HEALTHWAVE
WELLNESS & RECOVERY

Patient Name: _____ Date of birth: _____
Social Security Number: _____
Sex: M_____ F_____ Marital Status: S____M____ D____ W_____
Street Address: _____
City: _____ State _____ Zip Code: _____
Home Phone: (_____)_____ Work Phone: (_____)_____
Cell Phone: (_____) _____Email Address: _____

Emergency Contact Name: _____
Emergency Contact Phone: _____

Guarantor Name (if different from patient): _____
Relationship to Patient: _____Date of Birth: _____
Guarantor's Social Security Number: _____
Guarantor's Address: _____
City: _____ State _____ Zip Code: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____

Employer's Name: _____ Work Phone: _____
Employer's Address _____
City: _____ State _____ Zip Code: _____

Primary Insurance Company: _____
Insurance Address: _____
City: _____ State _____ Zip Code: _____
Phone: (_____) _____
Name of Policy Holder: _____
Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company: _____
Insurance Address: _____
City: _____ State _____ Zip Code: _____
Phone: (_____) _____
Name of Policy Holder: _____
Insurance ID Number: _____ Group Number: _____
Primary Care Physician _____Phone: (_____) _____
Street Address: _____City: _____State _____ Zip Code: _____
Referring Physician _____Phone: (_____) _____
Street Address: _____City: _____State _____ Zip Code: _____

Please Read and Sign:
I hereby release and acquit Healthwave, its agents, representatives, affiliates, employees, or assigns, of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, emergency medical technician, physician, or urgent care services. I certify that all the information provided herein is true and correct to the best of my knowledge.

Signature of Responsible Party: _____ **Date:** _____

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CONDITIONS FOR MEDICAL TREATMENT

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. This document gives a brief description regarding our office and financial policies. Please review and initial each section. We also require your or that of your legal representative acknowledging that you have read and understand our policies.

Consent to Treatment
I hereby consent to the administration of the recommended treatments/procedures and related services at Healthwave Medical and the physicians and clinicians. The general nature, purpose, risks, and benefits of the recommended treatments/procedures have been explained to me, and I understand that the administration of any treatments/procedures involves the risk of injury or even death. In so doing, I understand, acknowledge, and affirm that such treatments and related services may involve bodily contact, touching and/or direct contact of sensitive nature.

Initials _____

Explanation of Insurance Coverage
Insurance benefits can differ greatly depending on the insurance company and your policy. You acknowledge that you have provided all pertinent insurance information insurance information regarding possible insurance coverage. We will make a good faith attempt to verify your benefits and coverage prior to starting treatments. However, it is ultimately the responsibility of the patient or policyholder to know and understand the benefits of their policy. With your initials and signature, you acknowledge that you or your legal representative is responsible for payment of deductibles, co-pays, co-insurances, and non-covered services in full.

Initials _____

Co-Pay/Deductible/Co-Insurance
All Co-pays and deductibles are due at the time of service. All co-insurance amounts will be billed and will be due upon recipient of statement.

Initials _____

Assignment of Benefits/Medical Records Release
I hereby assign all benefits payable to me under my current policy to Healthwave and authorize release of any medical records necessary to facilitate my treatment, to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. All benefits are to be paid directly to Healthwave 2647 Cordes Drive, Sugar Land, TX 77479

Initials _____

Voluntary Termination of Care

If you should suspend or terminate your care at any time, all charges for professional services are immediately due and payable to this office. All services rendered by this office will be charged directly to you and become your responsibility regardless of your insurance coverage. **I agree and fully understand that the charges are for the services rendered and not for my expected results.**

Initials _____

_____ Date: _____
Patient Name (Print):

_____ **Date:** _____
Patient/Legal Representative Signature:

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PAST MEDICAL HISTORY

Do you have or have you had: Check if "yes" or if none apply check here _____)
High Blood Pressure _____ D i a b e t e s _____ Stroke _____ Headaches _____
Epilepsy or Seizures _____ Depression or Psychiatric Disease _ Arthritis _____
Thyroid _____ Heart Problems _____ Cancer _____ Kidney Disease _____
How much alcohol do you drink each week? _____
How many cigarettes do you smoke a day? _____ Do you take birth control pills? _____
Other Significant Illnesses: (please list): _____
_____

Previous Operations (list type and year) _____
_____

Any serious injuries? _____NO _____YES Describe _____

FAMILY HISTORY:

	If Living Age	Medical Problems	If Deceased Age at Death	Cause of Death
Father:				
Mother:				

	Number	Ages	Medical Problems	Number Deceased	Age at/Cause of Death
Brothers:					
Sisters:					
Children:					

Do you know of any Blood relative who has or had: (check and give relationship or if none check here ___):
Alzheimer's _____ Parkinson's _____ Stroke _____ Seizures _____
Multiple Sclerosis _____ Depression or Psychiatric Disease _____
Learning Disability _____ Lupus _____ Diabetes _____
Heart Disease _____ Cancer _____ Mental Retardation _____

OCCUPATION: _____

CONTINUE ON NEXT PAGE

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Referred here by: (check one)
Family _____ Friend _____ Doctor _____ Other Health Professional _____
Name, address, and phone number of Doctor making referral: _____
_____

Name, address, and phone number of the physician providing your general medical care: _____
_____

Briefly describe your present symptoms:

List medications you are currently taking:

Drug	Dosage/Frequency

Allergies	Reaction

CONTINUE ON NEXT PAGE

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SYSTEMS REVIEW

As you review the following list, please check those problems which you may be expressing or have experienced. If you do not have any of the problems listed in a section, please check NONE.

GENERAL:
___ Recent weight gain
___ Recent weight loss
___ Fatigue
___ Fever
___ Bleeding, low blood
___ Night sweats
___ None

EYES:
___ Pain
___ Loss of vision
___ Double or blurred vision
___ Dryness
___ None

EARS, NOSE, MOUTH, THROAT:
___Ringing in the ears
___ Loss of hearing
___ Loss of smell
___ Sinus infection
___ Sores in mouth
___ Loss of taste
___ Dryness
___ Hoarseness
___ Difficulty in swallowing
___ None

KIDNEY/URINE/BLADDER
___ Urinary tract Infections
___ Urgency
___ Incontinence
___ Retention
___ Discharge from penis/vagina
___ Rash/ulcers
___ Prostate trouble
___None

LYMPHATIC:
___ Swollen glands
____ Tender glands
____ None

HEART AND LUNGS:
___ Pain in chest
___ Irregular heartbeat
___ Shortness of breath
___ Difficulty in breathing at night
___ Swollen legs or feet
___ Blood clots in legs
___ High blood pressure
___ Heart murmurs
___ Cough
___ Coughing of blood
___ Wheezing
___ None

STOMACH AND INTESTINES:
____ Nausea/Vomiting
____ Stomach pain
____ Yellow jaundice
____ Increasing constipation
____ Persistent diarrhea
____ Blood in stools
____ Heartburn
____ None

SLEEP ABNORMALITIES:
___ Daytime Sleepiness
___ Snoring
___ None

SKIN:
___ Easy bruising
___ Rash
___ Hives
___ Sun
___ Tightness
___ Nodules/bumps
___ Hair loss
___ Color changes of hands/feet in the cold
___ None

MUSCLES/JOINTS/BONES:
___ Morning stiffness
___ Joint pain/swelling
___ Muscle tenderness
___ Other _____
___ None

ENDOCRINE:
____ Thyroid problems
____ Other _____
____ None

MOOD:
___ Depression
___ Anxiety
___ None

PHYSICIAN COMMENTS:

Patient Signature: _____ **Date:** _____

PHYSICIAN STATEMENT: I have reviewed the above with patient.

Physician Signature: _____ **Date:** _____

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