Magnolia Health, PLLC

DBA Chattanooga Wellness

2906 Ocoee St. North Cleveland, TN 37312 |6404 East Brainerd Rd Chattanooga, TN 37421

Patient Name_____ Date: _____
Email: _____SS #/SIN_____ DOB_____
□ Male □Female Home phone_____ Cell Phone _____
Check appropriate Box**:** □Minor □Single □Married □Divorced □Widowed □Separated
Patient's Address _____City _____ State_____
Zip_____ Employer Name: _____ Spouse's Employer_____
Patient's Guardian Name: _____ Whom may we thank for referring you? _____
Emergency Contact_____ Phone_____ In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence ____

X_____ X _____
Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account _____ Relationship to Patient _____
Address_____ City _____ ST ____ Zip _____
Home Phone _____ Cell Phone _____ E-Mail _____
Driver's License # _____ Date of Birth: _____
Is the person currently a patient at our office? □ Yes □ No
Do you have any medical insurance? □ Yes □ No if yes, complete the following:
Name of the insured_____ Relationship to patient_____
Birthdate_____ SS#/SIN_____ Name of Employer Work Phone _____ Address of Employer_____ State _____ Zip_____ Insurance Company_____
Group #_____ Union or local # _____ Ins. Co. Address _____
City _____ State _____ Zip_____ Phone Number _____

Chief Complaint:

_____

History of Present illness:
Location: _____ Quality: _____
(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc.)
Severity: _____ Duration: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being) (How long have you had this pain/ problem? the most severe?) (When did it start?)
Timing: _____ Context: _____ (Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)
Associated Signs/Symptoms _____
Modifying Factors _____
(What other associated problems have you been having?) (What makes the pain/problem worse or better? Have you had previous episodes?)

Secondary Complaints:_____
_____
_____

Past Medical History
(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Eyes/Ears/Nose/Throat/Respiratory			**Muscular/Skeletal**		
Measles	No	Yes	Anemia	No	Yes
Back Trouble	No	Yes	Hepatitis	No	Yes
Mumps	No	Yes	Bladder Infection	No	Yes
High Blood Pressure	No	Yes	Ulcer	No	Yes
Chicken Pox	No	Yes	Epilepsy	No	Yes
Low Blood Pressure	No	Yes	Kidney Disease		
Whooping Cough	No	Yes	Migraine Headaches	No	Yes
Hemorrhoids	No	Yes	Thyroid Disease	No	Yes
Scarlet Fever	No	Yes	Tuberculosis	No	Yes
Date of Last Chest X-Ray			Bleeding Tendency	No	Yes
Diphtheria	No	Yes	Diabetes	No	Yes
Asthma	No	Yes	Any Other Diseases		
Smallpox	No	Yes	Cancer	No	Yes
Hives of Eczema	No	Yes	Please List:	No	Yes
Pneumonia	No	Yes	Polio	No	Yes
AIDS & HIV	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Infectious Mono	No	Yes
Arthritis	No	Yes	Hernia	No	Yes
Bronchitis	No	Yes	Venereal Disease	No	Yes
Blood or Plasma	No	Yes	Mitral Valve Prolapses	No	Yes
Transfusion	No	Yes	Stroke	No	Yes

Previous Hospitalizations/Surgeries/Serious Illnesses
When? Hospital, City, State

Medications: (include nonprescription)

_____

Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: _____

Patient Social History:
Marital Status Single: __ Married: __ Separated: ___ Divorced: __ Widowed: __
Use of Alcohol Never: __ Rarely: __ Moderate:__ Daily: __
Use of Tobacco Never: __ Rarely: __ Moderate: __ Daily: __
Use of Drugs Never: __ Type/Frequency: _____
Excessive Exposure
At home or at work to: Fumes: __ Dust: __ Solvents: __ Airborne Particles:__ Noise: __

CLINICIAN SIGNATURE: _____ DATE REVIEWED:_____

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father: :			
Mother :			
Siblings :			
Spouse:			
Children:			

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Neurological						**General**					
Headaches	1	2	3	4	5	Fatigue	1	2	3	4	5
Migraines	1	2	3	4	5	Malaise	1	2	3	4	5
Dizziness	1	2	3	4	5	Weakness/Tiredness	1	2	3	4	5
Numbness	1	2	3	4	5	Lightheadedness	1	2	3	4	5
Tingling	1	2	3	4	5	Irritability	1	2	3	4	5
Pin/Needles	1	2	3	4	5	Constipation	1	2	3	4	5
Diarrhea	1	2	3	4	5	Feeling Foggy	1	2	3	4	5
Forgetfulness	1	2	3	4	5						

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 **Magnolia Health, PLLC** 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.
Signed this _____ day of _____, 20 ____.

X_____ (PATIENT SIGNATURE)

X_____ (PRINT PATIENT SIGNATURE)

X_____ (SIGNATURE OF GUARDIAN IF APPLICABLE)

X _____ (PRINT GUARDIAN NAME)

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ Signature of the Patient, Parent or Guardian

_____ Date

Doctor's Review

_____

_____

_____

_____

_____

_____

_____ Signature of Doctor

_____ Date

Pertinent Services Needed:

__X-Rays _____(Views)

__Bracing _____

__Regen PRP _____

__Chiropractic _____

__Knee Decompression _____

__Shockwave _____

__Laser Therapy _____

__TEC _____

__ChiroThin Diet Plan _____

__Lipo Laser _____

__ Detox Foot Baths _____

__NRT Nutrition Response Testing _____

__Neuropathy Package _____

__OTHER _____