WellCare Medical Associates, P.C.
118 Denny Rd, Valencia, PA 16059

Patient Information

Patient Name_____ DOB:_____ Date: _____

☐Male ☐Female SS #/SIN_____ Home phone: _____ Other Phone: _____

Email: _____ Check appropriate box**:** ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's Address _____ City _____ State_____ Zip_____

Employer Name: _____ Spouse's Name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Relationship to patient _____ Phone_____

Responsible Party

Name of the person responsible for this account _____ Relationship to Patient _____

Address _____Home Phone _____ Other Phone _____

Driver's License # _____ Date of Birth: _____ E-Mail _____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birth date _____ SS#/SIN_____ Name of Employer_____

Address of Employer_____ State _____ Zip_____

Insurance Company_____Group #_____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay WellCare Medical Associates as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Patient Signature: _____ Date: _____

Patient name printed: _____

Signature of Guardian _____ Date: _____
(if applicable)

WellCare Medical Associates, P.C.

Patient Name _____ **DOB** ____/____/____ **Date** ____/_____/____

Patient Health History

Referring Physician: _____ ____ Address: _____

Pharmacy Name: _____ Phone Number: _____-_____-_____

Reason for today's visit: _____

Please describe this problem: _____

_____

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as: **Fish Oil, Vitamin E, Plavix, Coumadin, Aspirin?** ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES** (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐ **NO** and Never have ☐ **YES** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ **NO** and Never have ☐ **Socially Only** ☐ **Daily** ☐ **Beer/ Wine** ☐ **Hard Liquor**

Occupation: _____ Hand dominance: ☐ **R** ☐ **L**

Please describe any family health issues below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
Mother			
Father			
Siblings			
Other			

Patient Health History con't

Do you have or have you ever had any of the following:

Symptoms/ Illness	NO	YES, Explain	Symptoms/ Illness	NO	YES, Explain
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			**Last Mammogram**		**Date: ____/____/____**
Hepatitis			Changes in Moles		
HIV/ Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**GENITOURINARY**		
Mobility/ Joint Problems			Genital or Oral Herpes		
GASTROINTESTINAL			S.T.D.'s		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/ Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
CARDIOVASCULAR			**Eyes**		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/ DVT			**ENT**		
Blood Clots in Lungs/ Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
RESPIRATORY			**PSYCHIATRIC**		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/ Depression		

Please list any other conditions/ illnesses not indicated above: _____

_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: _____ **Date: ____/____/____**

Physician Signature: _____ **Date Reviewed: ____/____/____**

WellCare Medical Associates, P.C.

Patient Name _____ DOB ____/____/____ Date ____/_____/____

Patient Musculoskeletal History

Reason for Visit?_____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unsure

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe) _____

Type of Pain: ☐Sharp ☐Dull ☐Stiff ☐Throbbing ☐Numbing ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramping ☐Swelling

☐Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐ Does not interfere

Indicate activities which are painful to perform (if applicable) ☐Lying down ☐Sitting ☐Standing ☐Walking ☐Bending

What treatment have you already received for your condition (if applicable) ☐Medication ☐Surgery ☐Physical Therapy

☐Chiropractic Services ☐None ☐Other _____

Name of person or facility that treated you (if applicable) _____

Date of last: Physical exam ____/____/____ Lab work ____/____/____ Spinal exam/X-ray ____/____/____

Chest X-ray ____/____/____ MRI, CT, bone scan ____/____/____

Is your condition due to an accident? ☐No ☐Yes Date of accident ____/____/____ Type of accident: ☐Auto ☐Work ☐Home

☐Other _____

Have you reported your accident? ☐No ☐Yes If so, where? ☐Auto Insurance ☐Employer ☐Worker's Compensation

☐Other _____

Is there any other information you would like the doctor to know?

_____

_____

_____

Patient Signature: _____ Date: ____/____/____

Physician Signature: _____ Date Reviewed: ____/____/____