New Patient Health and Wellness Survey

Welcome to our office! We constantly strive to make sure we are meeting your health and wellness goals. Please help us serve you better by letting us know what is important to you. We want to customize your care in our office.

I am interested in the following (check all that apply):

- ☐ Pain relief only
- ☐ Correction and maintenance of my problem
- ☐ Weight loss
- ☐ Healthy eating for disease prevention
- ☐ Exercise/strength/flexibility programs
- ☐ Family wellness care
- ☐ Other ____

Thank you! It is a pleasure to be a part of your Healthcare Team!

AdvancedWellness

PATIENT INFORMATION:	**INSURANCE INFORMATION**:
Today's Date: ______________________	Insurance Carrier: ______________________
Name: ________________________________	Address: ______________________________
Address: ______________________________	City: _____________ State: ____ Zip: ________
City:_______________ State:______Zip:_____	Telephone: ____________________________
Home Phone: ___________________________	Policy #: ______________________________
Cell Phone: ____________________________	Effective Date:__________________________
Business Phone: _________________________	Policyholder's Name:______________________
E-mail address: _________________________	Relationship to Patient: ___________________
Sex: ☐M ☐F Marital Status: ________	Policyholder's Social Security #______________
Social Security #: _______________________	Policyholder's Date of Birth: _______________
Date of Birth: ___________________________	Employer: ______________________________
Occupation/School: ______________________ Employer: _______________________________	**SECONDARY INSURANCE**:
	Name:_________________________________
Emergency Contact :_______________________ Phone: _________________________________ Relationship to Patient: ____________________	Address: ______________________________
	Telephone: ____________________________
Primary Care Physician: ____________________ Address: ______________________________	Effective Date: __________________________
Whom may we thank for referring you? _____________________________________	Policy #:_______________________________
	Policyholder: ___________________________
ACCIDENT INFORMATION:	Policyholder's Social Security #:______________
Is condition due to an ACCIDENT? ☐ Y ☐ N	Policyholder's Date of Birth:________________
Type of Accident: ☐Auto ☐ Work ☐ Home ☐ Other Date of Accident: ______________________	**ATTORNEY INFORMATION** (If applicable):
	Attorney Name:__________________________
To whom have you reported this accident? ☐ Auto Insurance Carrier ☐Workers Compensation Carrier ☐ Employer ☐ other_________________	Address:_______________________________
	Telephone Number: ______________________

Advanced Wellness of Marlboro

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, gua sha, and tuina (Chinese massage).

I have been informed that acupuncture is a generally safe method of treatment, but that it my have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are potential risks of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage or organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this describes the major risks of treatment, other side effects and risks may occur. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks or complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient record and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist Name(s): Veronica Bogomazova, L.Ac. : Hui Yang, L.Ac.	
Patient Signature:	Date:

(Indicate relationship if signing for patient)

Welcome to Acupuncture

Preliminary Information Form

Personal Information Today's Date:__/__/__

Patient Name:______________________________Age:____Ht:__(ft)__(in) Wt:____(lb)
Address:______________________________City:__________State:___Zip:________
Home#:______________ Cell#:____________ Email: ___________________________
DOB:___/___/____ Sex: *M F* Occupation:__________________________________
Marital Status *S M D W* Referred by:______________________________________

Health Information

Main reason for today's visit:_____________________________Date this started:_____
Describe what cause it____
Symptoms you are having____
Quality: Burn Itch Tingle Numb Rash Bleed Sharp Tender Vague Weak Other_______
Level of discomfort from 0 (None) to 10 (Worst): 0 1 2 3 4 5 6 7 8 9 10
Timing: Constant or Intermittent
When does this occur? Morning Afternoon Evening Night Certain activities:__________
What makes it **better**? Rest Motion Ice Heat Pressure Other:______________________
What makes it **worse**? Rest Motion Ice Heat Pressure Other:______________________
Can you add anything we didn't ask?_______________________________________
Have you consulted a physician regarding this? No Yes. Physician's Name:__________
Are you involved in a car accident? Yes No. If yes, any injury?:___________________
Other complaints:____
Current medications and vitamins:____
____
____

Health History

Last Physical: Date___/___/_____ Doctor:_____________ Result:__________________
Past Surgeries & Dates:____
____
Recent Lab tests, Immunizations & Date:____
Allergies: ____

Social & Life Style Information

General Mood: Good Bad Energy level from 0(Lowest) to 10(Highest) 0 1 2 3 4 5 6 7 8 9 10
Sleep: Hours_____ Good Poor Dreaming Insomnia Restlessness Sleepy
Exercise:___hours/week___days/week What do you do?____________________________
Diet Style: Meat Vegetarian Diabetic High-Cholesterol___Meals/day_____Snacks/day
Preferred Foods: Vegetable Fruit Meat Greasy Sugar Dairy Coffee Tea Alcohol Other____
Digestion: Good Bad Please explain: (Bloating, Gas, Acid Reflux, etc):_______________
____
Thirst: Yes No Prefer to drink: Cold Hot Room Temperature
Smoke: Yes No explain (Tobacco, Marijuana)_____________ Per Day____Age started___
Alcohol: Yes No If yes: ______drinks/week

Patient Name:____

Place: Check **"X"** in the box for your **CURRENT CONDITION**
Circle **"O"** around the box for your **PAST CONDITIONS**
Please provide the date, duration, frequency and intensity of pain for any condition you check or circle.

General Symptoms:
◊ Tremors
◊ Headaches
◊ Fever
◊ Sweats
◊ Dizziness
◊ Convulsions
◊ Insomnia
◊ Fatigue
◊ Nervousness
◊ Depression
◊ Loss of Weight
◊ Forgetfulness
◊ Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees or feet
◊ Paralysis

Cardiovascular:
◊ Rapid beating pulse
◊ Slow beating pulse
◊ Irregular beating pulse
◊ High blood pressure
◊ Low blood pressure
◊ Pain over heart
◊ Previous heart stroke
◊ Hardening of arteries
◊ Swelling of ankles
◊ Varicose veins

Eyes, Ears, Nose & Throat:
◊ Blurred Vision
◊ Eye pain
◊ Eye congestion
◊ Glaucoma
◊ Deafness
◊ Ear pain or stuffy
◊ Ear Noise (tinnitus)
◊ Nose Bleeds
◊ Nasal obstruction
◊ Loss of smell
◊ Sinus infection
◊ Sore throat
◊ Hoarseness
◊ Difficult swallowing
◊ Loss of taste
◊ Change in taste (sweet, sour, bitter, salty, spicy)
◊ Dental decay
◊ Gum troubles
◊ Tonsillitis
◊ Enlarged thyroid

Muscle & Joint:
◊ Stiff neck
◊ Bone spur
◊ Foot trouble
◊ Herniated disc
◊ Lower back pain
◊ Spinal scoliosis
◊ Faulty posture
◊ Swollen joints
◊ Painful joints
◊ Sore muscles
◊ Weak muscles
◊ Walking problems
◊ Sciatica

Skin:
◊ Skin Eruptions
◊ Clammy skin
◊ Dryness
◊ Bruises
◊ Boils
◊ Rashes
◊ Hives or allergy (food, pollen, chemical)

Respiratory:
◊ Frequent
◊ colds
◊ Chronic cough
◊ Spitting up phlegm
◊ Chest pain
◊ Difficult breathing
◊ Wheezing

Urinary:
◊ Frequent urination
◊ Scanty urine
◊ Painful urine
◊ Blood in urine
◊ Foul smelling urine
◊ Discolored urine
◊ Kidney infection or stones
◊ Bed wetting
◊ Inability to control urine
◊ Prostate trouble

Gastrointestinal:
◊ Poor appetite
◊ Excessive hunger
◊ Nausea
◊ Vomiting
◊ Distention of abdomen
◊ Blood in stool
◊ Colon trouble
◊ IBS
◊ Hemorrhoids (Piles)
◊ Parasite
◊ Pain in the ribs and hypochondrium
◊ Gall bladder stones
◊ Jaundice
◊ Overweight

Female:
◊ P.M.S.
◊ Painful menstrual cycle
◊ Irregular cycle
◊ Excessive flow
◊ Scanty flow
◊ Abnormal bleeding
◊ Previous miscarriage
◊ Vaginal pain
◊ Breast pain
◊ Lumps in breast
◊ Menopausal symptoms
◊ Hot flashes
◊ Endometriosis
◊ Reduced sexual activity
◊ Pregnancy complications

Male:
◊ Pain associated with genitals
◊ Reduced sexual activity
◊ Premature ejaculation

APPOINTMENT AND CANCELLATION POLICY

At Advanced Wellness, our goal is to provide quality care in a timely manner. We have implemented an appointment/cancellation policy which enables us to better utilize available appointments for our patients in need of care.

Scheduled Appointments

To schedule an in-office appointment by telephone, please call:

732-431-2155and select option #3

To schedule a surgery center/procedure appointment please call:

732-431-2155 and select option #5

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Cancellation of Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

Please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment.

Surgical Appointments

Cancellation of scheduled surgeries requires 24 hours’ notice. Because of the necessary time, supplies and equipment allotted for surgical procedures, any cancellation not made prior to 24 hours will be subject to a fee of $100.00 ($50.00 for Iovera patients). If you are a “no show” after confirming your appointment, you will be subject to a $250.00 fee. This fee will not be billed to insurance and is payable prior to your next appointment.

Lateness

Please be courteous of all fellow patients and be on time for your appointments. If you are running late, kindly call the office and we will advise as to whether you should come in.
If you are more than 10 minutes late, it is possible that you may not be seen and will be scheduled at the next available appointment time.

No Show Policy

A “no show” is someone who misses an appointment without canceling it in advance. No-shows inconvenience those individuals who need access to care in a timely manner.

A failure to present at the time of a scheduled in-office appointment will be recorded in the patient’s chart as a “no show”. Three “no shows” may result in the temporary suspension of services.

I have read, understand and agree to this policy:

Patient Signature:_____________________________________ Date: ___________________

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZATION FORM
ADVANCED WELLNESS CENTER

Financial Responsibility

I have requested professional services from ADVANCED WELLNESS (“Provider”) on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent’s behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. Furthermore, the Provider shall have every right and I hereby authorize the Provider to request a Summary Plan Description (“SPD”) on my behalf.

A photocopy of the Assignment/Authorization shall be as effective and valid as the original.

____   ______________________________

Patient   Date

____   ______________________________

Policyholder/Insured   Date

AdvancedWellness
A Comprehensive Wellness Approach

Office Policies

- Our office is a zero balance office. All services including copayments must be paid for at the time of service unless other arrangements have been made.
- All missed appointments must be made up according to your care plan.
- Please call 24 hours in advance if you need to reschedule your appointment.

ASSIGNMENT OF BENEFITS/HIPAA GUIDELINES

I certify that I, and /or my dependent(s) have insurance coverage with ____ and assign directly to Advanced Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

The above-named facility may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I am aware that Advanced Wellness Center (AWC) will abide by the HIPAA regulations for the purpose of keeping my records confidential and only upon my written consent will my records be allowed to leave AWC.

____
Signature of patient, parent or guardian Date

____
Print Name of patient, parent or guardian Date

Thank you and welcome to our office!

17 North Main Street, Marlboro, NJ 07746 Tel: (732) 431-2155; Fax: (732) 431-2889

AUTHORIZATION OF RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: ____

Date of Birth: ____________________________________

I hereby authorize medical providers and personnel of Advanced Wellness Center of Marlboro to discuss my protected health information with:

___________________________________	___________________________________
(Relationship)	(Name)
___________________________________	___________________________________
(Relationship)	(Name)
___________________________________	___________________________________
(Relationship)	(Name)

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
____ Psychotherapy notes from a Psychiatrist or Psychotherapist
____ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from _____________ until _______________ at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

____
Signature of Patient

____
Date

17 North Main Street, Marlboro, NJ 07746 Tel: (732) 431-2155; Fax: (732) 431-2889

Healthy Body Checklist

Name:______________________________ Date: ______________________________

Please check all applicable conditions. Then, rate your pain, stiffness, weakness or discomfort on a scale of 1-10.
1 = Not Concerned and 10 = Extremely Concerned.

Condition	Rate On Scale of 1-10
☐ **Headaches**	________
☐ **Allergies**	________
☐ **Neck Pain**	________
☐ **TMJ**	________
☐ **Thyroid Condition**	________
☐ **Shoulder Pain**	________
☐ **Upper Back Pain**	________
☐ **Mid Back Pain**	________
☐ **Elbow / Arm Pain**	________
☐ **Gastrointestinal Issues**	________
☐ **Fatigue**	________
☐ **Low Back Pain**	________
☐ **Wrist/Hand Pain**	________
☐ **Numb/Tingling Hands**	________
☐ **Hip Pain**	________
☐ **Weight Concerns**	________
☐ **Thigh Pain**	________
☐ **Knee Pain**	________
☐ **Calf Pain**	________
☐ **Shin Pain**	________
☐ **Autoimmune Conditions**	________
☐ **Hormonal Issues**	________
☐ **Diabetes**	________
☐ **Foot / Ankle Pain**	________
☐ **Numb/Tingling Feet**	________
☐ **Balance Problems**	________

Patient No.____________

Allergy History Survey

Clinic Name____ **Date**_______________

Patient Name___________________________________ **Age** _____________ **M/F**

COMPLAINTS:

Please circle the appropriate number 0-3 according to severity: **0 = absent** (no symptoms evident), **1 = mild** (symptoms present, but minimal awareness, easily tolerated), **2 = moderate** (definite awareness, bothersome, but tolerable), **3 = severe**

Symptom					Symptom				
Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itching	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Chronic fatigue	0	1	2	3
Watery eyes	0	1	2	3	Frequent sinus or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Gritty feeling (eyes)	0	1	2	3	Learning disability	0	1	2	3
Cough	0	1	2	3	Poor memory or concentration	0	1	2	3
Wheezing	0	1	2	3	Hyperactivity	0	1	2	3
Shortness of breath, difficulty breathing	0	1	2	3	Arthritis or muscle aching	0	1	2	3
Asthma: Yes No	0	1	2	3	Food intolerance	0	1	2	3

Other symptoms or specific foods causing you problems?

____

MEDICATIONS:

How often do you take medications for your allergy symptoms?

0 = never, 1 = occasionally (several times a month or less), **2 = frequently** (several times a week), **3 = daily**

Medication				
Antihistamines (Claritin, Zyrtec, Benadryl)	0	1	2	3
Nasal Steroids (Flonase, Nasacort)	0	1	2	3
Oral Steroids (Prednisone)	0	1	2	3
Asthma medication (Albuterol inhaler, Singulair, Advair)	0	1	2	3
Eye drops (Patanol, antihistamine/allergy eye drops)	0	1	2	3

Other allergy-related medications ____

Does any medication give you relief of symptoms? __________________________________

Which if any medications are you allergic to? _____________________________________

ALLERGY HISTORY:

How many months of the year do you have allergies? _______________ What year did they begin?:_____________

In what season are they worse: ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Have you been allergy tested before? ☐ Yes ☐ No

If yes, which type: ☐ Skin Prick/Puncture ☐ Serum-Specific IgE (blood draw)

Have you previously received allergy shots? _________ Allergy drops? ________If yes, when? ________________

Do you smoke or use tobacco products? ____

List any animals you have in or around the home ____________________________________

Who else in your family has allergies? ____

How did you hear about us?

☐ Yellow Pages

☐ Friend (Name:__________________________)

☐ Newspaper/Magazine (publication name:____)

☐ Physician (Name:______________________________)

☐ Website (Name:_______________________________)

☐ Insurance (Co. Name:___________________________)

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Sign up for Dr. Cilea's FREE Health Tip of the Week! Get life changing information for you and your family on the following subjects:

- Weight loss
- Exercise
- Nutrition
- Supplements
- Wellness

You must print your e-mail address clearly to subscribe to this FREE service.

Your Name: ____

Your e-mail Address: ____

PLEASE RETURN THIS SIGN UP SHEET TO THE FRONT DESK

*YOUR E-MAIL ADDRESS WILL NOT BE SHARED AND WILL BE KEPT CONFIDENTIAL.