

Patient Information

Name: _____
 Last First MI Preferred/Nickname Maiden
 Prefix(circle) Dr. Mr. Ms. Mrs. Miss Sex(circle) Female Male DOB: __/__/__ Age _____
 Street Address: _____ City: _____ State: ____ Zip: _____
 2nd/Seasonal Address: _____ City: _____ State: ____ Zip: _____
 Home phone: () ____ - ____ Work phone: () ____ - ____ Cell phone: () ____ - ____
 Marital Status(circle) Single Married Divorced Widowed Social Security Number: ____ - ____ - ____
 Primary Language(circle) English Spanish Other: _____
 Pharmacy Name: _____
 Pharmacy Phone: () _____
 Emergency Contact Name: _____
 Emergency Contact Phone: () ____ - ____ When did your pain first start? _____
 Primary Care Physician: _____ Phone: () ____ - ____

How did you hear about us? (circle)		
Newspaper	Magazine	Online
Flier/Brochure	Lecture	Friend
Yellow Pages	Physician	
Other: _____		

Responsible Party/Insurance Information

Primary Ins Name: _____	Secondary Ins Name: _____
Ins Address _____	Ins Address _____
Ins Phone: () ____ - ____	Ins Phone: () ____ - ____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Cardholder's Name: _____	Cardholder's Name: _____
DOB: __/__/__ SS#: ____ - ____ - ____	DOB: __/__/__ SS#: ____ - ____ - ____
Relation to Patient: _____	Relation to Patient: _____
Employer: _____	Occupation: _____
Employer Address: _____	Phone: () ____ - ____

If this is a job related injury, is this the employer you were working for at the time? _____
 If due to an injury, date of loss: __/__/__ First symptoms: _____

Will an attorney or Liability Carrier be involved in payment of charges? (circle) YES NO

If YES, please explain: _____

Is injury related to: (circle) Accident Auto Accident Job Related Other

If Job related: claim # _____ Case Manager _____ Phone() ____ - ____

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that while The CORE Institute® contracts with many insurance companies, it is my responsibility to verify with my plan that The CORE Institute® is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that The CORE Institute will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize The CORE Institute® to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guidelines.

Patient/Representative Name(print) _____

Signature _____

Date __/__/__



NEW PATIENT HISTORY FORM

Date (today): _____

Patient Name: _____

Date of Birth: _____ Age: _____

Referred by: self Follow-up ER visit Physician: _____

Reason for Visit: _____

MEDICAL HISTORY

Please include any medical conditions you have been treated for: None apply

- | | |
|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> History of steroid use | <input type="checkbox"/> History of blood clots |
| <input type="checkbox"/> Cancer (type) _____ | |
| <input type="checkbox"/> Other: _____ | |

SURGICAL HISTORY/ HOSPITALIZATION

Please list any previous surgeries or hospitalizations including dates: None

FAMILY HISTORY

Please include any family history that may apply: None apply

- | | <u>Family Member</u> | | <u>Family Member</u> |
|--|----------------------|--|----------------------|
| <input type="checkbox"/> Bone disease | _____ | <input type="checkbox"/> Rheumatoid arthritis | _____ |
| <input type="checkbox"/> Heart disease | _____ | <input type="checkbox"/> Lung Problems | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Cancer (type) | _____ |
| <input type="checkbox"/> Stroke | _____ | <input type="checkbox"/> Problems w/Anesthesia | _____ |

SOCIAL HISTORY

Please complete the following:

Marital status (circle): Married Single Divorced Widowed

Occupation (current or previous): _____

Do you have a history of **smoking**? If **yes**, how much and for how long? _____

Do you consume alcohol? _____ If yes, how often? _____

MEDICATIONS (please attach list if available) please include dosage and frequency

VITAMINS/SUPPLEMENTS (please attach list if available)

Patient Name _____

ALLERGIES

Please list any allergies to medications, food or environment: None

REVIEW OF SYSTEMS

Please mark if you are experiencing any of the following symptoms:

Constitutional

- Fevers
- Chills
- Night sweats
- Weight loss or gain

Head, Ears, Nose, Throat

- Headaches
- Light-headedness

Respiratory

- Shortness of breath
- Wheezing
- Coughing up blood

Genitourinary

- Difficulty with urinary void
- Incontinence
- Blood in urine
- Change in urinary symptoms
- Possible pregnancy

Integument

- Skin rash
- Skin lesions

Musculoskeletal

- Muscle weakness
- Joint pain
- Joint swelling

Endocrine

- Increased urination
- Hair Loss

Hematological/Lymphatic

- Easy bruising
- Bleeding disorder
- Other:

Eyes

- Change in vision

Cardiovascular

- Chest Pain
- Racing heart beat
- Feeling faint or dizzy
- Varicose veins
- Swelling in legs
- DVT (Blood Clot)

Gastrointestinal

- Nausea or vomiting
- Change in bowel habits
- Blood in stool
- Heartburn

Neurological

- Numbness in extremities
- Tingling in extremities
- Loss of balance
- Progressive weakness
- Shooting pains
- Difficulty walking

Psychiatric

- Difficulty sleeping
- Depression
- Anxiety

Allergy/Immunologic

- Sinus Allergies

Please check this box if you do not have any of the issues listed above.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of The CORE Institute®, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement.

Signature of Patient/Patient's Representative

Date

Printed Name of Patient/Patient's Representative

FOR OFFICIAL USE ONLY

I, _____, made a good faith effort to obtain written acknowledgement of _____'s receipt of the Notice of Privacy Practices of The CORE Institute®. I was unable to obtain written acknowledgement because:

- Individual refused to sign this acknowledgement
- A communication barrier prohibited obtaining signed acknowledgement
- An emergency situation prevented obtaining signed acknowledgement
- Other(please specify): _____

Employee Signature

Date

