



PACIFIC SPINE & SPORTS

3 Corporate Park, Suite 168, Irvine, Ca 92606

P 949.955.2655 F 949.955.2699 pssirvine.com

Patient Information

Date: _____ ID# (Office Use Only): _____

Name (First, Middle & Last): _____

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: _____ ID#: _____

Is patient covered by additional health insurance? Yes No

Name of 2nd insurance company: _____ ID#: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

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's Signature: _____ **Date:** _____

Consent of Minor Child

I, being the parent or legal guardian, hereby authorize Pacific Spine & Sports to administer treatment as deemed necessary to (Minor's Name) _____.

Guardian's 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.

I have read and understand the Appointment Cancellation and No Show Policy _____ **(Patient's Initials)**



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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? _____

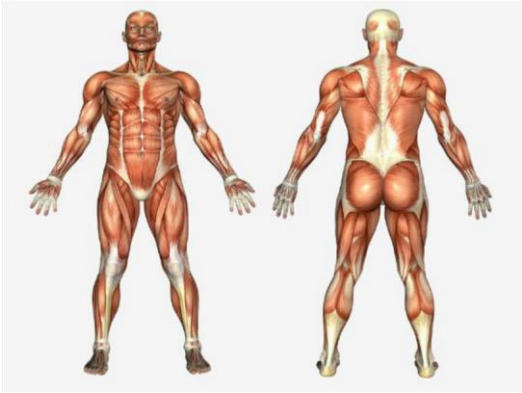
Are you experiencing pain, indicate below:

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. _____ Initials

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.

_____ Initials

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.

_____ Initials



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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's 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:

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

Check here if none of the above apply: _____



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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.

Furthermore, 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 Dinhlou, D.C. at 949-955-2655. If you would like further information about our privacy policies and practices please call 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: _____