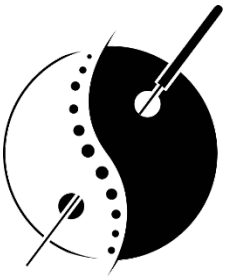
CONFIDENTIAL PATIENT INFORMATION



Integrated Health Center, P.C.

Medicine – Chiropractic – Acupuncture – Massage

New Patient Form

Name: _____ Gender: _____ DOB: _____

Address: _____ City: _____ State: SC Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Occupation: _____ Employment: _____

Emergency Contact: _____ Phone Number: _____

Referred to Integrated Health Center / Dr. Li Huang by: _____

Type of Insurance: _____ Preferred Payment Method: ☐ Cash ☐ Check ☐ Credit/Debit

Name of Insurance Company: _____ Policy#: _____

Name of Insured: _____ Insured DOB: _____

Reason for Visit / Major Complaints:

When & How did symptoms start?

Have you had similar symptoms before? When?

Which best describes your symptoms?

☐ Constant ☐ Come & Go ☐ Getting Better ☐ Getting Worse

If you were to guess, what do you believe is causing your problems?

What activities aggravate your condition?

What activities relieve your condition?

What medication or treatment have you previously had for your present condition?

Do you have any medication allergies? Explain.

Have you seen other medical professionals for this condition? Explain.

Anything else you would like the doctor to know?

CONFIDENTIAL PATIENT INFORMATION

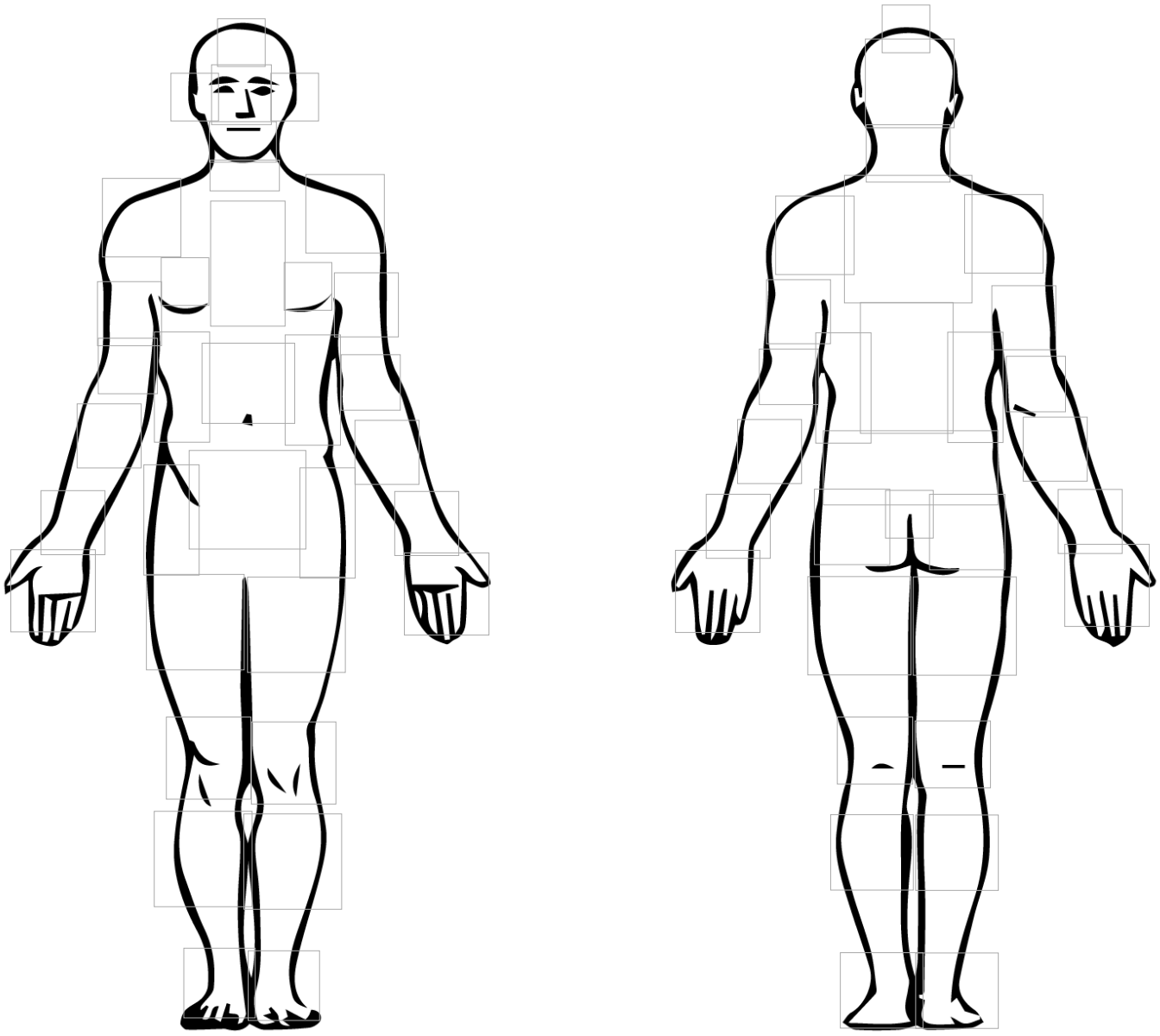
Patient's Name:_____

Tell us how you are today…

1. My progress is: ☐ Slower than Expected ☐ As Expected ☐ Good ☐ Great
2. My pain problem today is…

   _____

3. On a scale of 1-10, 10 being the worst, my current pain level is: 1 2 3 4 5 6 7 8 9 10
4. My pain frequency: ☐ Occasional (25-50%) ☐ Frequent (51-75%) ☐ Constant (76-100%)
5. Mark where you are currently experiencing pain…



- For Doctor's Use Only -

Subjective Complaints:

Objective Findings:

Notes:

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment:_____

Are you insured? ☐ Yes ☐ No

Name of Company:_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections form the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me and charged directly to me and that I am personally responsible for payment. I also understand that if I am suspended or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Dr. Li Huang (an appointed staff) to administer such treatments as necessary, and to perform services and or procedures as are considered necessary on the basis of findings during the course of said treatment. I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative mode of treatment which were explained to me. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature: _____ Date:_____

Guardian Signature:_____ Relationship:_____

(Required if Patient is under 18 years of age)

☐ By checking the box and submitting this form electronically, you agree to all terms stated in this form and you agree to accept your electronic signature as your actual signature for the purposes and intent of this document. You also agree to provide all necessary information to the Integrated Health Center office upon request and agree that all information contained in this form is true and accurate to the best of your knowledge. You also agree that failure to submit all required information as stated by this form, Integrated Health Center's website, and or staff representing the Integrated Health Office will delay the processing of this form, scheduling of your New Patient visit, and or the duration of your actual visit. You also agree that if you do not wish to use the electronic signature, you may print this form with the populated information and sign manually, then scan and email to the Integrated Health Center office.

Print Form & Sign Manually