The Mollen Clinic **PLEASE PRINT**

Is This Visit Due To An Accident? Yes / No What Type? ___ Motor Vehicle ___ Worker's Compensation ___ Other

Last Name:_______________ First Name:_______________ Middle______

Address:_______________ Apt #______ City _______________ State______ Zip_______________

Date of Birth:_______________ Sex: M / F Marital Status: S M D W
mm/ dd / yyyy

Home Phone ( ) _______________ Work Phone ( )_______________ Ext_____ Cell # ( ) _______________

Mailing Address: _______________ Apt #_____ City_______________ State _____ Zip_______________
(If Different From Above)

How did you hear about our office?_______________

S.S. #:_______________ Employment: FT / PT / Retired Student: FT / PT

Employer:_______________ Occupation:_______________

Primary Insurance Company:_______________ Phone #:_______________

I.D. #_______________ Group #:_______________

Policy Holder's Name:_______________ Date of Birth:_______________ S.S. #_______________

Employer:_______________ Work Phone ( ) _______________

Secondary Insurance Company:_______________ Phone #:_______________

I.D. #_______________ Group #:_______________

Policy Holder's Name:_______________ Date of Birth:_______________ S.S. #_______________

Employer:_______________ Work Phone ( ) _______________

Spouse / Significant Other Name:_______________ **Phone #**:_______________

Emergency Contact: _______________ **Relationship**:_______________

Home Phone ( ) _______________ Work Phone ( )_______________ Ext_____ Cell # ( ) _______________

Parent's Name if patient is a minor:
Mother's Name:_______________ Father's Name:_______________
Daytime Phone ( )_______________ Daytime Phone ( )_______________

I hereby authorize the Doctor to render professional services to me, as he/she deems necessary for diagnosis and treatment for the benefit of my health. I will notify The Mollen Clinic promptly of any change in my insurance coverage.
I understand that **payment is due at the time of service** unless pre-arrangement is made prior to treatment. I also understand that fees for those services are the responsibility of the patient regardless of insurance coverage. Should it be necessary to assign our claim to a collection agency, it is hereby agreed that the undersigned shall be responsible for all additional charges, attorney fees and all other costs.

I hereby authorize my insurance benefits to be paid to The Mollen Clinic directly and I am responsible for Co-payments, Co-insurance, Deductibles and Non-covered services. I also authorize the release of any medical information necessary to process my claims.

Signature:_______________ Date:_______________

Patient Account #:_______________

MOLLEN CLINIC

PATIENT MEDICATION/SUPPLEMENT LIST

PATIENT FULL NAME: ____

DATE OF BIRTH: ____

KNOWN ALLERGIES: ____

PRESCRIPTION MEDICATION	DOSAGE	HOW OFTEN TAKEN	DATE STARTED	DATE STOPPED OR LEAVE BLANK IF STILL ON MEDICATION
OVER COUNTER MEDICATION SUPPLEMENTS	DOSAGE	HOW OFTEN TAKEN	DATE STARTED	DATE STOPPED OR LEAVE BLANK IF STILL ON MEDICATION

SOUTHWEST HEALTH, LTD.

DBA THE MOLLEN CLINIC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________________, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights 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 healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

____

{Please Print Name}

____

{Patient Signature or legally authorized individual Signature}

____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) ____

Staff Signature_________________________________ Date____________________

Southwest Health Ltd
dba The Mollen Clinic

Patient Release of Information Form

Authorization For Family or Significant Others

I, ____authorize the treating

Physician, and/or his staff to discuss my care/case with the below designated

Individuals only:

Name:_____________________________________ Relationship_______________

Name:_____________________________________Relationship_______________

Name:_____________________________________Relationship_______________

Name:_____________________________________Relationship_______________

OR

I, ___________________________________, prefer you DO NOT speak with

anyone regarding my care/case.

To revoke this authorization I understand that I must do so by written request and that request will become effective on the date that it is received in the office.

Signature:_______________________________________Date:________________

HEALTH QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING HELATH QUESTIONS AS COMPLETELY AS POSSIBLE. THE INFORMATION YOU PROVIDE WILL BE KEPT IN STRICT CONFIDENCE. THANK YOU FOR YOUR COOPERATION.

DATE:______________________________ (XX/XX/XXXX)

FULL NAME:____

Sex: F_____M_____

BIRTHDATE:__________________________OCCUPATION:____

1. Have you ever been treated for or ever had any known indication of the following:
(check yes or no, if yes please explain in detail on back)

A. Disease of eyes, ears, nose or throat?	☐NO	☐YES
B. Dizziness, fainting, convulsions, headache, paralysis, or stroke: mental or nervous disease?	☐NO	☐YES
C. Shortness of breath, persistent hoarseness or cough, blood spitting, pleurisy, asthma, emphysema, tuberculosis, or chronic respiratory disease?	☐NO	☐YES
D. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease of the heart or blood vessels?	☐NO	☐YES
E. Jaundice, intestinal bleeding; ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other diseases of the stomach, intestines, liver or gallbladder?	☐NO	☐YES
F. Sugar, albumin, blood or pus in urine, stone or other disease of kidney, bladder, prostate or reproductive organs?	☐NO	☐YES
G. Diabetes, thyroid or other endocrine disease?	☐NO	☐YES
H. Neuritis, sciatica, arthritis, gout or disease or injury of the muscle or bones, including the spine, back, or joints?	☐NO	☐YES
I. Deformity, lameness or amputation?	☐NO	☐YES
J. Disease of the skin, lymph glands, cyst, tumor or cancer?	☐NO	☐YES
K. Allergies, anemia or the disease of the blood?	☐NO	☐YES
L. Excessive use of alcohol, tobacco, or any drugs?	☐NO	☐YES
2. Are you now under observation or taking treatment?	☐NO	☐YES
3. Are you currently taking prescribed medication?	☐NO	☐YES
4. Are you currently taking over-the-counter medication?	☐NO	☐YES

5. Other than above, have you within the past five years:

A. Had a mental or physical disease not listed above?	☐NO	☐YES
B. Had a checkup, consultation, illness, injury, or surgery?	☐NO	☐YES
C. Been a patient in a hospital, clinic, sanitarium, or other medical facility?	☐NO	☐YES
D. Had electrocardiograms, x-rays, or other diagnostic testing?	☐NO	☐YES
E. Been advised to have any diagnostic test, hospitalization, or surgery, which was not completed?	☐NO	☐YES

6. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?

	Age if living?	**Cause of death?**	**Age at death?**
Father:	___________	_____________	____________
Mother:	___________	_____________	____________

Brothers & Sisters:

Number Living	**Number Deceased**
____________	_______________

7. Females only:

A. Have you ever had any disorder of menstruation, pregnancy, female organs, or breasts? ☐NO ☐YES

B. To the best of your knowledge and belief, are you now pregnant? ☐NO ☐YES

8. Are you currently exercising? ☐NO ☐YES

If yes, name your exercise: ____

How often do you exercise? ____(times per week)

How long do you do exercise? ____________________________________(minutes each time)

How long have you been exercising? ___________________________________(days, months, years)

9. Do you consider yourself overweight? ☐NO ☐YES

If yes, how many pounds overweight? ____

What is your "ideal" weight? ____

What did you weigh 1 year ago? ____

Are you currently on a diet? ☐NO ☐YES

10. Have you ever been told you have high cholesterol? ☐NO ☐YES

11. How would you rate your current physical state of well-being?

☐ POOR ☐ FAIR ☐ AVERAGE ☐ GOOD ☐ VERY GOOD ☐ EXCELLENT

12. How would you rate your current emotional state of well-being?

☐ POOR ☐ FAIR ☐ AVERAGE ☐ GOOD ☐ VERY GOOD ☐ EXCELLENT

If you answered yes to any of the preceding questions, please list the question number (and letter if applicable) and explain in detail?

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