Patient ID# P _____

☐ **MN ID Verified**

Patient Name (LAST, FIRST, MIDDLE): _____
Last First MI

Date of Birth: _____ **Race/Ethnicity:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Email:** _____

I the undersigned,

- Acknowledge that it is my responsibility to pay for all charges
- Acknowledge the receipt of the Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact Assured Health.
- Authorize Assured Health to release information from the patient's health records for purposes of processing and paying claims, coordinating benefits, coordinating care, quality care review studies, and other functions that support treatment, payment and healthcare operations, including those functions that my caregiver is required by my health plan or other third-party payers to perform.
- Authorize the patient's health plan to release health information to appropriate accreditation and quality review/measurement personnel, to disease, pharmacy, or case management providers and to other third parties for purposes related to treatment, payment, or healthcare operations.
- Acknowledge that I have the rights with respect to my protected health information (PHI):
  *The right to reasonable requests to receive confidential communication of my PHI
  * The right to inspect and copy my PHI
  * The right to receive an accounting of disclosures of my PHI
  * The right to request an amendment of my PHI
- Acknowledge that I understand that I may revoke (cancel) this consent, in writing anytime. Revoking consent does not apply information that has already been disclosed.

_____ _____
PRINT Name of Guardian/Legal Representative Relationship to Patient

_____ _____
SIGNATURE of Patient or Legal Representative Date

PATIENT NAME: _____ DOB: _____

Review of Systems

Check if applicable:

Constitutional
□ Excessive daytime sleepiness
□ Fatigue
□ Fevers
□ Low energy
□ Trouble getting to sleep
□ Trouble staying asleep
□ Weight gain
□ Weight loss

Eyes
□ Blurred Vision
□ Double Vision
□ Loss of Vision

Ears, Nose, Mouth, and Throat
□ Loss of sense of smell
□ Hearing loss
□ Ringing in your ears

Cardiovascular
□ Chest pain
□ Palpitations
□ Shortness of breath

Gastrointestinal
□ Constipation
□ Diarrhea
□ Heartburn
□ Nausea
□ Vomiting

Skin
□ Changes in hair or nails
□ Change in skin color
□ Itching
□ Rash

Neurological
□ Confusion
□ Falling down
□ Headaches
□ Incoordination
□ Involuntary movements or jerking
□ Lightheaded or dizzy
□ Loss of consciousness/fainting/passing out
□ Numbness
□ Seizures or convulsions
□ Spinning or vertigo
□ Tingling
□ Tremor
□ Trouble speaking
□ Trouble walking
□ Weakness
□ Trouble swallowing

Musculoskeletal
□ Back pain
□ Joint pain or swelling
□ Muscle pain or cramps
□ Neck pain

Endocrine
□ Heat or cold intolerance
□ Increased thirst
□ Loss of hair

Memory, Thinking, Mood, Psychiatric
□ Anxiety
□ Depressed mood
□ Hallucinations (seeing or hearing things)

Hematologic (blood) & lymphatic
□ Anemia
□ Easy bruising or bleeding
□ Slow to heal after cuts

PATIENT NAME: _____ DOB: _____

Have you ever had: □ a car accident □ loss of consciousness □ heart attack □ loss of vision
□ abnormal heart rhythm □ seizure □ panic attacks □ head injury
□ stroke □ paralysis □ back injury □ psychiatric disorder

Do you have any allergies to medications or other substances? ☐ **NO** ☐ **YES** (if yes, please specify on next line)

_____

Current & Past Medical Conditions

	Please List	Date of onset *(mm/yy)*		Please List	Date of onset *(mm/yy)*
1		/	11		/
2		/	12		/
3		/	13		/
4		/	14		/
5		/	15		/
6		/	16		/
7		/	17		/
8		/	18		/
9		/	19		/
10		/	20		/

Surgeries/Hospitalizations

List type of surgery (such as gallbladder) or condition for which you were hospitalized (such as heart attack, pneumonia)

	Please List	Date of onset *(mm/yy)*		Please List	Date of onset *(mm/yy)*
1		/	6		/
2		/	7		/
3		/	8		/
4		/	9		/
5		/	10		/

Medications

Please include name and dosage of all medications.

1		6	
2		7	
3		8	
4		9	
5		10	

DATE: / / 2022