Patient Name:_____DOB: _____ Date: _____

AMS ADVANCED MEDICAL SOLUTIONS

DEMOGRAPHICS

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: _____

Spouse or Patient's Guardian name:_____

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

HEALTH HISTORY

Chief Complaint _____

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**	**Stroke**	**NO**	**YES**
Mumps	**NO**	**YES**	**Bladder Infection**	**NO**	**YES**	**High Blood Pressure**	**NO**	**YES**	**Hepatitis**	**NO**	**YES**
Chicken Pox	**NO**	**YES**	**Epilepsy**	**NO**	**YES**	**Low Blood Pressure**	**NO**	**YES**	**Ulcer**	**NO**	**YES**
Whooping Cough	**NO**	**YES**	**Migraine Headaches**	**NO**	**YES**	**Hemorrhoids**	**NO**	**YES**	**Kidney Disease**	**NO**	**YES**
Scarlet Fever	**NO**	**YES**	**Tuberculosis**	**NO**	**YES**	**Asthma**	**NO**	**YES**	**Thyroid Disease**	**NO**	**YES**
Diphtheria	**NO**	**YES**	**Diabetes**	**NO**	**YES**	**Hives of Eczema**	**NO**	**YES**	**Bleeding Tendency**	**NO**	**YES**
Small Pox	**NO**	**YES**	**Cancer**	**NO**	**YES**	**AIDS & HIV**	**NO**	**YES**	**Any Other Disease**	**NO**	**YES**
Pneumonia	**NO**	**YES**	**Polio**	**NO**	**YES**	**Infectious Mono**	**NO**	**YES**	**Please List:** _____		
Rheumatic Fever	**NO**	**YES**	**Glaucoma**	**NO**	**YES**	**Bronchitis**	**NO**	**YES**	_____		
Arthritis	**NO**	**YES**	**Hernia**	**NO**	**YES**	**Mitral Valve Prolepses**	**NO**	**YES**	_____		
Venereal Disease	**NO**	**YES**	**Blood or Plasma Transfusion**	**NO**	**YES**				**Date of last chest x-ray:** _____		

Allergies: _____

Previous Hospitalizations/Serious Illnesses: _____ **When?** **Hospital, City, State**

_____ _____ _____

Previous Surgeries:_____ _____ _____

_____ _____ _____

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: _____

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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					
Asthma	1 2 3 4 5	**Itchy/Watery Eyes**	1 2 3 4 5	**Headache**	1 2 3 4 5
Muscle Aches	1 2 3 4 5	**Drainage**	1 2 3 4 5	**Fatigue**	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	**Earache or Ear Infection**	1 2 3 4 5	**Migraines**	1 2 3 4 5
Fibromyalgia	1 2 3 4 5	**Itching**	1 2 3 4 5	**Malaise**	1 2 3 4 5
Hay Fever	1 2 3 4 5	**Hoarseness**	1 2 3 4 5	**Dizziness**	1 2 3 4 5
Arthritis	1 2 3 4 5	**Shortness of Breath**	1 2 3 4 5	**Weakness/Tiredness**	1 2 3 4 5
Sore Throat	1 2 3 4 5	**Elbow Pain**	1 2 3 4 5	**Numbness**	1 2 3 4 5
Joint Pain	1 2 3 4 5	**Shoulder Pain**	1 2 3 4 5	**Tingling**	1 2 3 4 5
Low Back Pain	1 2 3 4 5	**Knee Pain**	1 2 3 4 5	**Irritability**	1 2 3 4 5
Chest Congestion	1 2 3 4 5	**Ankle/Foot Pain**	1 2 3 4 5	**Wrist/Hand Pain**	1 2 3 4 5
Neck Pain	1 2 3 4 5	**Pain b/t shoulder blades**	1 2 3 4 5	**Frequent Sneezing**	1 2 3 4 5
Wheezing	1 2 3 4 5	**Hip Pain**	1 2 3 4 5	**Chronic Cough**	1 2 3 4 5
Lightheadedness	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

_____ _____

Clinician Signature Date

Patient Name:_____DOB: _____ Date: _____

ADVANCED MEDICAL SOLUTIONS

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please notify the Doctor.

Do you suffer from neck pain with pain in your shoulder, arms or hands? **NO YES**
Comment:_____

Do you have weakness, numbness or burning in your shoulder, arms or hands? **NO YES**
Comment:_____

Do your hands or arms fall asleep regularly? **NO YES**
Comment:_____

Do you have reduced feeling (sensation) or swelling in your hands or arms? **NO YES**
Comment:_____

Do you suffer from a loss of handgrip strength? **NO YES**
Comment:_____

Do you suffer from back pain with pain in your buttocks, legs or feet? **NO YES**
Comment:_____

Do you have weakness, numbness or burning in your buttocks, legs or feet? **NO YES**
Comment: _____

Do your legs or feet fall asleep regularly? **NO YES**
Comment: _____

Do you have reduced feeling (sensation) or swellings in your legs, feet? **NO YES**
Comment:_____

Do you suffer from cold hands or feet? **NO YES**
Comment:_____

Do you suffer from headaches, dizziness or memory loss? **NO YES**
Comment:_____

Do you have difficulty maintaining your balance? **NO YES**
Comment:_____

Do you suffer from vertigo or blurred vision? **NO YES**
Comment:_____

Do you suffer from a reduced hearing capacity? **NO YES**
Comment:_____

Do you suffer from ringing in your ears? **NO YES**
Comment:_____

Do you have bladder or bowel control problems on a regular basis? **NO YES**
Comment:_____

Patient Name:_____DOB: _____ Date: _____

AMS ADVANCED MEDICAL SOLUTIONS

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION ACKNOWLEDGEMENT

I acknowledge that I have received the Practice's Notice of Privacy Practices for protected health information.

Date:_____Name of Patient:_____DOB:_____

Signature of Patient/Personal Representative: _____

Documentation of Good Faith Effort to Obtain Written Acknowledgement:

_____

Note: This written acknowledgement must be completed no later than the first date health care services or treatment is provided to the patient after April 12, 2013. This acknowledgement must be retained in the patient's permanent record.

CONSENT TO TREAT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.
You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____Date _____

Witness Signature_____Date_____

Patient Name:_____DOB: _____ Date: _____

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ADVANCED MEDICAL SOLUTIONS

FORM OF DISCLOSURE

I,_____, direct my health care and medical services, providers, and payers to disclose and release my protected health information as described below to:

Health Information to be disclosed upon the request of the person named above:
(Please check either A or B)

- A. I **DO NOT** disclose my health record to anyone.
- B. I **DO** disclose my complete health record, as above, **but do not disclose the following** (check as appropriate)
  - Mental Health Records
  - Communicate Diseases (Including HIV and AIDS)
  - Alcohol/Drug Abuse Treatment
  - Other please specify: _____
    _____

Name:_____Relationship: _____

Phone Number: _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- An electronic record or access through an online portal
- Hard copy

This authorization will be effective until (check one):

- All past, present and future periods.
- Date or event:_____unless I revoke it. (Note: You may revoke this authorization in writing at any time by notifying your health care providers in writing.)