CONFIDENTIAL PATIENT DATA

SWC Family Care

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle Initial:	Nickname:	Date of Birth:	Sex: ❑M ❑F

Street address:	Work Phone:	Home Phone:	Preferred Phone: ❑Home ❑Work ❑Cell

Address Line 2:	Cell Phone:	Cell Service Provider:	Social Security #:

City:	State:	Zip Code:	Email:

Employer: Occupation:

Would you like to receive appointment reminders? Choose ONE: ❑Email ❑Text Message ❑Phone ❑None

Marital Status: ❑Single ❑Married ❑Divorced ❑Partnered ❑Widowed ❑Other

Preferred Language: ❑English ❑Spanish ❑German ❑French ❑Italian ❑Russian ❑Portuguese ❑Chinese ❑ Japanese ❑Korean ❑Vietnamese ❑Decline to Answer ❑Other _____

Please check ALL races that apply: ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Decline to Answer

Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic nor Latino ❑Declined to Answer

Preferred Communication: ❑Cell Phone ❑Home Phone ❑Work Phone ❑Mail ❑Email ❑In Person

Smoking Status: ❑Current everyday ❑Current some days ❑Former ❑Never Start Year _____ Quit Date _____

Current Medications:
1.Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
2. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
3. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
4. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
5. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____

Drug Allergies:
1. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
2. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
3. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
Other Allergies:_____

Alcohol Use: ❑None ❑Light ❑ Moderate ❑Heavy	Drug Use: ❑None ❑Light ❑ Moderate ❑Heavy	Exercise: ❑None ❑Light ❑ Moderate ❑Heavy

INSURANCE INFORMATION

Primary Insurance:	Insured ID:

Insured Name:	Group Number:

Patient is the ❑Spouse ❑Child ❑Self ❑_____ to the insured.	Ins. Date of Birth:

Secondary Insurance:	Insured ID:

I certify that I, and/ or my dependent(s), have insurance coverage with _____
and assign directly to **SWC Family Care** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. **I also understand that any illicit or sexually suggestive remarks made by me will result in immediate termination of the any session, and I will be liable for payment of the scheduled appointment.**

X _____ _____ _____

Signature of Patient/ Guardian Date Please print Patient/ Guardian

FAMILY HISTORY							
Please indicate which conditions exist or have existed by marking the boxes below.							
	Self	Mother	Father	Sister	Brother	Son	Daughter
Bone Cancer	❑	❑	❑	❑	❑	❑	❑
Brain Cancer	❑	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑	❑
Esophageal Cancer	❑	❑	❑	❑	❑	❑	❑
Gastric Cancer	❑	❑	❑	❑	❑	❑	❑
Kidney Cancer	❑	❑	❑	❑	❑	❑	❑
Leukemia	❑	❑	❑	❑	❑	❑	❑
Liver Cancer	❑	❑	❑	❑	❑	❑	❑
Muscle Cancer	❑	❑	❑	❑	❑	❑	❑
Other Cancer	❑	❑	❑	❑	❑	❑	❑
Ovarian Cancer	❑	❑	❑	❑	❑	❑	❑
Pancreatic Cancer	❑	❑	❑	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑
Rectal Cancer	❑	❑	❑	❑	❑	❑	❑
Skin Cancer	❑	❑	❑	❑	❑	❑	❑
Thyroid Cancer	❑	❑	❑	❑	❑	❑	❑
Clotting Disorder	❑	❑	❑	❑	❑	❑	❑
Deep Vein Thrombosis	❑	❑	❑	❑	❑	❑	❑
Pulmonary Embolism	❑	❑	❑	❑	❑	❑	❑
Unknown Clotting Disorder	❑	❑	❑	❑	❑	❑	❑
Dementia/Alzheimer's	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Gestational Diabetes	❑	❑	❑	❑	❑	❑	❑
Impaired Fasting Glucose	❑	❑	❑	❑	❑	❑	❑
Insulin Resistance	❑	❑	❑	❑	❑	❑	❑
Maturity onset Diabetes (MODY)	❑	❑	❑	❑	❑	❑	❑
Pre-Diabetes	❑	❑	❑	❑	❑	❑	❑
Type 1 Diabetes	❑	❑	❑	❑	❑	❑	❑
Type 2 Diabetes	❑	❑	❑	❑	❑	❑	❑
Colon Polyp	❑	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑	❑
Familial adenomatous polyposis (FAP)	❑	❑	❑	❑	❑	❑	❑
Gastrointestinal Disorder	❑	❑	❑	❑	❑	❑	❑
Irritable Bowel Syndrome	❑	❑	❑	❑	❑	❑	❑
Ulcerative Colitis	❑	❑	❑	❑	❑	❑	❑
Lynch Syndrome	❑	❑	❑	❑	❑	❑	❑
Angina	❑	❑	❑	❑	❑	❑	❑
Coronary Artery Disease	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑
Unknown Heart Disease	❑	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑	❑
Cystic Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Chronic Kidney Disease (assoc. Diabetes Type 2)	❑	❑	❑	❑	❑	❑	❑
Congenital Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Kidney Nephrosis	❑	❑	❑	❑	❑	❑	❑
Nephritis	❑	❑	❑	❑	❑	❑	❑
Nephrotic Syndrome	❑	❑	❑	❑	❑	❑	❑
Other Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Unknown Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑
COPD	❑	❑	❑	❑	❑	❑	❑
Chronic Bronchitis	❑	❑	❑	❑	❑	❑	❑
Chronic Lower Respiratory Disease	❑	❑	❑	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	❑	❑	❑
Influenza	❑	❑	❑	❑	❑	❑	❑
	Self	Mother	Father	Sister	Brother	Son	Daughter
Pneumonia	❑	❑	❑	❑	❑	❑	❑

Osteoporosis	❑	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑	❑
ADHD	❑	❑	❑	❑	❑	❑	❑
Autism	❑	❑	❑	❑	❑	❑	❑
Bipolar Disorder	❑	❑	❑	❑	❑	❑	❑
Dementia	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑
Eating Disorder	❑	❑	❑	❑	❑	❑	❑
Mental Disorder	❑	❑	❑	❑	❑	❑	❑
OCD	❑	❑	❑	❑	❑	❑	❑
Panic Disorder	❑	❑	❑	❑	❑	❑	❑
Personality Disorder	❑	❑	❑	❑	❑	❑	❑
Pace Maker	❑	❑	❑	❑	❑	❑	❑
Lung Cancer	❑	❑	❑	❑	❑	❑	❑
PTSD	❑	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑	❑
Social Phobia	❑	❑	❑	❑	❑	❑	❑
Septicemia	❑	❑	❑	❑	❑	❑	❑
Stroke/Brain Attack	❑	❑	❑	❑	❑	❑	❑
Sudden Infant Death Syndrome	❑	❑	❑	❑	❑	❑	❑

PATIENT HISTORY

Please describe your past accidents:

1.Accident: _____ ❑Job ❑Auto ❑Other Date: _____
2.Accident: _____ ❑Job ❑Auto ❑Other Date: _____
3.Accident: _____ ❑Job ❑Auto ❑Other Date: _____

Please describe your past surgeries:

1. Surgery: _____ Date: _____
2. Surgery: _____ Date: _____
3. Surgery: _____ Date: _____

Do you have any implants? ❑Yes ❑No If yes, please describe _____

Are you currently pregnant? ❑Yes ❑No If yes, please list your due date: _____

Vitals to be completed by Staff Member

Weight:_____Height:_____BP:_____/_____Pulse:_____Temp:___

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

AIDS	❑	Allergies	❑	Anemia	❑	Arthritis	❑
Asthma	❑	Back Pain	❑	Bladder Trouble	❑	Bone Fracture	❑
Cancer	❑	Chest Pain	❑	Concussion	❑	Constipation	❑
Convulsions	❑	Depression	❑	Diarrhea	❑	Dislocated Joints	❑
Epilepsy	❑	Fibromyalgia	❑	German Measles	❑	Headache	❑
Heart Trouble	❑	Hepatitis	❑	Herniated Disk	❑	High Blood Pressure	❑
High Cholesterol	❑	HIV/ARC	❑	Kidney Disorder	❑	Loss of Bowel Control	❑
Lung Disease	❑	Menstrual Cramps	❑	Migraine Headaches	❑	Multiple Sclerosis	❑
Muscular Dystrophy	❑	Neck Pain	❑	Nervousness	❑	Numbness	❑
Osteoporosis	❑	Parkinson's disease	❑	Pinched Nerve	❑	Polio	❑
Poor circulation	❑	Reproductive disorder	❑	Rheumatic Fever	❑	Rheumatism	❑
Rheumatoid Arthritis	❑	Scarlet Fever	❑	Scoliosis	❑	Serious Injury	❑
Sinus Trouble	❑	Stroke	❑	Thyroid Problems	❑	Tuberculosis	❑
Tumors or Growths	❑	Ulcers	❑	Venereal Disease	❑	_____	❑
Pregnant	❑		❑		❑		❑

Pharmacy:	Location/Phone#:
Emergency Contact Name:	Emergency Contact Phone:

Office Use Only:

Patient Name:_____Date:_____

What health issues do you want to focus on during this visit?

Habits:	Social History:
What do you do for exercise?_____ How often?_____ Tobacco (chew / smoke): _____per day Alcohol (beer / wine, etc.):_____ per day Street Drugs (marijuana, etc.):_____ Caffeine (coffee / tea / soda):_____ per day Any trouble sleeping? □ Yes □ No Describe your eating habits: (poor, well-balanced, vegetarian, gluten-free, etc.)_____ Do you eat out more than twice a week? □ Yes □ No	Relationship Status: Are you retired? □ Yes □ No Work Type:_____ Do you enjoy your job?_____ Do you wear sunscreen? □ Yes □ No □ Sometimes Who do you live with:_____ How many children do you have? _____ Do you have an eye exam at least every two years? □ Yes □ No Any major stresses in your life? _____ _____ Do you feel you ever have been abused (verbally, physically, or sexually? □ Yes □ No Do you have a dental exam at least yearly? □ Yes □ No

General Symptoms: Fever, unexplained tiredness, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out **Eyes**: Vision loss, eye pain, blurred vision **Ears/Nose/Mouth & Throat**: Sore throat, runny nose, hearing loss, problems with mouth, voice changes **Breasts:** Lumps, skin changes, nipple discharge Lungs & Heart: Chest pain/pressure, irregular heart beat, cough, wheezing, breathing trouble **Skin:** Rashes, changing moles, changes in hair/skin/nails	**Neurological:** Unusual or new headaches, weakness or numbness, falling **Abdomen:** Nausea, vomiting, pain, heartburn, diarrhea, constipation, bloody stools **Sleep:** Difficulty falling asleep, frequent awakening Musculoskeletal: Joint/muscle pain, muscle weakness **Mood**: Worry too much, felt down and depressed in the last two weeks, loss of desire to do things you used to enjoy, thoughts of self harm or suicide **Men Only:** Difficulty starting or weak stream, difficulty getting/maintaining erections, feeling like bladder won't empty, getting up at night to urinate, testicular pain/lumps, possible sexually transmitted infections	**Women Only**: Heavy periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, possible sexually transmitted infections, severe pain with periods, leaking urine **Period Questions:** Still having periods? □ Yes □ No □ Regular □ Irregular Date of last period:_____ Birth Control type:_____ Hysterectomy: □ Yes □ No If yes, what age?_____ Due to what?_____ Number of pregnancies:_____ Vaginal deliveries _____ C-section deliveries _____ Other (stillbirth, miscarriage/abortion) Diabetes in pregnancy? □Yes □ No Have you ever had an abnormal pap or colposcopy? □ Yes □ No

*****The following will be completed and used by clinic staff: *****

Prevention	Everyone:
Women: Last Pap Test:_____ Chlamydia Screening:_____ Mammogram:_____ Bone Density:_____ Other:_____ Men: PSA Screening:_____ Other:_____	Colonoscopy:_____ Lipid Panel:_____ Fasting Glucose_____ HgbA1c_____ Other:_____ _____ Immunizations: Tdap:_____ Zostavax:_____ Pneumovax:_____ Influenza:_____ Gardasil:_____ Other:_____ _____ _____

CANCELLATION POLICY: 24 hours' notice is necessary for cancelled appointments. We reserve the right to bill for missed appointments. _____Initials _____Date

INSURANCE: SWC Family Care will help you with your insurance billing. This is a service we provide for you, yet is a clinic expense. Please understand that we have a primary relationship with you, and not your insurance company. If you are planning on using your insurance coverage to pay for your services at SWC Family Care you must provide us with the INSURANCE PAPER WORK. We expect that you will arrive at the office will ALL your insurance information including your insurance card. If you have been unable to complete the INSURANCE PAPER WORK, we will kindly require you to pay for our services at your appointment. We accept Visa, MC, Care Credit, cash and check. For your convenience, we will provide a statement for you to turn in for reimbursement. If you have questions regarding your insurance, please make sure to discuss all questions to our insurance and billing department.

_____Initials _____Date

PATIENT CONSENT FORM (HIPAA)I understand that, under the Health Insurance portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to: ~Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. ~Obtain payment from third party payers ~Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by The Spine and Wellness Center of our Notice to Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing of this consent. I understand that this organization has the right to change its Notice to Privacy Practices from time to time and that I may contact The Spine and Wellness Center to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand The Spine and Wellness Center is not required to agree to my requested restrictions, but if The Spine and Wellness Center does agree then they are bound to abide by such restrictions. I understand that if I correspond by email or texting with The Spine and Wellness Center that email and texting source is not HIPAA secure and my medical information shared via email or text could be compromised. I understand that I may revoke this consent in writing at any time, expect to the extent that The Spine and Wellness Center has taken action relying on the consent. You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law. We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name. We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence. You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you

_____Initials _____Date

I also acknowledge that from time to time, SWC Family Care and/or the other affiliated Department's may take photographs of me participating in programs or activities offered by the Department for use and publication in various publications or media, including but not limited to the SWC Family Care website, department program brochures or materials, and SWC Family Care affiliated Department's informational, promotional or marketing materials, and I hereby expressly grant to the SWC Family Care, Spine and Wellness Center/Borja Inc. and other affiliated Department's the right to use and publish such photographs as contemplated herein, all without compensation or payment for such use and publication .

_____Initials _____Date

CONSENT TO Consent for Evaluation and/or Treatment By signing below, I am giving my consent to the practice of SWC Family Care for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/or treatments and given the option to accept or decline. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____Initials _____Date

RECORDS RELEASE AUTHORITY

TO: _____

_____

I, _____ HEREBY REQUEST THAT YOU RELEASE
(Patients's name or guardian)
_____ RECORDS TO:

SWC Family Care

3933 PERKIOMEN AVENUE SUITE 101
READING, PA 19606
PHONE: 610-779-4588
FAX: 610-779-8040

A report of my diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to your treatment of me from _____ to **PRESENT** .

__All records __X-rays __MRI Films __Bloodwork __Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is **valid for 1 year** from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

I DO UNDERSTAND THAT THE RELEASING OFFICE/FACILTY MAY CHARGE A FEE FOR THESE RECORDS. THIS FEE IS NOT IN ASSCIATION WITH SWC Family Care.

_____ _____
Patient's OR Guardian's Signature Patient's Name **PLEASE PRINT**

_____
Address

_____
City, State, Zip Code

Patients DOB: _____ Please: **Fax Report** x____

Patients SSN: _____ **Mail Films/CD** x____