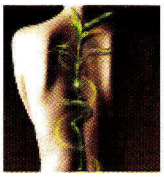

Oxford Medical Health & Wellness Center
5144 College Corner Pike, Suite A
Oxford, OH 45056
p 513.524.4800
f 513.523.8631
oxfordmedical.medicfusion.com

Patient: _____

Patient Profile

Personal Information

Full Name: _____ Jr / Sr
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ H / M / B Alternate Phone: _____ H / M / B

Birth Date: ___/___/___

Social Security Number #: ___-___-___

Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown/Unavailable

Prim. Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Greek ☐ Hebrew ☐ Italian
☐ Japanese ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Time Zone: _____

Does your time zone participate in Daylight Savings Time? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have any dependents? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Health Insurance? ☐ Yes ☐ No

Responsible Party: ☐ You ☐ Other (parent, spouse, etc.) _____

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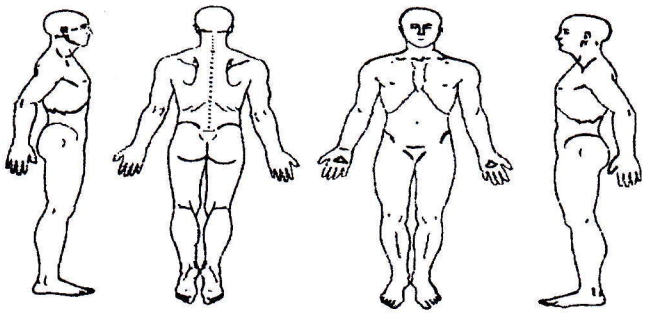
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

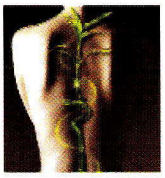
If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

_____Additional information on back side of sheet.



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Authorizations and Releases

Patient Name: _____

Consent to Professional Treatment
I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.
Initial ___

Consent to Perform and Interpret X-rays
I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.
Initial ___

Females: Regarding Possibility of Pregnancy
This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ___

Females: Consent to X-Ray During Pregnancy
This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ___

Assignment of Benefits and Release of Records
I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.
Initial ___

Financial Obligation
I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.
Initial ___

Signature _____ Date _____

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Patient: _____

Health Insurance Information

Are you the insured party? ☐ Yes ☐ No (if no please fill out the Policy Holder Information)

Policy Holder Information

Full Name: _____
Last *First* *M.I.*

Relationship to you: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Birth Date: ___/___/___

Social Security Number #: ___-___-___

Insured's Occupation: _____

Insured's Employer: _____

Employer Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. _____

Insurance Company Information

Insurance Company Name: _____

Address: _____
Street Address *Unit #*

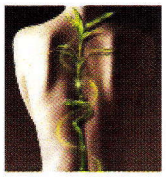
_____
City *State* *ZIP Code*

Phone: _____ Ext. _____ Fax: _____

Group #: _____

Policy/Subscriber #: _____

Effective Date: ___/___/___ Expiration Date: ___/___/___



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Responsible Party Form

Responsible Party Information

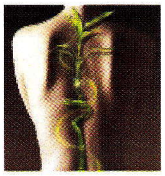
Relationship to You: _____

Full Name: _____
First *M.I.* *Last*

Same as your address? ☐ Yes ☐ No

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*



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Physician Form

Physician Information

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: ______________________________
First Name *Last Name*

Address: ______________________________
Street Address *Unit #*

____
City *State* *ZIP Code*

Phone: ______________ Ext. ______ Fax: ______________

Email Address: ______________________________

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: ______________________________
First Name *Last Name*

Address: ______________________________
Street Address *Unit #*

____
City *State* *ZIP Code*

Phone: ______________ Ext. ______ Fax: ______________

Email Address: ______________________________

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: ______________________________
First Name *Last Name*

Address: ______________________________
Street Address *Unit #*

____
City *State* *ZIP Code*

Phone: ______________ Ext. ______ Fax: ______________

Email Address: ______________________________

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: Oxford Health & Wellness Center is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Oxford Health & Wellness Center, including its designated associates and assistants and hereby release Oxford Health & Wellness Center from any consequence and/or liability concerning the same.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Oxford Health & Wellness Center any monies due it on account, the same to be deducted from any settlement made of my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that is not covered by my insurance policy or if for any reason the insurance company and/or attorney refuse and/or fails to pay my claim.

UNPAID INSURANCE BALANCE: I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO CARE FOR A MINOR: I hereby authorize Oxford Health & Wellness Center to administer care as deemed necessary to: _____.

OBLIGATIONS AS TO SERVICES: I hereby acknowledge that I am receiving (or about to receive) health care services at Oxford Health & Wellness Center and that I have been advised that Oxford Health & Wellness Center is willing to wait for payment for these services so long as there continues to be a likelihood that payment will be made either by my insurance company and/or out of the settlement of my liability case.

I understand and agree that, in the event that:

A. It is determined that there is no insurance company obligation to pay for Oxford Health & Wellness Center's services;
B. The insurance company for the undersigned refuses to acknowledge an assignment to Oxford Health & Wellness Center or to take other actions for the protection of the interest of Oxford Health & Wellness Center.
C. My attorney fails and/or refuses to agree to protect the interest of Oxford Health & Wellness Center as determined in its sole discretion; or
D. I fail to retain an attorney

Then payment of services at Oxford Health & Wellness Center will be made on a current basis and my bill paid in full within sixty (60) days from my last treatment.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than thirty (30) days overdue, I will incur interest on my past due balance of ten percent (10%) per annum. I further acknowledge and agree that Oxford Health & Wellness Center shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Oxford Health & Wellness Center.

By my signature below, I make the foregoing authorizations, assignments and agreements.

_____	_____	_____
Patient Name (Please Print)	Patient Signature	Date Signed

Oxford Medical Health & Wellness Center
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Employer Form

Employer Information

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: ___/___/___ End Date: (If you are no longer working here.) ___/___/___

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

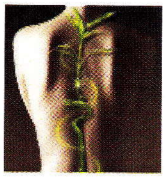
Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: ___/___/___ End Date: (If you are no longer working here.) ___/___/___



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Patient: ______________________________

Health History Form

Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________

Medication: ______________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ______________________