

Intake Form

Name: _____ M F Birth Date: _____ SS#: _____

Mailing Address: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Social Media (e.g. Twitter, Facebook, Yelp): _____

OK to leave messages on voicemail or email? Yes No

Is English your first language? Yes No Do you need an interpreter? Yes No

Preferred Language: _____

Current Marital Status: Single Married Widowed Divorced

Race: American Indian or Alaskan Native Asian Native Hawaiian or Other Pacific Islander

African American Caucasian Hispanic Other Race Refuse to Report

Ethnicity: Hispanic or Latino Not Hispanic Refuse to report

Occupation: _____ Employer: _____

Primary Care Physician: _____ Phone: _____

Other physicians or health care providers that you are currently seeing including chiropractors, therapists, etc.

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Subscriber: Self Spouse Parent Other

Subscriber's Name: _____ SS#: _____ DOB: _____

Name of Insurance: _____ ID#: _____ Group: _____

Address to submit claims: _____ Phone: _____

Secondary Insurance Subscriber: Self Spouse Parent Other

Subscriber's Name: _____ SS#: _____ DOB: _____

Name of Insurance: _____ ID#: _____ Group: _____

Address to submit claims: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone: _____

I authorize the release of any medical information necessary to process my claims to the insurance company, attorney or other physicians. I understand that I am responsible for all charges incurred. I further authorize my insurance to make direct payment to the Comprehensive Spine & Sports Center for all medical benefits.

Patient Signature: _____ Date: _____

Patient: _____ Date: _____

Referral: How did you hear about us? Physician/Practice Name:

 Internet (Please specify): _____

 Other: _____

What do you hope to achieve today? _____

HISTORY OF PRESENT ILLNESS

How long have you noticed your pain? _____ Days _____ Weeks _____ Months _____ Years

 Was there any injury/event that caused your pain? Yes No (Please describe your pain below): _____

Where is your pain located?
 Neck/Mid Back/Low Back Buttock/Hip/ Legs

 Shoulder/Elbow/ Hand Foot/Ankle

 Other _____

Rate your usual pain (CIRCLE NUMBER BELOW THAT BEST APPLIES):

No Pain 0 1 2 3 4 5 6 7 8 9 10 The Worst Pain Imaginable

Describe your pain (Check all that apply):
 Burning Sharp-Shooting Tingling Numbness

 Pinprick Stabbing Deep-pressure Tightness

 Spasms Other: _____

What makes the pain worse? _____

What makes the pain better? _____

Which of the following have been affected because of your pain? (Check all that apply):
 Household Chores Office Work Driving Walking/Running Sports Concentration

 Depression Anxiety Mood Appetite Sleep Relationships

Past Treatment:
Which of the following treatments/ evaluations have you tried for your pain? (Check all that apply):
 MRI X-Ray CT EMG Bone Scan Blood/Laboratory Epidurals Physical Therapy

 TENS Heating Pad Ice Injections Exercise Steroids

 Surgery Massage Medications Acupuncture Hypnotherapy

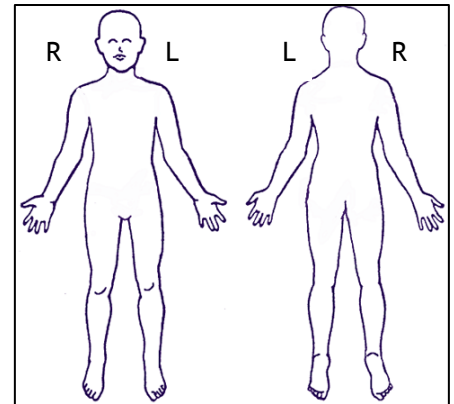
CURRENT MEDICATIONS:

<u>Name of Medication</u>	<u>Strength</u> (e.g. mg, mcg)	<u>Number of Pills</u> (e.g. once a day)	<u>Frequency</u>	<u>Prescribing Physician</u>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Where is the Pain?

(Indicate location of pain in diagram below):



What Pharmacy do you use (Name, Address, Phone Number)? _____

PAST MEDICAL HISTORY (Check all that apply):

- Brain Heart Lungs Liver Kidneys Diabetes Bleeding/Anemia Depression/ Bipolar
 Psychiatric Arthritis Fibromyalgia Headaches Suicide ideation/ attempts Alcohol/
 Drug Problems State/ SS Disability Other: _____

ALLERGIES (List reactions): _____

PAST SURGICAL HISTORY (List all surgeries below or write N/A):

<u>Surgery Type</u>	<u>Date of Surgery (Mo/Yr)</u>	<u>Surgeon</u>

HOSPITALIZATION (List all hospital visits below or write N/A):

<u>Reason for Most Recent Hospitalization or ER visit?</u>	<u>Date of Admission (Mo/Yr)</u>	<u>Name of Hospital</u>

FAMILY HISTORY (Check all that apply):

- Stroke Seizure Heart Lungs Liver Kidney/ Bladder Cancer Migraines Diabetes
 High Blood Pressure Thyroid Bleeding/ Anemia Stomach/ Bowel Fibromyalgia Gout
 Arthritis Suicide ideation/ attempts Depression/Bipolar Mental Disorders
 Alcohol/ Drug Problems State/ SS Disability Other: _____

SOCIAL HISTORY:

What is your highest level of education? _____

Are you employed? Full Time Part Time Unemployed Disability Retired

Employer: _____ Job Title: _____

Relationship Status: Are you: Single? Married? Separated? Divorced? Widowed?

Do you have children? Yes- How many? _____ No

Smoking Status? Are you a: Current Smoker? How many packs a day? _____ Former Smoker?

How many years since you smoked? _____ Never Smoker?

Do you drink alcohol? Yes How many glasses per day? _____ No

Do you use recreational drugs? Yes No

Have you ever abused drugs in the past? Yes No

Have you ever abused alcohol in the past? Yes No

Have you ever been treated at a drug or alcohol rehabilitation center? Yes No

Office Use Only: Ht: _____ Wt: _____ BP: _____ HR: _____

Campbell Location - 3425 S. Bascom Ave. Suite 200, Campbell, CA 95008 | Ph: 408.356.5292

Morgan Hill Location - 18181 Butterfield Blvd. Suite 140, Morgan Hill, CA 95037 | Ph: 510.342.5721

Fremont Location - 39055 Hastings Street, Suite 204, Fremont, CA 94538 | Ph: 408.356.5292

Authorization for Use or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to as the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____, hereby authorize this medical practice to use and disclose health information related to my personal health, treatment or payment for treatment as follows:

This health information may be disclosed to:

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"):

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.

Patient Signature

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CONDITIONS OF ADMISSION / CONSENT FOR SERVICES

Please read and sign the following agreement so that we may proceed with your care and treatment at the Comprehensive Spine & Sports Center.

CONSENT TO MEDICAL CARE: The undersigned hereby consent to the procedures that may be performed today as well as in the future during outpatient treatment, including emergency services, or other services rendered under the general and special instructions of my physician.

PERSONAL VALUABLES: It is understood and agreed that Comprehensive Spine & Sports Center maintains a safe environment for personal belongings. The staff shall not be liable for the loss or damage to any money, jewelry, glasses, documents, clothing, electronic devices or other personal articles of unusual value.

FINANCIAL AGREEMENT: The undersigned, whether signing as a patient or representative of the patient, agrees to pay all charges for medical services not otherwise covered by health care benefits, in accordance with the rates and terms of the Comprehensive Spine & Sports Center. If the account is referred to an attorney or collection agency, the undersigned agrees to pay actual collection costs, including attorney’s fees, together with interest at the legal rate.

ASSIGNMENT OF BENEFITS: The undersigned, whether signing as a patient or representative of the patient, authorizes direct payment to the Comprehensive Spine & Sports Center of any health care coverage benefits otherwise payable to or on behalf of the patient for medical services rendered by us, including emergency services, if any. Health care coverage benefits include Medicare, other governmental health care program benefits, as well as coverage under a Worker’s Compensation, automobile, life/accident, and disability insurance plan. The undersigned authorizes release of medical information necessary to determine the eligibility and benefits payable and to submit and process claims for payment.

AUTHORIZES REPRESENTATIVE: The undersigned hereby authorizes the Comprehensive Spine & Sports Center, at its election but without obligation, to represent the patient regarding any application and appeal for eligibility and benefits pursuant to the patient’s applicable health benefit plan, including Medicare, or other governmental program benefits relating to services rendered at Comprehensive Spine & Sports Center.

ADVANCED DIRECTIVE: An advanced directive is a document outlining the patient’s medical wishes should he or she be unable to speak for themselves. It also designates a Healthcare Agent who is authorized to make medical decisions on the patient’s behalf. Does the patient have an Advanced Directive? Yes No

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THIS FORM AND ACCEPTS AND AGREES TO ABIDE BY ITS TERMS.

Patient or Patient Representative Signature

Date

Relationship

Witness Signature (CSSCtr Staff Use Only)

Date

Patient Rules & Regulations

Our goal at Comprehensive Spine & Sports Center (CSSCtr) is to provide top quality care to our patients in a compassionate and professional environment. We do our best to stay on time with our scheduled and give you our undivided attention.

As a patient of the CSSCtr, we appreciate you following the rules and regulations of the practice which help us maintain our goals.

1. If you are unable to keep an appointment, kindly call our office at least 72 hours prior to your appointment. We can then reschedule your appointment to a more convenient time.

2. A \$200 fee will be applied to all New Patient appointments not cancelled within the 72 hour period or if you fail to keep your appointment. A fee of \$100 will be applied to all follow-up appointments not cancelled within 72 hours

3. Please arrive 15 minutes prior to your appointment time. It is important to have your questionnaire and registration forms completed. If the forms are not complete at the time of your appointment, or you are more than 15 minutes late, you may need to be rescheduled for a later date.

4. Cash payments and co-pays must be paid at the time of check-in.

5. We do not accept checks for the initial consultation.

6. If you have recently moved, had a change to your insurance, claims adjuster, attorney, primary treating physician, or had any other change to your personal information, please supply us with the new information. Please provide the new information within 10 days of the change so we can keep up to date records.

Phone: (408) 356-5292

Fax: (408) 356-5307

Mail: 3425 S. Bascom Ave., Ste. 200 Campbell, CA 95008

7. You are responsible for knowing the coverage and benefits of your particular insurance company. If you are not sure of the requirements of your insurance company, please check with them prior to obtaining medical services. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to ascertain beforehand what your portion of the charges will be and to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

Patient Signature

Print Name

Date

Witness Signature (Staff Use Only)

Print Name

Date

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