Principled Healthcare Solutions, Inc.

PATIENT INFORMATION SHEET

First Name: ______________________ Last Name: ______________________ MI: ___________

Preferred Name: ______________________ E-mail Address: ______________________________

Social Security #: ______________________ Birth Date: __________________ Age: ___________

Gender: ___________ Marital Status: ___________ Height ___________ Weight: ___________

Address: ____

Home Phone: ____________________________ Cell Phone: ____________________________

Employer: _______________________________________ Work Phone: ___________________

Occupation: ____

Emergency Contact: ________________________________ Relationship: __________________

Emergency Contact Phone: ____

Primary Physician: ____

REFERRAL SOURCE: ____

Accident 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? __________________________________

PLEASE PROVIDE THIS 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 all 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.

SIGN (X) ____ **DATE** __________________

CONSULTATION/HISTORY FORM

Name: ______________________________ Date: ______________

List primary reason for your appointment - specific areas of pain or discomfort - all recent injuries incurred.

____

____

Is your pain a result of: Auto Accident: ______ Work Injury: ______ Other: ______

Over the past ________ (days, weeks, months, years)

Recent Accidents/Injuries (auto, work, falls)

____

____

____

Old Accidents/Injuries (even from childhood)

____

____

____

My health problems have been:

Rapidly getting worse Staying about the same
Gradually getting worse Getting better
Comments: ______________________________

____

I would describe my pain as (circle as many as apply):

Constant Frequent Intermittent Occasional
Very Severe Severe Moderate Mild Stabbing
Sharp Dull Aching
Other: ______________________________

I have tried the following solutions:

____

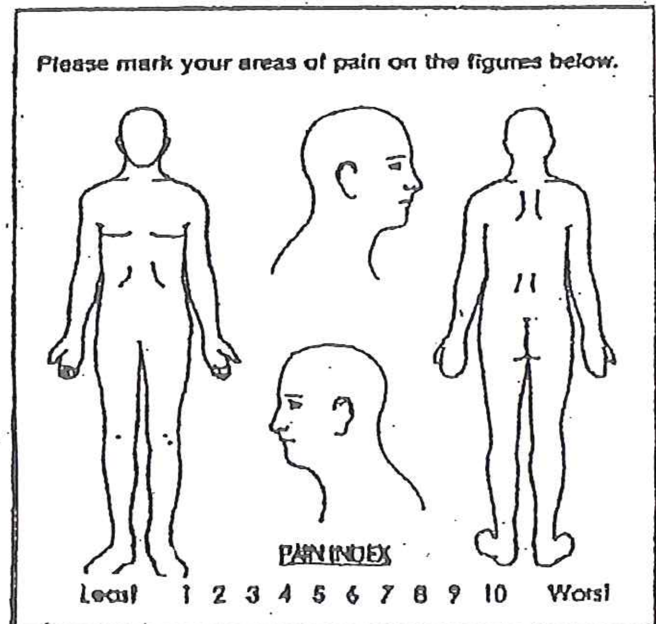
____

Other Doctors seen for this condition: ________

____

____

Have you been treated by a Doctor for any health Condition in the last year? Yes ______ No _____



Office Use Only:

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HEALTH HISTORY

Please check to indicate if you have any of the following conditions

□ Neck Pain/Stiffness	□ Pins/Needles in Arms	□ Light Bothers Eyes	□ Sudden Weight Loss	□ Nausea
□ Back Pain/Stiffness	□ Pins/Needles in Legs	□ Depression	□ Arm/Hand Pain	□ Fatigue
□ Nervousness	□ Loss of Memory	□ Chest Pain	□ Leg/Knee Pain	□ Tension
□ Sleeping Difficulties	□ Jaw Problems	□ Fever	□ Headaches	□ Constipation
□ Fainting	□ Dizziness	□ Allergies	□ Asthma	
□ Stomach Problems	□ Shortness of Breath	□ Blurred Vision	□ Bowel/Bladder Changes	

Please check to indicate if you have any of the following

□ AIDS/HIV	□ Cancer	□ Hepatitis	□ Mumps	□ Stroke
□ Alcoholism	□ Cataracts	□ Hernia	□ Osteoporosis	□ Suicide Attempt
□ Allergy Shots	□ Chemical Dependency	□ Herniated Disc	□ Pacemaker	□ Thyroid Problems
□ Anemia	□ Chicken Pox	□ Herpes	□ Parkinson's Disease	□ Tonsillitis
□ Anorexia	□ Diabetes	□ High Blood Pressure	□ Pinched Nerve	□ Tuberculosis
□ Appendicitis	□ Emphysema	□ High Cholesterol	□ Pneumonia	□ Tumors/Growths
□ Arthritis	□ Epilepsy	□ Kidney Disease	□ Prostate Problems	□ Typhoid Fever
□ Asthma	□ Fractures	□ Liver Disease	□ Prosthesis	□ Ulcers
□ Bleeding Disorder	□ Glaucoma	□ Measles	□ Psychiatric Care	□ Vaginal Infections
□ Breast Lump	□ Goiter	□ Migraines	□ Rheumatoid Arthritis	□ Venereal Disease
□ Bronchitis	□ Gonorrhea	□ Miscarriage	□ Rheumatic Fever	□ Whooping Cough
□ Bulimia	□ Gout	□ Mononucleosis	□ Scarlet Fever	
	□ Heart Disease	□ Multiple Sclerosis	□Other ______________________	

Are you currently under drug and/or medical care? □Yes □No If yes, explain______________________________

Please list any medications you are currently taking ____

Please list any surgeries and/or hospitalizations you have had (type and date) ___________________________

Please list any allergies ____

Please list any supplements you are currently taking (vitamins/herbs/minerals) ____________________________

Is there a family history of any of the following? (parents, grandparents & siblings)

□ Heart Disease______________ □ Diabetes ______________

□ Cancer ______________ □ Arthritis ______________ □ Other ______________

Do you exercise? □ frequently □ moderately □ occasionally □ None

Do your work activities mostly involve: □ sitting □ standing □ light labor □ heavy labor

What is your daily/weekly intake of the following?

Caffeine __________ cups/day Alcohol __________ drinks/week Cigarettes __________ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGN (X) ______________________________________ **DATE** ____________________

Principled Healthcare Solutions, Inc.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to inspect and copy your information:
2. The right to request corrections to your information:
3. The right to request that your information be restricted:
4. The right to request confidential communications:
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	
Contact Person	Cindy Grimes
Phone Number	513-887-9400

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified or changed in any way.

____

Patient or Representative Name (please print)

____ ____________________

Patient or Representative Signature Date

□ Patient refused to sign □ Patient was unable to sign because ______________________