Welcome to Harbor Comprehensive Health

Patient Information

Date: ______________________________

Name: ____
Last First M.I.

Email address: ____

Address: ______________________ City: ______________ State: ________ Zip: __________

Phone # (H)____________________ (W) __________________ (C) ________________

Can we call you at work? ❑ Yes ❑ No Date of Birth:________________ Sex: ❑ Male ❑ Female

SS#: ____________ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

Occupation: ________________________ Employer: __________________________

Employer Address: ______________________________ Phone: ________________

How did you hear about our practice? ____

Emergency contact: Name: ______________ Relation: __________ Phone #: ________________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other ________

Has it been reported? ❑ Yes ❑ No If yes, to whom? ______________________________

Financial Information

Name of person responsible for this account: ______________________________________

Relationship to patient (if other than self): ____________________ Phone # ____________________

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: __________________________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: __________________________

Health History

Reason for today's visit ____________________ When did you first notice your symptoms? ____________

Is the condition getting progressively worse? ____

Where specifically is/are the problem(s) located? ____

Rate the severity of your pain (1 for mild/discomfort to 10 for severe): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ____

What treatment have you received for your condition:

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ Other:________________________

Name and contact information of other doctor(s) who have treated you for this condition:____________________

____

Please check to indicate if you are currently experiencing any of the following conditions:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Other ______________________________
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain ______________________________

Please list any medications you are currently taking: ______________________________

____

Please list any surgeries and/or hospitalizations you have had (type & date): ______________________________

____

____

Please list any allergies: ______________________________

Please list any supplements you are currently taking (vitamins/herbs/minerals): ______________________________

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

❑ Heart Disease ________________ ❑ Diabetes ________________
❑ Cancer ________________ ❑ Arthritis ________________ ❑ Other ________________

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following?

Caffeine __________ cups/day Alcohol ________ drinks/week Cigarettes ______ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I understand that I am financially responsible for all charges whether or not paid by insurance. Harbor Comprehensive Health may use my healthcare information and may disclose such information to your insurance company or lawyer and their agents for the purpose of obtaining payment for services and determining benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE ______________________________ DATE ________________

NEUROLOGICAL / MRI / VASCULAR PATIENT QUESTIONNAIRE

NAME: ______________________________ DATE: __________

For any YES answer, please explain under comment and notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: ______________________________
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: ______________________________
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: ______________________________
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: ______________________________
5. Do you suffer from cold hands/feet? NO YES
   Comment:______________________________
6. Do you suffer from skin discoloration, loss of hair, wounds that don’t heal? NO YES
   Comment:______________________________
7. Do you suffer from a loss of handgrip strength? NO YES
   Comment: ______________________________
8. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: ______________________________
9. Do you have weakness, numbness or burning in our buttocks, legs or feet? NO YES
   Comment: ______________________________
10. Do your legs or feet fall asleep regularly? NO YES
    Comment: ______________________________
11. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
    Comment: ______________________________
12. Have you tried any medications such as anti-inflammatory? NO YES
    Comment: ______________________________
13. Have you tried any physical therapy or chiropractic treatments before? NO YES
    Comment: ______________________________
14. Have you had an MRI/ NCV/ Vascular Test? When? (within the last year?) NO YES
    Comment: ______________________________
15. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    Comment: ______________________________
16. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: ______________________________

Notice: your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information in this form may be shared with Medicare. Your health information that Medicare sees will be kept confidential with Medicare.

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare. If known or to learn through health care procedures from whatever he/she is suffering from latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities whether related to the prescribed care otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing

____ ____________________

Patient's Signature Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ____

Check all that apply:

___ There is no possibility that I may be pregnant at this time

___ Yes, I am definitely pregnant

___ No, I am definitely not pregnant at this time

___ I request that x-ray films not be taken because _________________

____

____

Date of last menstrual period______________________

___________________________________ _____________________

Patient's Signature Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Harbor Comprehensive Health
803 Figueroa Street
Wilmington, CA 90744
Phone : (310) 864-6003

Date: ____________

Patient: Claim

Group: SSMD#:

I hereby instruct and direct the ____

Insurance Company to pay by check made out and mailed directly to:

Harbor Comprehensive Health
803 Figueroa Street
Wilmington ,CA 90744
Phone: 310-830-0863

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

See Above Address

For the professional expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at Harbor Com Health this ____________day of _________20 _____

Signature of Policy Holder   Signature of member if other than Policy Holder