

Name:	Date of Birth:	Gender:	Age:
Marital Status: Single, Married, Divorced, Widowed, Engaged, Domestic Partner	Race: White, Asian, African American, American Indian, Alaska Native, Native Hawaiian, Pacific Islander, or Other: _____		Ethnicity: Caucasian, Hispanic Latino, or Other: _____

MEDICAL ILLNESSES OR CONDITIONS					
Prior history of condition/diagnosis (check only if applicable)	Dates (if known) MM/YY-MM/YY	Currently on Meds? (check yes)	Prior history of condition/diagnosis (check only if applicable)	Dates (if known) MM/YY-MM/YY	Currently on Meds? (check yes)
<input type="checkbox"/> Hearing Disorder		<input type="checkbox"/> Yes	MUSCULOSKELETAL		
<input type="checkbox"/> Eye disorder		<input type="checkbox"/> Yes	<input type="checkbox"/> Gout		<input type="checkbox"/> Yes
<input type="checkbox"/> Allergy (seasonal)		<input type="checkbox"/> Yes	<input type="checkbox"/> Osteoarthritis		<input type="checkbox"/> Yes
<input type="checkbox"/> Infection		<input type="checkbox"/> Yes	<input type="checkbox"/> Osteoporosis		<input type="checkbox"/> Yes
<input type="checkbox"/> Seizure disorder		<input type="checkbox"/> Yes	<input type="checkbox"/> Collagen vascular disease		<input type="checkbox"/> Yes
<input type="checkbox"/> Migraine headaches		<input type="checkbox"/> Yes	<input type="checkbox"/> Degenerative disc disease		<input type="checkbox"/> Yes
<input type="checkbox"/> Transient ischemic attack		<input type="checkbox"/> Yes	<input type="checkbox"/> Fractures		<input type="checkbox"/> Yes
<input type="checkbox"/> Cerebral vascular accident		<input type="checkbox"/> Yes	<input type="checkbox"/> Scoliosis		<input type="checkbox"/> Yes
<input type="checkbox"/> Cerebral hemorrhage		<input type="checkbox"/> Yes	<input type="checkbox"/> Other Joint Disorders		<input type="checkbox"/> Yes
<input type="checkbox"/> Parkinson's disease		<input type="checkbox"/> Yes	<input type="checkbox"/> Dental Disorders		<input type="checkbox"/> Yes
<input type="checkbox"/> Peripheral nerve disorder		<input type="checkbox"/> Yes	<input type="checkbox"/> Back Pain		<input type="checkbox"/> Yes
<input type="checkbox"/> Cognitive or psychiatric disorder		<input type="checkbox"/> Yes	BLOOD		
<input type="checkbox"/> Depression		<input type="checkbox"/> Yes	<input type="checkbox"/> Clotting problems		<input type="checkbox"/> Yes
<input type="checkbox"/> Post-traumatic stress disorder		<input type="checkbox"/> Yes	<input type="checkbox"/> Anemia		<input type="checkbox"/> Yes
<input type="checkbox"/> Sleep apnea		<input type="checkbox"/> Yes	<input type="checkbox"/> Other:		<input type="checkbox"/> Yes
<input type="checkbox"/> Headache		<input type="checkbox"/> Yes	GASTROINTESTINAL		
<input type="checkbox"/> Insomnia		<input type="checkbox"/> Yes	<input type="checkbox"/> Peptic ulcer disease		<input type="checkbox"/> Yes
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Yes	<input type="checkbox"/> GERD		<input type="checkbox"/> Yes
<input type="checkbox"/> Anorexia Nervosa		<input type="checkbox"/> Yes	<input type="checkbox"/> Liver disease		<input type="checkbox"/> Yes
<input type="checkbox"/> Emphysema COPD		<input type="checkbox"/> Yes	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Yes
<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Yes	<input type="checkbox"/> Pancreatitis		<input type="checkbox"/> Yes
<input type="checkbox"/> Asthma		<input type="checkbox"/> Yes	<input type="checkbox"/> Gastrointestinal bleed		<input type="checkbox"/> Yes
<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Yes	<input type="checkbox"/> Gallstones		<input type="checkbox"/> Yes
<input type="checkbox"/> Yeast Infection		<input type="checkbox"/> Yes	<input type="checkbox"/> Cholecystitis		<input type="checkbox"/> Yes
CARDIOVASCULAR			<input type="checkbox"/> Inflammatory bowel disease		<input type="checkbox"/> Yes
<input type="checkbox"/> Angina		<input type="checkbox"/> Yes	<input type="checkbox"/> Diverticulitis		<input type="checkbox"/> Yes
<input type="checkbox"/> Myocardial Infarction		<input type="checkbox"/> Yes	<input type="checkbox"/> Irritable Bowel Syndrome		<input type="checkbox"/> Yes
<input type="checkbox"/> Congestive Heart Failure		<input type="checkbox"/> Yes	<input type="checkbox"/> Constipation		<input type="checkbox"/> Yes
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Yes	<input type="checkbox"/> Hernia		<input type="checkbox"/> Yes
<input type="checkbox"/> Cardiac arrhythmia		<input type="checkbox"/> Yes	<input type="checkbox"/> Anorexia		<input type="checkbox"/> Yes
<input type="checkbox"/> Peripheral vascular disease		<input type="checkbox"/> Yes	METABOLIC		
<input type="checkbox"/> Congenital heart disease		<input type="checkbox"/> Yes	<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> Yes
<input type="checkbox"/> Syncope		<input type="checkbox"/> Yes	<input type="checkbox"/> Obesity		<input type="checkbox"/> Yes
<input type="checkbox"/> Valvular heart disease		<input type="checkbox"/> Yes	<input type="checkbox"/> Hyperthyroidism		<input type="checkbox"/> Yes
<input type="checkbox"/> Coronary artery disease		<input type="checkbox"/> Yes	<input type="checkbox"/> Hypothyroidism		<input type="checkbox"/> Yes
<input type="checkbox"/> Hyperlipidemia		<input type="checkbox"/> Yes	<input type="checkbox"/> Hyperparathyroidism		<input type="checkbox"/> Yes
<input type="checkbox"/> Hypercholesterolemia		<input type="checkbox"/> Yes	WHOLE BODY		
<input type="checkbox"/> Gilbert's Syndrome		<input type="checkbox"/> Yes	<input type="checkbox"/> Cancer		<input type="checkbox"/> Yes
GENITOURINARY			<input type="checkbox"/> Alcoholism		<input type="checkbox"/> Yes
<input type="checkbox"/> Kidney disorder		<input type="checkbox"/> Yes	<input type="checkbox"/> Drug abuse		<input type="checkbox"/> Yes
<input type="checkbox"/> Kidney Stones		<input type="checkbox"/> Yes	<input type="checkbox"/> Drug allergies/reactions		<input type="checkbox"/> Yes
<input type="checkbox"/> Bladder pain		<input type="checkbox"/> Yes	<input type="checkbox"/> Immune deficiency disease		<input type="checkbox"/> Yes
<input type="checkbox"/> Urinary tract infection		<input type="checkbox"/> Yes	<input type="checkbox"/> Fatigue		<input type="checkbox"/> Yes
<input type="checkbox"/> Tumor of breast		<input type="checkbox"/> Yes	<input type="checkbox"/> Weakness		<input type="checkbox"/> Yes
<input type="checkbox"/>		<input type="checkbox"/> Yes	<input type="checkbox"/> Other Allergy (Non-Drug)		<input type="checkbox"/> Yes
<input type="checkbox"/>		<input type="checkbox"/> Yes	<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Yes
<input type="checkbox"/>		<input type="checkbox"/> Yes			<input type="checkbox"/> Yes

MEDICAL ILLNESSES OR CONDITIONS CONT.					
Prior history of condition/diagnosis (check only if applicable)	Dates (if known) MM/YY-MM/YY	Currently on Meds? (check yes)	Prior history of condition/diagnosis (check only if applicable)	Dates (if known) MM/YY-MM/YY	Currently on Meds? (check yes)
DERMATOLOGY (SKIN)			OTHERS NOT LISTED		
<input type="checkbox"/> Eczema		<input type="checkbox"/> Yes	<input type="checkbox"/>		<input type="checkbox"/> Yes
<input type="checkbox"/> Psoriasis		<input type="checkbox"/> Yes	<input type="checkbox"/>		<input type="checkbox"/> Yes
<input type="checkbox"/> Acne		<input type="checkbox"/> Yes	<input type="checkbox"/>		<input type="checkbox"/> Yes
<input type="checkbox"/> Rosacea		<input type="checkbox"/> Yes	<input type="checkbox"/>		<input type="checkbox"/> Yes

First day of last menstrual period?	Date:
Gender assigned at birth (Male/Female):	Gender:

CURRENT MEDICATIONS:		ALLERGIES: (include drugs, foods, chemicals, insects, etc.)		
Drug Name:	Dose:	Item:	Date:	Type of Reaction:

HOSPITALIZATIONS AND SURGERIES			
Reason/Diagnosis/Procedure:	Date:	Reason/Diagnosis/Procedure:	Date:

IMMUNIZATIONS AND PREVENTITVE SERVICES:								
Women Only		Date:	Men Only		For Men and Women over the age of 50:	Immunizations:		
<input type="checkbox"/> Pap Smear			<input type="checkbox"/> PSA		<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Stress Test	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Mammogram					<input type="checkbox"/> EKG / ECG	<input type="checkbox"/> Eye Exam	<input type="checkbox"/> Flu/Influenza	<input type="checkbox"/> Shingles
<input type="checkbox"/> Bone Density								

PERSONAL HABITS (Check all that apply):					
<input type="checkbox"/> Currently Use Tobacco		<input type="checkbox"/> Consume Alcohol		<input type="checkbox"/> Exercise Regularly	
Type: <input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigars	<input type="checkbox"/> Pipe	<input type="checkbox"/> Chewing Tobacco	Type: <input type="checkbox"/> Exercise Regularly	Type: <input type="checkbox"/> Exercise Regularly
Amount/Day:	Years:			Amount/Day:	Years:
<input type="checkbox"/> Former Smoker	Years:	Quit Date:		<input type="checkbox"/> Use recreational drugs	Years:
Amount/Day:				Type: <input type="checkbox"/> Use recreational drugs	Frequency:
				Frequency:	Years:

RESEARCH STUDY HISTORY	
Have you ever participated in a clinical trial? <input type="checkbox"/> Yes* <input type="checkbox"/> No	
*If YES – please list the date(s) you were on the trial and as many details of the trial as you can remember (i.e. Sponsor, Study Drug, Indication)	
1.	
2.	
3.	



ADVANCED SPECIALTY RESEARCH PATIENT DEMOGRAPHIC INFORMATION

PATIENT CONTACT INFORMATION

NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PRIMARY PHONE NUMBER: _____ SECONDARY PHONE NUMBER: _____
EMPLOYER: _____ WORK PHONE: _____
EMAIL ADDRESS: _____ SOCIAL SECURITY NUMBER: _____
DO YOU AUTHORIZE / PREFER TO BE CONTACTED BY (Please Check One or More of the Following):
 Phone Call Text Message E-Mail

EMERGENCY CONTACT INFORMATION

CONTACT NAME	RELATIONSHIP	PHONE NUMBER
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

ADDITIONAL INFORMATION

MARITAL STATUS: _____ SPOUSE'S NAME: _____
SPOUSE'S EMPLOYER _____ PHONE NUMBER: _____
HOW DID YOU HEAR ABOUT US?: _____

PRIMARY CARE PHYSICIAN INFORMATION

PHYSICIAN NAME: _____
ADDRESS: _____
PHONE NUMBER _____ FAX: _____

HIPAA CONSENT

In signing this form, you consent to the use and disclosure of your protected health information by Advanced Specialty Research, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You have the right, and we encourage you, to review our NOTICE OF PRIVACY PRACTICES prior to signing this consent. It provides more detail on how we may use and disclose your information. The NOTICE OF PRIVACY PRACTICES may change at our discretion, as necessary. A copy may be requested when you are being seen as a patient or sent to your residence.

You may also revoke this consent in writing. Information on treatment and services provided or prior consents may still be used for purposes of treatment, payment, or health care options. Please refer to the NOTICE OF PRIVACY PRACTICES for further information.

Signature of Patient/Authorized Representative: _____ Date: _____
(Must be over 18 for signature)

CONSENT TO TREAT

I attest that I have completed the above information accurately and completely to the best of my ability. My signature below represents consent to be treated by Advanced Specialty Research. This consent encompasses all procedures and treatments as are found to be necessary or desirable, in the judgment of the professional staff of Advanced Specialty Research. I further understand that my consent for treatment may be revoked in writing at any time.

Signature of Patient/Authorized Representative: _____ Date: _____
(Must be over 18 for signature)

Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

**Give form to the
requester. Do not
send to the IRS.**

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See Specific Instructions on page 3.	1	Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)		
	2	Business name/disregarded entity name, if different from above.		
	3a	Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____ Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ <i>(Applies to accounts maintained outside the United States.)</i>	
	3b	If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions <input type="checkbox"/>		
	5	Address (number, street, and apt. or suite no.). See instructions.	Requester's name and address (optional)	
	6	City, state, and ZIP code		
	7	List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Social security number									
				-					
or									
Employer identification number									

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	Date
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they



200 N 3rd St Ste 110
Boise, ID 83702
(P) 208.906.1600
(F) 208.579.2451

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____

THIS IS TO AUTHORIZE THE MEDICAL INFORMATION TO BE SENT TO THE REQUESTING PARTY

TO _____ FROM _____ ADVANCED SPECIALTY RESEARCH

TO _____ FROM _____

Phone _____ Fax _____

TO _____ FROM _____

Phone _____ Fax _____

Purpose or need for records: _____

COPIES TO BE RELEASED: (CHECK ALL THAT APPLY)

- ALL RECORDS
- LABS
- EKG
- PATHOLOGY
- X-RAY REPORT
- PROCEDURE NOTES
- PHYSICIAN'S/MIDLEVEL ORDERS & PROGRESS NOTES
- ALCOHOL OR DRUG ABUSE RECORDS _____ (MUST INITIAL TO BE VALID)
- STD AND/OR AID DIAGNOSIS, HIV, AND/OR HIB TESTS _____ (MUST INITIAL TO BE VALID)
- BEHAVIORIAL HEALTH/COUNSELING NOTES _____ (MUST INITIAL TO BE VALID)

THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM TODAY'S DATE UNLESS REVOKED IN WRITING. THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME WITH THE EXCEPTION OF INFORMATION RELEASED PRIOR TO THE DATE OF THE WRITTEN REVOCATION. ADVANCED SPECIALTY RESEARCH CANNOT CONDITION TREATMENT OR ELIGIBILITY OF BENEFITS ON WHETHER THE AUTHORIZATION IS SIGNED. PROTECTED HEALTH INFORMATION, ONCE RELEASED, HAS THE POTENTIAL TO BE REDISCLOSED TBY THE RECIPIENT AND IS NO LONGER PROTECTED BY ADVANCED SPECIALTY RESEARCH AND MAY NO LONGER BE PROTECTED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

PARTICIPANT SIGNATURE: _____

DATE: _____

PARENT OR GUARDIAN SIGNATURE: _____

DATE: _____

WITNESS SIGNATURE: _____

DATE: _____