Please type in the form, save it and email it back to us.

Who can we thank for referring you to us? _____

Balanced Well Health Center

WELCOME

Date: _____

PATIENT INFORMATION

Name:_____
Last First MI

Email Address:_____

Mailing Address:_____ City_____ State_____ Zip_____

Phone # (H)_____ (W)_____ (Cell)_____

Date of Birth _____ Sex: ☐ Male ☐ Female SS#_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Occupation:_____ Employer:_____

Employer Address: _____ Phone:_____

Emergency contact: Name:_____ Relation:_____ Phone #: _____

Phone # (H)_____ (W)_____ (Cell)_____

ACCIDENTAL INFORMATION

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other _____

Has it been reported? ☐ Yes ☐ No If yes, to whom _____

INSURANCE INFORMATION

Policy Holder Name:_____ D.O.B. :_____

Relationship to patient (If other than self):_____ Phone # :_____

Do you have health insurance? ☐ Yes ☐ No Name of Carrier_____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier_____

PLEASE PROVIDE OUR OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

ASSIGNMENT AND RELEASE (INSURED PATIENTS)

I certify that I (or my dependent) have insurance coverage with_____and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE X _____ **DATE**_____

Medical Information

Are you currently under drug and/or medical care? ☐ Yes ☐ No Who is your primary care Dr?_____

Please list all medications: (include dosage and frequency) _____

_____

Supplements (vitamins/herbs/minerals):_____

Allergies: _____Sulfa Allergy: ☐ Yes ☐ No

WOMEN ONLY: Do you currently take hormone supplements of any kind (including birth control): ☐ Yes ☐ No

MEN ONLY: Do you currently take any form of hormone replacement/testosterone? ☐ Yes ☐ No

Surgical History:

Surgeries and/or hospitalizations (type & date) _____

_____

Family History: Is there a family history of any of the following conditions? (parents, grandparents, children & siblings)

☐ Heart Disease_____ ☐ Diabetes_____ ☐ Thyroid disease_____

☐ Cancer _____ ☐ Arthritis _____ ☐ Other _____

Social History:

Intake of following: Cigarettes_____packs/day Alcohol_____drinks/week Caffeine_____cups/day

Please check your current level of exercise:

☐ None

☐ Light exercise: 1-3 times per week, easy pace, stretching, walking, etc.

☐ Moderate exercise: 2-3 times per week, moderate pace, some weights, etc.

☐ Heavy exercise: 3-4 times per week, vigorous pace, weights, fast running, etc.

Do you have any pain that prevents you from doing activities or exercise?

☐ Low Back Pain ☐ Tension Across Top of Shoulders ☐ Pain between Shoulder Blades ☐ Neck Pain ☐ Knee Pain

☐ Numbness/Tingling in Arms/Hands ☐ Numbness/Tingling in Legs/Feet ☐ Tension/Headaches ☐ Pain in the legs

☐ Pain in the feet

How would you rate your current Intake of food?

☐ Very nutritious ☐ Somewhat nutritious ☐ Not as healthy as I know I should be ☐ Not nutritious, please help!

On average, which of the following reflects your daily eating habits? (Please check all that apply)

☐ 3 meals with healthy snacks ☐ 3 meals ☐ 2 meals or less

☐ Graze, small, frequent meals (How many per day? _____) ☐ Skip breakfast or other meals

☐ Generally eat on the run ☐ No regular eating pattern ☐ Often crave sweets/carbs

Is there anything else you would like our healthcare provider to know?

_____

_____

I attest that the above information is true to the best of my knowledge: **X** SIGNATURE **X** _____

NAME:_____DOB:_____Age:_____ Date of Exam:_____

Please tell us what brings you in today? _____

Please check to indicate if you are currently or have ever experienced any of the following conditions:

Medical

- ☐ Alcoholism
- ☐ Allergies
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Diabetes
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Loss of Memory
- ☐ Measles
- ☐ Mononucleosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Sinus
- ☐ Skin Rashes
- ☐ Tuberculosis
- ☐ Tumors/Growths

Please list all medical conditions NOT Listed elsewhere on this form:

_____
_____
_____
_____
_____
_____
_____
_____
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_____

Metabolic / Nutritional

- ☐ Metabolic/Nutritional
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Cold Sores
- ☐ Bleeding Disorders
- ☐ Constipation
- ☐ Blurred Vision
- ☐ Bowel/Bladder Changes
- ☐ Bulimia
- ☐ Cold Feet/Hands
- ☐ Dizziness ·
- ☐ Fatigue
- ☐ Goiter
- ☐ Weight gain
- ☐ Gout
- ☐ Hair Loss
- ☐ Headaches
- ☐ Insomnia
- ☐ Liver Disease
- ☐ Light Bothers Eyes
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Sleeping Difficulties
- ☐ Stomach Problems
- ☐ Sudden Weight Loss
- ☐ Ulcers
- ☐ Food cravings
- ☐ Vitamin D deficiency
- ☐ Abdominal Pain

Physical

- ☐ Arthritis
- ☐ Neck Pain/Stiffness
- ☐ Mid Back pain/stiffness
- ☐ Low Back pain/stiffness
- ☐ Sciatica
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot pain
- ☐ Numbness/tingling
- ☐ Wrist pain
- ☐ Shoulder pain

Hormonal

- ☐ Depression
- ☐ Low Body Temp
- ☐ Migraines
- ☐ Miscarriage
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Prostate Problems
- ☐ Breast Lump
- ☐ Suicide Attempt
- ☐ Vaginal Infections
- ☐ Low libido
- ☐ Oral contraceptive use
- ☐ Thyroid Problems

Cardiology

- ☐ Ankle Swelling
- ☐ Arm/Hand Pain
- ☐ Cold Sweats
- ☐ Chest Pain
- ☐ Fainting
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Varicose Veins
- ☐ Carotid artery blockage
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Low magnesium
- ☐ Low potassium
- ☐ Stroke
- ☐ Anemia

- ☐ PCOS
- ☐ Fibroids
- ☐ Breast Cancer
- ☐ Prostate cancer
- ☐ Triglycerides >100

Balanced Well Health Center

BALANCED WELL HEALTH CENTER

26·01 PELLACK DRIVE, 2nd FLOOR

FAIR LAWN, NJ 07410

201-794-4500 I 201-794-4502 (FAX)

CHANGING THE HEALTH OF THE WORLD, ONE FAMILY AT A TIME….

NOTICE OF PRIVACY FOR: Patient's Protected Health Information

(This notice describes how health care Information about you may be used and disclosed and how you may receive access to this information. Please review It carefully.

This office abides by the terms described in this policy. This office uses and discloses your protected health care Information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to Insurance companies (or Worker's Compensation Claim) to verify that treatment has been rendered.
- To determine a patient's benefits in a health care plan.
- Releasing Information required by State or Federal Public Health law
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-In logs may be disclosed to verify office visits.
- To Family and Close Friends Involved in your Care: Our office has an open, family-centered approach to wellness and we believe It Is In all our patient's best interests to have the support and cooperation of their families. Therefore, our office requires that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for treatment and wellness.
- Any other uses or disclosures will only be made with your specific written prior authorization.
- To send text messages and emails.

YOU HAVE THE RIGHT TO:

- Revoke authorization, In writing at any time, by specifying what you want restricted and to whom.
- Speak to our privacy officer, who is: Or. Douglas L. Kaner, and may be reached at 201-794-4500, regarding privacy issues.
- Inspect, copy, and amend your protected health Information and amend it as allowed by law.
- Obtain an accounting of disclosures of ·your protected health Information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.
- You have the right to request a restriction In how we use or disclose your PHI. However, we are not required to agree to your request.
- If you object to the presence of your spouse or significant other at your report, please let us know Immediately.

In addition, we may disclose your Personal Health Information (PHI) to a family member or dose friend If those persons accompany you while you are receiving health care services or if we determine that It Is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to family member or someone else who helps pay for your health care treatment. This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that It maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED THIS NOTICE WITH FULL UNDERSTANDING.

NAME OF THE PATIENT

_____/_____/_____

Signature **Print Name** **Date**

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CONSENT TO TREAT

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from: latent, pathological defects; illnesses; or, deformities, which would otherwise not come to the attention of the physician.

I hereby authorize the Doctor's to treat my case as they deem appropriate through the use of medical evaluations, exams, physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injection and diagnostic testing.

I have read and understood the foregoing.

Patient's Signature_____ Date_____

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name _____

_____ There is a possibility that I may be pregnant at this time.

_____ Yes, I am definitely pregnant.

_____ No, I am definitely not pregnant.

_____ I request that x-rays not be taken because:_____

Date of last menstrual period_____

Patient Signature _____ **Date** _____

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Primary Care Physician Name:_____

Phone Number: _____

Address: _____

_____

I _____, allow Balanced Well Health Center to release any information regarding my treatment to my primary care physician.

Patient Signature _____ **Date** _____

Balanced Well Health Center

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FAIR LAWN, NJ 07410

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Dear Valued Practice Member:

As an integrated Well ness Center, our clinic tries to offer the best Physical Medicine, Chiropractic Rehab, and Medical Services to our patients.

While providing you with a multi-disciplinary health care approach, our on-staff physicians and therapists may be utilizing insurance benefits billed under their clinic or doctor's names.

If you receive an Explanation of Benefits (EOB) or a check we ask that you give the EOB with the attached check to our front desk so that the doctor's account may be cleared of payment for services.

We ask that you bring the check in within five days of .the date of issue; otherwise, you acknowledge by signing this that you will be personally responsible for the full payment.

Thank you for trusting our Well ness Center with your most precious gift - your health!

Sincerely,
Patients Accounts

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

DATE: _____

info@balancedwellhealthcenter.com

www.balancedwellhealthcenter.com