

# Advanced Alternative Healthcare, LLC

4730 S. National Ave, Suite B4  
Springfield, MO 65810  
417.890.5585 Office 417.877.0970 Fax

## New Patient Registration Form

Today's Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Patient Information Sex: M F Marital Status: S M D W

Legal Name: \_\_\_\_\_  
First Middle Initial Last

Home Address: \_\_\_\_\_  
Street Apt # City State Zip

Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long: \_\_\_\_\_

Email Address (optional): \_\_\_\_\_

May we **email** you: To Confirm Appointments: Yes No AAH Newsletters: Yes No

Responsible Party/Insured Information: If any of the information is the same as above, please indicate by writing 'same' in appropriate section. If Advanced Alternative Healthcare, LLC will be filing insurance, **this information must be the Primary Insured's Information**.

Relationship to patient: Self Spouse Parent Other: \_\_\_\_\_

Legal Name: \_\_\_\_\_  
First Middle Initial Last

Home Address: \_\_\_\_\_  
Street Apt # City State Zip

Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Advanced Alternative Healthcare, LLC**

4730 S. National Ave, Suite B4  
 Springfield, MO 65810  
 417.890.5585 Office 417.877.0970 Fax

**NEW PATIENT  
 INTAKE FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

To help us establish you with our practice, please provide us with your complete health history

Main Problems or Reasons for Appointment:  
 (Please rank in terms of importance to you)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

\*Note: we may not be able to address every problem during this visit

When did these problems begin?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Since these problems began, have they:  
 Worsened  Improved  Stayed the same

Is there anything that improves the problem or pain?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there anything that worsens the problem or pain?

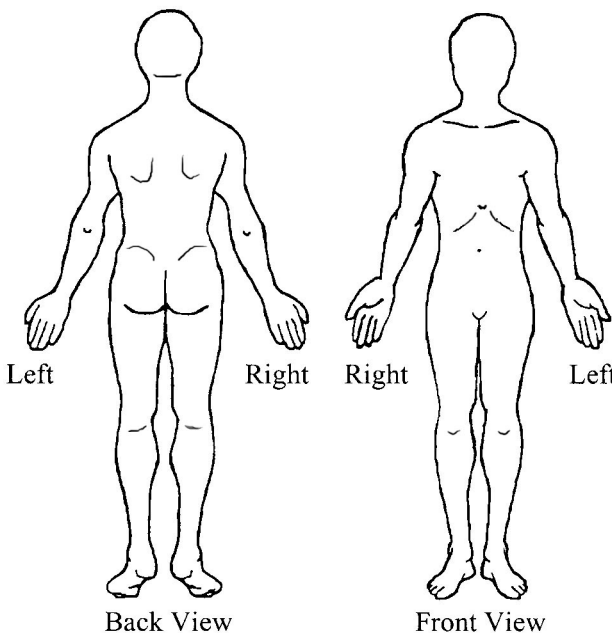
\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are there other symptoms you experience with these problems? \_\_\_\_\_

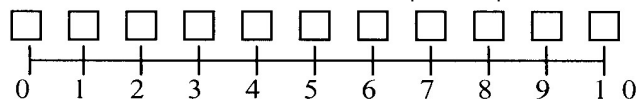
\_\_\_\_\_  
 \_\_\_\_\_

Locate your pain on the figures below, using the symbols given below.

Ache    Numbness    Pins/Needles    Burning    Stabbing    Other  
 ▲▲▲    =====    ○○○    xxxxx    ////    ●●●



Please rate your pain on the scale below with  
**W**=Worst pain level, **B**=Best pain level, **C**=Current pain level  
 "0" = No Pain and "10" = Worst possible pain



**Past & Current Medical Problems:**

Diagnosis                      Month/Year First Diagnosed

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Past Surgeries, Procedures & Hospitalizations:**

Reason/Procedure                      Month/Year

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Doctor's Notes: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name: \_\_\_\_\_

Current Medications: (Include regular meds, herbs, vitamins, other supplements)				Allergies: (Include Medications, Food, Chemical, and Environmental)
Name of Med.	Strength(mg)	How many/day	Reason for taking	
_____				_____
_____				_____
_____				_____
_____				_____
_____				_____
_____				_____
_____				_____
_____				_____
_____				_____
_____				_____

Trauma History: (Include accidents, falls, broken bones, or loss of consciousness)			
What Happened	Date	Age	Were you hospitalized
_____			
_____			
_____			
_____			
_____			

Social History:	
Education level: _____	Marital status (circle): Single Married Divorced Widowed
Number of children/dependents: _____	Ages/Sex: _____
Employer: _____	Type of Work: _____
Are you currently on disability: <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, why: _____ How long: _____
Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	How much/day: _____ How long: _____ I want to quit: <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	How much/day: _____ How long: _____ I want to quit: <input type="checkbox"/> Yes <input type="checkbox"/> No
Coffee Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	How much/day: _____ How long: _____ I want to quit: <input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	How much/day: _____ How long: _____ I want to quit: <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you follow a particular diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type: _____ How long: _____
Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type: _____ How often: _____

Family History (Indicate any significant illness or disease that runs in your family)		
Illness/Disease	Relationship to you	Living Age or Age at death
_____		
_____		
_____		

Review of Systems			
Please mark any symptoms you have experienced in the <b>last month</b> . If not marked it is considered negative or non-pertinent.			
<p><b>Constitutional</b></p> <input type="checkbox"/> Appetite, excessive <input type="checkbox"/> Appetite, poor <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fevers <input type="checkbox"/> Insomnia <p><b>Head</b></p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Grinding Teeth <input type="checkbox"/> Headache <input type="checkbox"/> Jaw Pain or Click <input type="checkbox"/> Tooth Pain <p><b>Eyes</b></p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Floaters or Spots <input type="checkbox"/> Vision Change <input type="checkbox"/> Vision Loss <p><b>ENT</b></p> <input type="checkbox"/> Ear Pain <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ringing or Buzzing <input type="checkbox"/> Nosebleed <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Change in Taste <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Sore Throat <input type="checkbox"/> Trouble Swallowing	<p><b>Cardiovascular</b></p> <input type="checkbox"/> Blood Clots <input type="checkbox"/> Chest Pain <input type="checkbox"/> Short of Breath with Activities <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Lightheaded <input type="checkbox"/> Swelling Feet <p><b>Respiratory</b></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cough <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Pneumonia <input type="checkbox"/> Short of Breath <input type="checkbox"/> Wheezing <p><b>Gastrointestinal</b></p> <input type="checkbox"/> Bleeding <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Ulcer <input type="checkbox"/> Vomiting <input type="checkbox"/> Bloody or Dark Stools <input type="checkbox"/> Loss of Bowel Control	<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Broken Bones <input type="checkbox"/> Difficulty Standing <input type="checkbox"/> Difficulty Sitting <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Morning Stiffness <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Numb Hands/Fingers <input type="checkbox"/> Numb Feet/Toes <p><b>Neuro/Psych</b></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Falling Asleep <input type="checkbox"/> Difficulty Staying Asleep <input type="checkbox"/> Fainting <input type="checkbox"/> Head Injury <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Poor Balance <input type="checkbox"/> Poor Coordination <input type="checkbox"/> Seizures <input type="checkbox"/> Tingling Sensation <input type="checkbox"/> Tremor or Shakes <p><b>Skin</b></p> <input type="checkbox"/> Dry <input type="checkbox"/> Itchy <input type="checkbox"/> Rashes	<p><b>Genitourinary</b></p> <p>-Urination that is:</p> <input type="checkbox"/> Bloody <input type="checkbox"/> Burning <input type="checkbox"/> Frequent <input type="checkbox"/> Painful <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Loss of Urinary Control <input type="checkbox"/> Wake Up to Urinate <p><b>Reproductive</b></p> <input type="checkbox"/> Infertility <input type="checkbox"/> Pain with Sex <input type="checkbox"/> Erection Problems <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Painful Periods <input type="checkbox"/> Hot Flashes ___ # of Pregnancies ___ # of Live Births ___ Age Periods Began ___ Age Menopause Began <p><b>Immune/Endocrine</b></p> <input type="checkbox"/> Anemia <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Frequent Infections <input type="checkbox"/> High / Low Blood Sugar <input type="checkbox"/> Low thyroid <input type="checkbox"/> High thyroid <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Weight Gain or Loss

Tests/Studies						
Please indicate where and when (month/year) you had any of the following tests done for the appropriate region.						
Anatomy	Procedure	X-ray	MRI	CT Scan	Bone Scan	EMG
Head/Brain						
Cervical						
Thoracic (Mid Back)						
Lumbar (Low Back)						
Chest						
Upper Extremity						
Lower Extremity						
Abdomen						
Pelvis						
Other						

Patient Name: \_\_\_\_\_

**YOUR PRIMARY CARE DOCTOR'S NAME:** \_\_\_\_\_

**DR's PHONE #** \_\_\_\_\_

**YOUR PRIMARY CARE DOCTOR'S ADDRESS:**

\_\_\_\_\_

**MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR?**  Yes  No

**This history record has been designed to facilitate our patient's continuity of care at Advanced Alternative Healthcare, LLC. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.**

\_\_\_\_\_  
**Patient/Guardian signature who filled out the history**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

# Advanced Alternative Healthcare, LLC

4730 S. National Ave, Suite B4, Springfield, MO 65810

417.890.5585 Office 417.877.0970 Fax

Patient Name: \_\_\_\_\_

## Authorization, Consent, and Financial Obligation

1. **Release of Information:** I authorize the disclosure of any or all information in my medical record to:
    - a. Any person, corporation, or agency responsible for all or part of services who may be responsible for determining the necessity, appropriateness, payment, or other matters related to treatment or services;
    - b. This includes but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Center for Medicare and Medicaid Services or its intermediaries or carriers, or other carriers.
  2. **Assignment of Benefits:** I assign to Advanced Alternative Healthcare, LLC the benefits due me covering services, under my policy(s), managed care plan, HMO, or the Center for Medicare and Medicaid Services or its intermediaries or carriers.
  3. **Medicare Patients:** I authorize Advanced Alternative Healthcare, LLC to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.
  4. **Financial Obligation:** I agree that I am financially responsible for payment of all amounts for services provided by Advanced Alternative Healthcare, LLC. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between Advanced Alternative Healthcare, LLC and my insurer, or if prohibited by applicable state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO), I understand that I am financially responsible for non-covered services or deductibles, co-pay, or co-insurance as defined in my policy or plan. I agree that this Authorization shall be governed by and construed in accordance with the laws of the State of Missouri. I further understand that in the event of litigation pertaining to this Authorization, including, but not limited to, collection of amounts due for services rendered (together with collection costs, interest, court costs, attorney's fees and expenses) the exclusive forum, venue, and place of jurisdiction shall be in the Circuit Court of Greene County, Missouri.
- **Guarantor's Responsibility:** I have read and understand the financial obligation above and agree to the terms as stated.
  - **Consent for Treatment:** As a patient of Advanced Alternative Healthcare, LLC, I agree, request, and authorize my physician to administer such treatment as is necessary. Treatment may include such services, care, procedures, and/or medical, osteopathic, or acupuncture treatments, as the physician deems reasonable and necessary.
  - **Authorization for Disclosure:** I give express permission to discuss with the individual(s) I have listed below the following information [check the appropriate box(es)]:  
 Any aspect of my health care     Health information only     Financial information only
  - I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**X Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Acknowledgment of Receipt of Notice of Privacy Practices:** The Notice of Privacy Practices of Advanced Alternative Healthcare, LLC sets forth the ways in which my personal health information may be used or disclosed by Advanced Alternative Healthcare, LLC, and outlines my rights with respect to such information. I acknowledge that on today's date:

I received a copy of the Notice of Privacy Practices     I declined a copy of the Notice of Privacy Practices

**X Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_