PACIFIC SPINE & SPORTS
3 Corporate Park, Suite 168, Irvine, Ca 92606
P 949.955.2655 F 949.955.2699 pssirvine.com

Patient Intake Form
Personal Information
Date: _____ ID# (Office Use Only): _____
First, Middle & Last Name: _____
Cell#: _____ Home#: _____ Work#: _____
Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Emergency Contact Name & Phone#: _____
Employer: _____ Occupation: _____
Gender: __Female __Male Age: _____ Date of Birth: _____
Marital Status: __Single __Married Do you have children? __Yes __No Are you pregnant? __Yes __No
Referral: □ Google □ Yelp □ Health Insurance Directory □ Family □ Friend □ Doctor
If referred by a person please provide us the name: _____
If you used a search engine please provide us what you typed: _____

Patient Insurance Information
Name of party responsible for payment: _____
Relationship to patient: _____ Phone#: _____
Name of insurance company: _____
Group#: _____ ID#: _____
Is patient covered by additional health insurance? __Yes __No
Name of insurance company: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Group#: _____ ID#: _____

Patient Consent
I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately paid by me. I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of this signature below on all insurance submissions.
Patient Consent
Patient Signature: _____ Date: _____

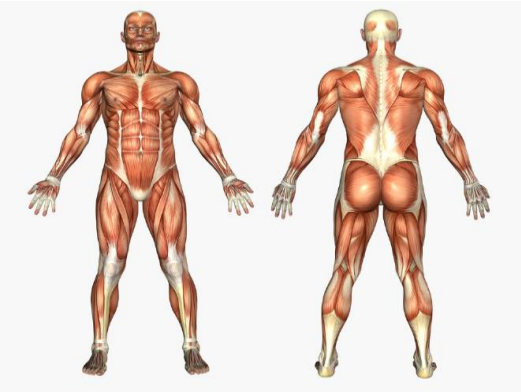
Consent of Minor Child
I, being the parent or legal guardian, hereby authorize Dr. _____ and whomever the doctor may designate as assistants to administer treatment as deemed necessary to
_____ .
Guardian Signature: _____ Date: _____
Relationship to patient: _____ Witnessed by: _____

Appointment Cancellation and No Show Policy
Your appointment time is reserved for you in advance; however, we understand that situations arise in which you must cancel your appointment. Since Pacific Spine and Sports is committed to deliver excellent service to all our patients, we request that you notify us within **24 hours prior to your appointment** which enables other people to be scheduled in that time slot.

- There will be a **$30.00 fee for all missed appointments** without a 24-hour advance notice.
- Patients who do not show up for their appointment without a call to cancel at least 24 hours in advance will be considered as a **"NO SHOW" and subject to a $65.00 fee** for that appointment.

Patient Current Condition

Have you been seen by any other doctors for this condition? If yes, please provide doctor's name and phone#.
_____
Briefly describe your major complaint and its location:
_____
How long has this condition been present? _____
Are you experiencing pain, indicate below:
__Sharp __Dull __Tingling __Burning __Throbbing __Cramp __Numbness __Stiffness __Swelling
What movements are painful to perform? __Sitting __Standing __Bending __Walking __Laying
Rate intensity from 1-10 (1=lowest and 10=highest): _____
Please circle the location currently in pain:



Patient Massage Therapy History

Massage Pressure: __Light __Medium __Deep

Areas you would like the therapist to focus on:
__Head __Neck __Shoulders __Arms __Hands __Upper Back __Mid Back __Lower Back __Legs __ Feet __Full Body

Please explain if you have any medical conditions and/or allergies.
_____

I understand that massage is given for the purpose of stress reduction, relief from muscle tension, spasm, scar tissue remodeling, pain relief, increasing blood circulation, and energy flow to restricted tissue.
____ Initial

I am aware that massage is not a substitute for medical examination or diagnoses and that it is recommended that I see a physician for any physical ailment I might have.
____ Initial

I have stated all my known medical conditions and take it upon myself to keep the massage therapist informed of any changes in my physical health.
____ Initial

Patient Medical History

Name of General Physician: _____ Phone#: _____

Have you been treated for any other conditions in the last year? __Yes __No If yes, please describe.

_____

Please list any surgeries, broken bones, injuries and/or major illnesses in the last year.

_____

Have you had any x-rays or mri taken in the last year? __Yes __No If yes, please provide location and phone#.

_____

Please list any medications you are currently taking.

_____

Please provide any family medical history.

_____

Please check all that apply to you:

___	Food allergies	___	Hypoglycemia	___	Bronchitis
___	Food intolerance	___	Cancer	___	Appendicitis
___	Constipation	___	Thyroid issues	___	Cataracts
___	Vegetarian	___	Anemia/low iron	___	Chemical dependency
___	Eating disorder	___	Depression	___	Emphysema
___	Digestive issues	___	Anxiety	___	Epilepsy
___	Fatigue	___	Frequent headache/migraine	___	Glaucoma
___	Frequent cold/flu	___	Menopause	___	Blood clots
___	High cholesterol	___	Currently pregnant	___	Hernia
___	Osteoporosis	___	Breastfeeding	___	Herniated disk
___	Overweight	___	Asthma	___	Joint/muscular/tendon pain/injury
___	Obesity	___	Lung disease	___	Tuberculosis
___	Heart disease	___	Herpes	___	Kidney disease
___	High blood pressure	___	Aids/HIV	___	Liver disease
___	Diabetes	___	Hepatitis	___	Parkinson's disease
___	Pneumonia	___	Polio	___	Stroke
___	Ulcers	___	Varicose veins	___	Tumors

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Pacific Spine & Sports, we may use or disclose personal and health related information about you in the following ways:

-Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
-Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer.
-Your name, address, phone number, email address and your health care records may be used to contact you regarding appointments to provide information about alternatives to your present care, or for other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine or text message. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Under Federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

-If we are providing health care services to you based on the orders of another health care provider.
-If we provide health care services to you in an emergency.
-If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
-If there are substantial barriers to communicating with you, but in our judgment we believe that you intend for us to provide care.
-If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or regarding the status on your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice; we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health records in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rights.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Anne Dinhluu, D.C. at 949-955-2655

If you would like further information about our privacy policies and practices please contact Dr. Anne Dinhluu, D.C. at 949-955-2655

This notice is effective as of when signed. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Signature: _____

Date: _____