Context: ________________________________
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms ____________________ ____________________________
____
(What other associated problems have you been having?)

Modifying Factors
____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles............... NO YES
Anemia.......................NO YES
Back Trouble..................NO YES
Hepatitis.........................NO YES
Mumps................ NO YES
Bladder Infection.......NO YES
High Blood Pressure......NO YES
Ulcer.................................NO YES
Chicken Pox......... NO YES
Epilepsy........................NO YES
Low Blood Pressure.......NO YES
Kidney Disease...............NO YES
Whooping Cough... NO YES
Migraine Headaches. NO YES
Hemorrhoids..................NO YES
Thyroid Disease.............NO YES
Scarlet Fever.......... NO YES
Tuberculosis.................NO YES
Date of Last Chest X-Ray____________
Bleeding Tendency.......NO YES
Diphtheria............... NO YES
Diabetes.......................NO YES
Asthma............................NO YES
Any Other Disease.......NO YES
Small pox................ NO YES
Cancer............................NO YES
Hives of Eczema.............NO YES
(Please List):
Pneumonia............. NO YES
Polio...............................NO YES
AIDS & HIV........................NO YES
Rheumatic Fever... NO YES
Glaucoma.....................NO YES
Infectious Mono...............NO YES
____
Arthritis.................. NO YES
Hernia...........................NO YES
Bronchitis.........................NO YES
Venereal Disease... NO YES
Blood or Plasma Transfusion.................NO YES
Mitral Valve Prolepses....NO YES
____
Stroke................................NO YES

Previous Hospitalizations/Surgeries/Serious Illnesses When?
Hospital, City, State

______________________________ ____________ ________________
______________________________ ____________
____
______________________________ ____________
____

Medication: (include nonprescription)

____
____
Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: ______________________________

Patient Social History:

Marital Status Single: ______ Married: ______ Separated: _______ Divorced: _______
Widowed: _______
Use of Alcohol Never: ______ Rarely: _______ Moderate: _______ Daily: ________
Use of Tobacco Never: ______ Rarely: _______ Moderate: _______ Daily: _________________
Use of Drugs Never: ______ Type/Frequency:
____
Excessive Exposure
At home or at work to: Fumes: ______ Dust: ______ Solvents: ______ Airborne Particles: _______
Noise: _______

CLINICIAN SIGNATURE: ________________________________ **DATE REVIEWED:**____________________

Patient Name: _________________________DOB: ________________Date: ___________

Family Medical History:

Age Disease If Deceased, Cause Of Death

Father _________ ______________________________________ ____________________________
Mother _________ ______________________________________ ____________________________
Siblings _________ ______________________________________ ____________________________
_________ ______________________________________ ____________________________
_________ ______________________________________ ____________________________
Spouse: _________ ______________________________________ ____________________________
Children: _________ ______________________________________ ____________________________
_________ ______________________________________ ____________________________
_________ ______________________________________ ____________________________

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		**Muscular/Skeletal**	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5

Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5
Wheezing	1 2 3 4 5		

Neurological		**General**	
Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
		Diarrhea	1 2 3 4 5
		Feeling foggy	1 2 3 4 5
		Forgetfulness	1 2 3 4 5

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

Provider’s Review

_________________________ ___________________

Signature of Provider Date

_________________________ ___________________

Signature of Consulting Physician Date