CORDOBA HEALTH
GROUP

## PATIENT AND INSURANCE INTAKE FORM

Last Name: _____ First Name: _____ MI: _____

DOB:_____ SS#: _____ Sex: _____ Marital Status: _____

Address: _____ City:_____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email: _____

Referred By:_____ (Friend/Family, Doctor, Yelp, Google, Facebook, Flyer, Groupon, Living Social, Massage Therapist)

List any person(s) with whom we can discuss your protected health information? _____

Employer Name and Employer No: _____

Emergency Contact Name and No: _____

Pharmacy Name and Phone No: _____

## Insurance Information

Primacy Insurance Co:_____ ID#: _____ GRP#: _____

Secondary Insurance Co:_____ ID#: _____ GRP#_____

Policyholder Name:_____ ID#:_____ Relationship to Insured _____

Policyholder DOB: _____ Address: _____

Policyholder SS# _____ Policyholder Sex:_____ Copay amount: _____

☐ HMO ☐ PPO ☐ Other _____

## Patient Authorization

I _____ authorize the release of any medical information necessary to process any claim. I authorize payment of the medical benefits to the physician for services rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor):_____ Date:_____

## Consent for Evaluation and/or Treatment

By signing below, I am giving my consent to the practice of Cordoba Health Group LLC for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of an medically recommended diagnostic procedures and/or treatments and given the option to accept or decline.

Patient Name (printed):_____ Signature: _____ Date:_____

## Cancellation Policy

In order to serve our patients better, we have instituted a cancellation policy. We require 24-hour notice for all cancellations. If an appointment is missed, canceled, or rescheduled without 24 hour notice there will be a $50.00 charge billed to the patient.

By signing below I acknowledge that I have been notified of and consent to the cancelation policy.

Patient or Parent-Guardian Signature: _____ Date: _____

## Managed Care/ HMO Patients

I _____ understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient or Parent-Guardian Signature: _____ Date:_____

## HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I certain right to privacy regarding my Protected Health Information. I understand that the information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly indirectly. Obtain payment from the third party payers. Conduct normal healthcare operations such as quality assessments and physician certifications.I have been informed by you or your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organizations Privacy offer to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restriction, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (printed): _____ Relationship to Patient (if minor): _____

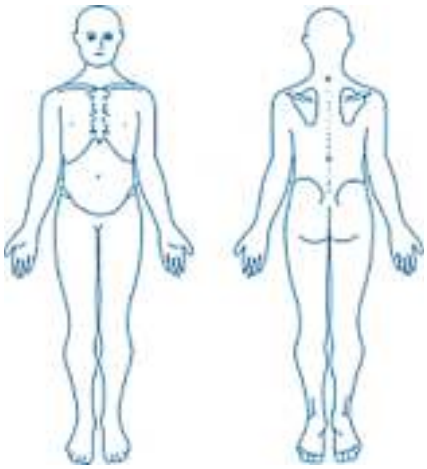
Signature: _____ Date: _____

Name: _____ Age: _____ Date: _____

**PAIN DIAGRAM**

Mark the areas on your body where you now feel your typical pain. Include all areas.

Pain XXXXXX Numbness OOOOOO Pins and Needles //////



FRONT BACK

☐ No Pain

**When did your pain start?** _____

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

**How often do you have you pain?** ☐ Constant ☐ Comes and Goes ☐ Rare ☐ Once

**What caused the onset of pain?** _____

**Pain progression?** ☐ Getting Better ☐ Getting Worse ☐ Unchanged

**Quality of pain ?** ☐ Stabbing ☐ Shooting ☐ Aching ☐ Burning ☐ Cramping ☐ Sharp ☐ Dull ☐ Other

**How severe is your pain at worst?** 1 2 3 4 5 6 7 8 9 10 **At best?** 1 2 3 4 5 6 7 8 9 10

(0=no pain, 10=worst pain imaginable)

**What makes the pain worse?** _____

**What makes the the pain better?** _____

**Have you had any of the following?**

☐ MRI ☐ CT scan ☐ Bone Scan ☐ X-rays ☐ Nerve Testing ☐ Massage ☐ Physical Therapy ☐ Medications
☐Chiropractor ☐ Acupuncture ☐ Injections (Joint, Spine) ☐ Trigger Point Injections ☐ TENS Unit
☐ Traction Device ☐ Other _____

## REVIEW OF SYSTEMS

Mark any of the following symptoms that you have had during the past year.

**CONSTITUTIONAL SYMPTOMS**
- ☐ Recent weight change
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Lack of energy or fatigue
- ☐ Decreased appetite
- ☐ None of the above

**EYES**
- ☐ Eye pain or redness
- ☐ Loss of vision
- ☐ Blurred vision or double vision
- ☐ None of the above

**EARS/NOSE/MOUTH/THROAT**
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Post-nasal drip
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Bad breath
- ☐ None of the above

**CARDIOVASCULAR**
- ☐ Chest pain
- ☐ Abnormal heartbeat
- ☐ Shortness of breath with activity
- ☐ Shortness of breath when lying flat
- ☐ Swelling of feet or ankles
- ☐ None of the above

**RESPIRATORY**
- ☐ Chronic or frequent coughs
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of breath with activity
- ☐ Shortness of breath with lying down
- ☐ None of the above

**GENITOURINARY**
- ☐ Bloody urine
- ☐ Urgency of urination
- ☐ Frequent urination
- ☐ Painful or difficult urination
- ☐ Dribbling or incontinence of urine
- ☐ Numbness over groin, genitalia or buttocks
- ☐ Loss of bowel or bladder control
- ☐ Sexually transmitted disease
- ☐ Sexual difficulties
- ☐ Erectile dysfunction
- ☐ Infertility
- ☐ Kidney stones
- ☐ None of the above

**MUSCULOSKELETAL**
- ☐ Joint pain, stiffness, or swelling
- ☐ Muscle pain or cramps
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Wrist Pain
- ☐ Low back pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Foot pain
- ☐ None of the above

**SKIN/BREAST**
- ☐ Rash
- ☐ Skin sores or ulcers
- ☐ Breast pain, lump or discharge
- ☐ None of the above

**STOMACH AND INTESTINES**
- ☐ Frequent nausea or vomiting
- ☐ Bloody vomiting
- ☐ Abdominal pain
- ☐ Recurring diarrhea
- ☐ Blood in stools
- ☐ Frequent or severe constipation
- ☐ None of the above

**NEUROLOGICAL**
- ☐ Headaches
- ☐ Light headedness or dizziness
- ☐ Convulsions or seizures
- ☐ Numbness or tingling in arms or legs
- ☐ Weakness in arms or legs
- ☐ Frequent falls
- ☐ None of the above

**PSYCHIATRIC**
- ☐ Difficulty sleeping
- ☐ Memory loss or confusion
- ☐ Nervousness or anxiety
- ☐ Stress
- ☐ Depression
- ☐ None of the above

**ENDOCRINE**
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Increased thirst or urination
- ☐ None of the above

**HEME/LYMPH**
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen/painful lymph nodes

## PAST MEDICAL HISTORY

Mark any condition(s) that you have or have had previously.

☐ High blood pressure
☐ High cholesterol
☐ Abnormal heart rhythm
☐ Heart disease
☐ Asthma
☐ Emphysema
☐ Pneumonia
☐ Tuberculosis
☐ Migraine headaches
☐ Seizures

☐ Head injury
☐ Stroke or TIA
☐ Depression
☐ Fibromyalgia
☐ Drug or alcohol addiction
☐ Diabetes
☐ Thyroid problems
☐ Osteoporosis
☐ Osteoarthritis
☐ Gout
☐ Acid Reflux/GERD

☐ Irritable bowel syndrome
☐ Stomach/duodenal ulcer
☐ Gallbladder disease
☐ Liver disease
☐ Cancer, type _____
☐ Chronic use of Prednisone
☐ IV drug use
☐ HIV infection/AIDS
☐ Rotator Cuff Injury
☐ Knee Surgery
☐Low Back Pain/Sciatica

☐ Back Surgery
☐ Carpal Tunnel Syndrome
☐ Tennis Elbow
☐ Plantar Fasciitis
☐ None of the above

Please list any other illnesses, hospitalizations.
_____
_____
_____
_____
_____
_____
_____
_____

**SURGICAL HISTORY:** _____

**ALLERGIES:** List all allergies to medications_____

**CURRENT MEDICATIONS:**

| Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**FAMILY MEDICAL HISTORY: List any illnesses that run in the family. (Example: diabetes, cancer, stroke, heart problems, muscle problems, nerve problems, depression, alcoholism, etc.)**

_____

Tobacco Use? ☐ Yes ☐ No If yes, what type? _____ How frequent? _____

Alcohol Use? ☐ Yes ☐ No If yes, what type? _____ How frequent? _____

Illicit Drug Use? ☐ Yes ☐ No If yes, what type? _____ How frequent? _____

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity: ☐ Sitting ☐ Standing ☐Light Labor ☐ Heavy Labor Occupation: _____