

360 SPORTS, SPINE AND WELLNESS
18800 DELAWARE ST. SUITE 150, HUNTINGTON BEACH, CA 92648
OFFICE: 714-848-9319 FAX: 714-847-2310

WELCOME TO OUR OFFICE!

By completing this patient information form, you will help us to serve you more efficiently. Should you have any questions concerning our professional services or office procedures, please ask.

CONTACT INFORMATION

Date: _____/_____/_____

Name: (last) _____ (first) _____ (M.I.) _____

Street Address: _____ (apt. #) _____

(city) _____ (zip) _____

Phone: (home) (_____) _____ - _____ (cell) (_____) _____ - _____

Email address: _____@_____

Birth date: ____/____/____ Age: ____ Sex: ____ Drivers license#: _____

Married? Yes No Social Security Number: ____-____-____

Primary care physician: _____ Phone: (_____) _____ - _____

Emergency contact: _____ Phone: (_____) _____ - _____

Referred by: _____ Phone: (_____) _____ - _____

EMPLOYMENT INFORMATION / STUDENT INFORMATION

Employer: _____ Phone: (_____) _____ - _____

Job Title: _____

If student, school name: _____ Year in school: _____

INSURANCE INFORMATION

Please fill out the following insurance information to the best of your knowledge.

Name of Primary Medical Insurance: _____ Type: PPO HMO EPO

Name of Insured: _____ Relationship: _____

If name of insured is not you, please give their social security number: ____-____-____

Policy Number: _____ Group: _____

Name of Secondary Medical Insurance: _____ Type: PPO HMO EPO

Name of Insured: _____ Relationship: _____

If name of insured is not you, please give their social security number: ____-____-____

Policy Number: _____ Group: _____

MEDICAL HISTORY

ALLERGIES: (Please list all allergies, medicines, latex, food, etc.)

Are you currently taking any medications? Yes No

 If Yes, please list **ALL** medications:

Do you now have/or have you ever had any of the following conditions (Please circle):

Alcoholism	Yes	No	Gout	Yes	No
Anemia	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Kidney Disease	Yes	No
Edema (swelling)	Yes	No	Liver Disease	Yes	No
Bleeding Disorder	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Anxiety	Yes	No
Emphysema	Yes	No	Migraine Headaches	Yes	No
Epilepsy	Yes	No	Pacemaker	Yes	No
Glaucoma	Yes	No	Stomach Ulcers	Yes	No
Drug Abuse	Yes	No	Sleep Apnea	Yes	No
Asthma	Yes	No	Stroke	Yes	No
Heart attack	Yes	No	Tuberculosis	Yes	No
HIV/AIDS	Yes	No	Hepatitis A, B or C	Yes	No
High cholesterol	Yes	No	Cancer	Yes	No

 If Yes, what type and what treatment was given:

List any other diagnoses not listed above? _____

Female Patients

Are you pregnant? Yes No Date of last period: ____/____/____

SURGICAL HISTORY

Please list all surgeries and approximate dates:

FAMILY HISTORY

Have your close relatives (parent, siblings, grandparents, or children) had any of the following?

	<u>Circle</u>	<u>Family Member</u>		<u>Circle</u>	<u>Family Member</u>
Heart attack, angina	Yes	No _____	Osteoporosis	Yes	No _____
Seizures/Epilepsy	Yes	No _____	Anemia	Yes	No _____
High cholesterol	Yes	No _____	HIV/AIDS	Yes	No _____
Thyroid Disease	Yes	No _____	Stroke	Yes	No _____
Breast Cancer	Yes	No _____	Kidney Disease	Yes	No _____
Other Cancer? Type: _____	Yes	No _____	Diabetes	Yes	No _____

INJURY HISTORY

Please complete this page to the best of your knowledge. Please include ALL pertinent information regarding the injury you are currently seeking treatment for, as well as any past injuries or surgeries.

Are you right handed, left handed or ambidextrous? RIGHT LEFT AMBIDEXTROUS

Area(s) to be treated: _____

When did your symptoms begin: _____

Describe how the injury occurred:

Have you had previous treatment for this problem? (i.e. Physical therapy, injections) Yes No

<u>Type of treatment</u>	<u># of Treatments</u>	<u>Helped/Did not help</u>
Acupuncture		
Physical Therapy		
Chiropractic Care		
Massage Therapy		
Injections		
Other: _____		

Have you had any diagnostic workup for this problem? (i.e. MRI, EMG nerve study) Yes No

If Yes, what did workup reveal? _____

Have you had surgery related to this condition? Yes No

If Yes, please list Doctor, date, and type of surgery: _____

What makes your pain worse?

What makes your pain better?

Any weakness in the upper or lower extremities? Yes No

If Yes, where? _____

Any numbness or tingling in the upper or lower extremities? Yes No

If Yes, where? _____

Any recent fevers or night sweats? If Yes, explain:

Any changes in your bowel or bladder habits? If Yes, describe:

Pain Evaluation

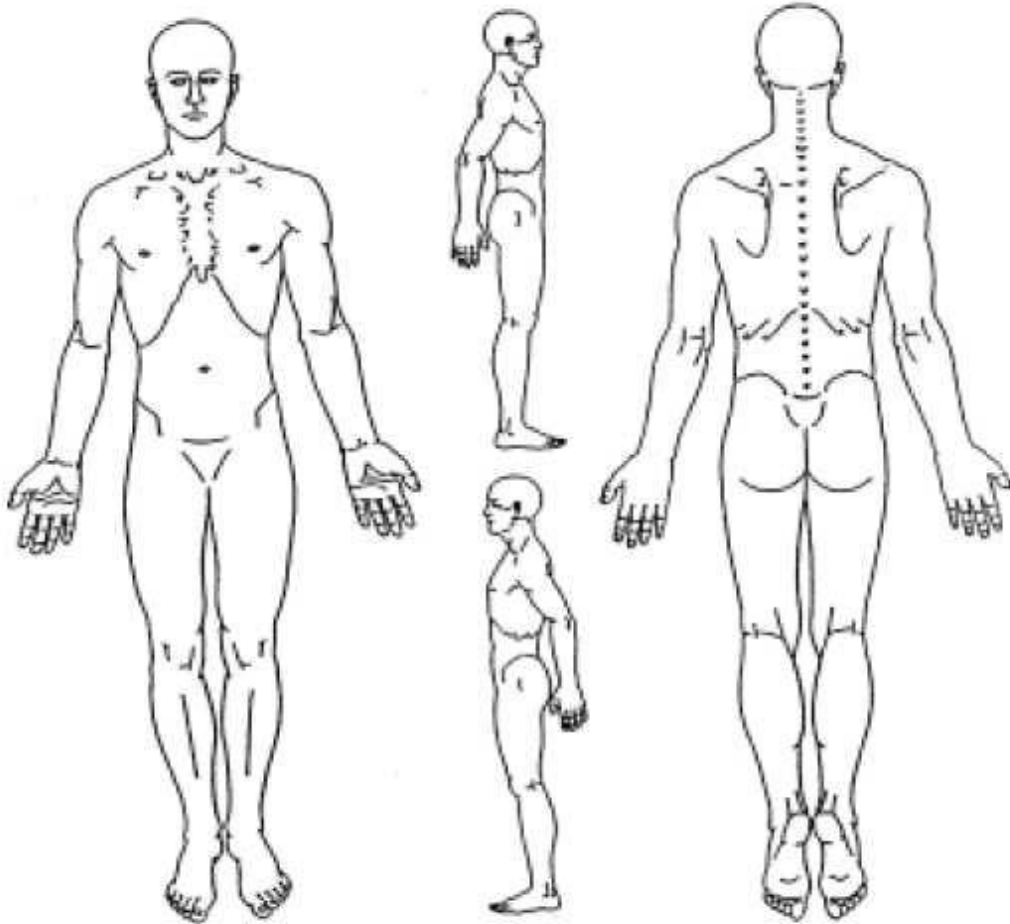
Please rate your pain **today** on the following numeric scale by **circling** the number which best describes your pain level.

0 1 2 3 4 5 6 7 8 9 10
 No pain Emergency

At best my pain is ___/10.

At worst my pain is ___/10.

Indicate your symptoms on the body diagrams using symbols in the key below:



Key

///// Stabbing

XXXX Ache

000 Pins & Needles

===== Numbness

Patients Name: _____

Patients Signature: _____ Date: ____/____/____

Physician Signature _____ Date: ____/____/____

Welcome to 360 Sports, Spine and Wellness! We are committed to serving your health care needs with dedication, professionalism, and compassion. Your understanding of our financial policy is important to our professional relationship. Please be advised of the following:

Office Policy and Payment Terms

Payment of co-payments, anticipated co-insurance, and deductibles will be collected in full and is due at the time services are rendered. For your convenience, 360 Sports, Spine and Wellness accepts Visa, MasterCard, American Express, Discover, Cash, and Check. It is the responsibility of the patient/member to verify that our office is affiliated with their insurance carrier or PPO prior to services being rendered. Also, it is the responsibility of the patient/member to understand their benefits and any plan restrictions or plan limitations. Please contact your insurance carrier directly for questions regarding your plan's benefits and any limitations therein.

We will provide you with an itemized statement of services or insurance claim form upon request. As a courtesy, choosing joy, inc. does provide insurance billing services. However, accounts not resolved within ninety (90) days from the date services were rendered, may be referred to any outside collection agency.

I, the undersigned, understand and agree to the above office policy and understand my participation and financial responsibility.

Patient Signature

Date

If patient is a minor:

Parent/Guardian Signature

Date

Payment Responsibility Form

Dear Patient:

360 Sports, Spine, and Wellness is committed to providing you with the best possible care. Your understanding of our financial policy is important to our professional relationship. Please be advised of the following:

Any and all co-payments, deductibles and co-insurance are due and payable at time of services. Professional services are charged to the patient. As a courtesy to you, we will complete necessary forms to help expedite insurance carrier payments, however, the patient is ultimately responsible for all fees, regardless of insurance coverage.

(initial)

Collection measures: Accounts not resolved within sixty (60) days may be referred to an outside agency for further follow up.

(initial)

Assignment of Insurance Benefits and Private Insurance Waiver

1. I hereby authorize payment directly to 360 Sports, Spine, and Wellness of benefits due me for services rendered. I also hereby authorize 360 Sports, Spine, and Wellness to furnish information to my insurance carrier as necessary to secure payment of benefits, and hereby assign to 360 Sports, Spine, and Wellness any and all payments for services rendered.
2. I further agree that a photocopy of this agreement shall be as valid as the original.
3. I understand in the event any check or credit card payment is not honored by my bank or financial institution that I will be charged a service fee of \$25.00, and I will be responsible to make immediate restitution to my account balance. I understand that subsequent visits may be on a cash basis only.
4. I understand that if my insurance carrier refuses to pay and/or process my claims or denies to authorize medical treatment for services rendered, that I will be financially responsible for the charges incurred at this facility.

Patient Name: _____

Patient Signature: _____ Date: ____/____/____

Disclosure Statement and Consent for Medical Treatment

This information is true and correct to the best of my knowledge. I hereby consent to and authorize the administration of all treatments that may be considered advisable or necessary in the judgment of the physician/therapist and I authorize this medical clinic and the physician/therapist to furnish information to the insurance carriers of this treatment. I also agree to any and all medical examinations, diagnostic and therapeutic recommendations as ordered or viewed as medically necessary per the Doctors and Associates at choosing joy, inc.

Patient/Guardian: _____ Date: ____/____/____

Relationship of other responsible party: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

General Permission for Release of Medical Records

I _____ am hereby authorizing choosing joy, inc. direct access to my medical records, history's, laboratory results, etc., if available, per this request. I understand the medical confidentiality still prevails for both parties. I am also authorizing choosing joy, inc. to provide release of necessary documentation to myself and my insurance carrier in order to secure payment of claims for services rendered. I am also authorizing choosing joy, inc. to provide release of necessary documentation to my insurance adjustor, and/or attorney if applicable.

Patient Signature: _____ Date: ____/____/____

Important 360 Sports, Spine, and Wellness. Policies

Patient Responsibility Payment Extensions

All co-payment, co-insurance, or deductible payments must be paid at the time of your treatment. Any other arrangements must be made in person with the medical director.

Initial_____

24-Hour Advance Notice

If you wish to cancel an appointment, we require a minimum 24-hour advance notice. Anything less than that will result in a \$50 fee applied to your account. In the event of an emergency or other such extenuating circumstances, please notify the office staff immediately to make the appropriate arrangements regarding your appointment.

Initial_____

Late Policy

Being late by more than 15 minutes may require your session to be modified at the discretion of the staff. In the event of extenuating circumstances, please notify the office staff immediately that you are running late so that the best course of action can be determined.

Initial_____

No-Shows

If you fail to show for 3 appointments without prior notice to the office staff, all further appointments you have scheduled will be removed. You may contact us and reschedule appointments on a “first come, first serve” basis, but it will not be guaranteed.

Initial_____

Patient contact information

In order to maintain constant communication, please make sure to provide a valid phone number and email address on the first page of the paperwork so that reminders can be sent regarding appointment dates and times. If you do not wish to receive reminders please inform the office staff at the time of your initial appointment.

Initial_____

I have carefully read and agree to all the above policies. In the event such policies are broken, I agree to the consequences set forth.

Patient Signature: _____ Date: ____/____/____