Office Use

F/C: INS_____ MC_____ SP_____CFW# _____
Included: Insurance Card Copy_____ Referral/Authorization_____

Patient Information

Thank you for choosing the Center For Wellbeing. In order to help us complete our records and submit accurate bills to your insurance company, please assist us by providing the following information:

First Name:_____M.I.:_____ Last Name: _____
Date of Birth:_____ Patient's SS #:_____Sex:_____
Mailing Address: _____
City:_____ State: _____ Zip Code: _____
Home #:_____ Cell#: _____Work#_____
Email:_____ Employer: _____
Referred By: _____
PCP Name: _____ Phone #: _____

Insurance Information

Complete the following Insured information if RELATION is other than SELF.

Primary Insurance	
Relationship to Insured:	Self:_____Spouse:_____Child:_____Other:_____
Insured's Name:	
Insured's Date of Birth:	
Insured's ID#:	
Insured's Employer:	

Secondary Insurance	
Relationship to Insured:	Self:_____Spouse:_____Child:_____Other:_____
Insured's Name:	
Insured's Date of Birth:	
Insured's ID#:	
Insured's Employer:	

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process Insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges; which may also include legal, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing. I designate provider and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from my doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of doctor services.
I understand that for any balance remaining on my account past 30 days, pursuant to Physical Medicine Associate's discretion, my account may be turned over to collections or there will be a monthly late fee assessed of $15 for up to 3 months, and after that time my account may be turned over to collections.

Patient Signature : _____ Date : _____

NEW PATIENT INTAKE - ALLERGY

Full Name: _____ Date: _____

Sex (circle): M F Birth Gender (circle): M F

Race (ie: White, Asian, African American): _____ Hispanic or Latino: ___Yes ___No

Marital Status: ___Single ___Married ___Widowed ___Separated ___Divorced

Name of Emergency Contact: _____Phone: _____

Relationship to Patient: _____

Please list all ***known DRUG and FOOD allergies***:

Drug Name and/or Food:	Reaction:
_____	_____
_____	_____
_____	_____

List **ALL** medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check **ALL medical conditions** that you may have had or currently have now:

__ADD/ADHD	__Depression	__Hepatitis	__Miscarriage
__Alcoholism	__Diabetes	__High Blood Pressure	__Multiple Sclerosis
__Allergy	__Eczema	__High Cholesterol	__Parkinson's
__Alzheimer's	__Emphysema	__High Blood Sugar	__Pneumonia
__Anemia	__Epilepsy/seizures	__HIV/AIDS	__Raynaud's
__Appendicitis	__Fibromyalgia	__Irritable Bowel	__Rheumatoid Arthritis
__Asthma	__Gall Bladder	__Kidney Stones	__Ringing in ears
__Arthritis	__Goiter	__Low Blood Pressure	__Sinus Infection
__Cancer	__Gout	__Low Blood Sugar	__Stroke
__Celiac Disease	__Heart Attack	__Lyme Disease	__Thyroid Problems
__Chronic Fatigue	__Heart Disease	__Lupus	__Ulcers
__Migraine	__Vertigo/Dizziness		

Other: _____

Please list all previous surgeries & dates:

_____

_____

Alcohol use? Yes / No Amount _____ Daily / Weekly / Socially

Tobacco use? Yes / Never / Former Smoker PPD _____ How many years? _____

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes_____ No_____

I fully understand that my signature is consent and authorization to be examined by the Center for Wellbeing medical team.

Patient Signature _____ Date _____

Authorization to Disclose Medical Records and Health Information

Patient Name:

Date of Birth:_____ Phone:

Records Release To:

Provider/Clinic/Organization:_____CENTER FOR WELLBEING

Address:_____3201 Lafayette Road Portsmouth, NH 03801

Phone:_____603-380-9159_____Fax_____603-427-8290

I hereby authorize the release of my medical records to the provider designated above.

Please Initial

_____ Complete Medical Record

Patient Signature:_____ Date:

CENTER FOR WELLBEING®

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment, you provide a 24-hour notice. Appointments which are cancelled within less than 24-hour notice may be subject to pay the full balance owed at the time of cancellation. Cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel with less than a 24-hour notice, fees may be waived upon management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no-show fees can be directed to the front desk at (603) 380-9159.

Please sign that you have read, understand, and agree to this cancellation and no-show policy.

_____

Patient Name (Please Print) Date

_____

Signature of Patient Date

CENTER FOR WELLBEING
REGENERATE. REJUVENATE. RESTORE.

INITIAL ALLERGY EVALUATION

Patient Name: _____

Patient Number: _____ Date: _____

PATIENT HISTORY

	YES	NO
Do you have symptoms, or have you ever had symptoms, such as sneezing, watery nasal discharge, throat itching or dry mouth?	_____	_____
Do you have, or have you ever had, frequent "colds", sinus problems or chronic nasal congestion?	_____	_____
Do you have, or have you ever had, your eyes itch, water, get red or swell?	_____	_____
Are your symptoms seasonal only, or do they get worse in certain seasons?	_____	_____
Are your symptoms worse around animals?	_____	_____
Do you have, or have you ever had asthma, eczema or hives?	_____	_____
Do you have sensitivities to foods?	_____	_____

FOR PHYSICIANS USE ONLY

ORDER FOR ALLERGY TESTING AND TREATMENT IF INDICATED
___95004 TESTING ___ Blood Spot Testing IgE (laboratory will bill patient insurance)
___95165 TREATMENT
ICD – 10 DIAGNOSIS CODE: J30.1 ALLERGIC RHINITIS DUE TO POLLEN J30.5 ALLERGIC RHINITIS DUE TO FOODS

_____
PHYSICIAN SIGNATURE

☐ Negative Screening
☐ Screening Appropriate refer to allergy program ☐ Patient Declines

ASTHMA, ALLERGY AND IMMUNOLOGY REVIEW

Patient Name: _____ Age: _____ Occupation: _____

Date of Birth: _____ Today's Date: _____ Physician that referred you (If any): _____

Please answer all questions on both pages to the best of your ability. Base your answers on your own observations and not what you have been told by others or what you may have presumed based on previous allergy tests. Complete the questionnaire before you see the Physician as the information will organize your thinking and facilitate understanding of your case.

I. Describe in your own words your problem(s) which might indicate an allergic or exaggerated reaction:

_____

_____

_____

II. Add an X in the blanks that apply to your symptoms:

EYE SYMPTOMS (Do you wear contacts? _____)

	Present Problem	Past Problem	Physician Comments
Itching	____	____	_____
Watering	____	____	_____
Redness	____	____	_____
Swelling	____	____	_____
Burning	____	____	_____
Dryness	____	____	_____
Foreign Body Sensation	____	____	_____

SYMPTOMS IN THE UPPER RESPIRATORY TRACT (NOSE, SINUSES, THROAT, EUSTACHIAN TUBES, VOICE BOX)

	Present Problem	**Past** Problem	Physician Comments
Itching	____	____	_____
Sneezing	____	____	_____
Congestion	____	____	_____
Headache	____	____	_____
Obstruction	____	____	_____
Drainage	____	____	_____
Dryness	____	____	_____
Hoarseness	____	____	_____
Hearing Loss	____	____	_____
Polyps	____	____	_____
Impaired Smell/Taste	____	____	_____
Snoring	____	____	_____

CENTER FOR WELLBEING
REGENERATE. REJUVENATE. RESTORE.

ASTHMA, ALLERGY AND IMMUNOLOGY REVIEW (Cont.)

SYMPTOMS IN THE LOWER RESPIRATORY TRACT (WINDPIPE, BRONCHI, LUNGS)

	Present Problem	Past Problem	Physician Comments
Itching	____	____	_____
Coughing	____	____	_____
Sputum Production	____	____	_____
Tightness - Congestion	____	____	_____
Wheezing	____	____	_____
Shortness of Breath	____	____	_____

III. Place an X in the blanks that are Aggravated or precipitated by Exposure or during:

	Eyes	Nose/Ears/ Sinuses	Chest	Hives/ Digestive	Swelling	Eczema
Spring (Mar, Apr, May)	____	____	____	____	____	____
Summer (Jun, Jul, Aug)	____	____	____	____	____	____
Autumn (Sep, Oct, Nov)	____	____	____	____	____	____
Winter (Dec, Jan, Feb)	____	____	____	____	____	____
Sleep	____	____	____	____	____	____
On awakening	____	____	____	____	____	____
At work	____	____	____	____	____	____
At play	____	____	____	____	____	____
Exercise	____	____	____	____	____	____
Emotional upset – laughter, anger	____	____	____	____	____	____
Weather changes	____	____	____	____	____	____
Heat	____	____	____	____	____	____
Cold	____	____	____	____	____	____
Air conditioning	____	____	____	____	____	____
Sunlight	____	____	____	____	____	____
Irritant fumes/aerosols/sprays	____	____	____	____	____	____
Smog	____	____	____	____	____	____
Cosmetics/perfumes	____	____	____	____	____	____
Tobacco smoke	____	____	____	____	____	____
Newsprint	____	____	____	____	____	____
House Dust	____	____	____	____	____	____
Road Dust	____	____	____	____	____	____
Cats	____	____	____	____	____	____

IV. Place an X in the blanks that are Aggravated or precipitated by Exposure or during:

	Eyes	Nose/Ears/ Sinuses	Chest	Hives/ Digestive	Swelling	Eczema
Dogs	____	____	____	____	____	____
Birds/Feathers	____	____	____	____	____	____
Other animals: _____	____	____	____	____	____	____
Egg	____	____	____	____	____	____
Milk / dairy products	____	____	____	____	____	____
Wheat / wheat products	____	____	____	____	____	____
Corn / Corn products	____	____	____	____	____	____
Strawberries / other berries	____	____	____	____	____	____
Peanut / other nut	____	____	____	____	____	____
Shrimp /lobster / other seafood	____	____	____	____	____	____
Beer/Wine	____	____	____	____	____	____
Chocolate	____	____	____	____	____	____
Other food(s)_____	____	____	____	____	____	____

Provider Signature_____ Date:_____