CADUCEUS
MEDICAL GROUP

**Please PRINT and complete all sections below**

# PATIENT REGISTRATION INFORMATION

| Insurance cards copied ☐ | Account #: | Insurance: | Copayment: $ |
|---|---|---|---|

Is patient's condition a result of an auto accident? YES ☐ NO ☐ Date of Injury _____

## PATIENT'S PERSONAL INFORMATION

Name _____ (Last) _____ (First) _____ (MI) Age _____ Date of Birth _____

☐ M or ☐ F Language Spoken: ☐ English ☐ Spanish ☐ Other _____ Social Security # _____

Address _____ Apt# _____ City _____ Zip _____

Preferred method of contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ E-mail

Cell Phone _____ Approval to leave message? ☐ Y ☐ N

Home Phone _____ Approval to leave message? ☐ Y ☐ N

Work Phone _____ Approval to leave message? ☐ Y ☐ N

E-mail Address _____ Approval to leave message? ☐ Y ☐ N

## FINANCIALLY RESPONSIBLE PARTY INFORMATION

Financially Responsible Party _____ Relationship to Patient: ☐ Mother ☐ Father Other _____

Date of Birth _____ CA Driver's License _____ Social Security # _____

Responsible Party's Home Phone _____ Work Phone _____

Address _____ Apt# _____ City _____ Zip _____ E-mail _____

Employer _____ Phone _____ Responsible Party's Occupation _____

Address _____ Suite# _____ City _____ Zip _____

Preferred method of contact: ☐ Cell ☐ Home ☐ Work Approval to leave message or email? ☐ Y ☐ N

## PATIENT'S INSURANCE INFORMATION AND ELIGIBILITY GUARANTEE

**Primary Insurance Company Name** _____ Subscriber (if other than patient) _____

Insured's Relation to Patient _____ Date of Birth _____ Subscriber S.S. # _____

Group # _____ Insurance ID# _____

Insurance Billing Address _____ City _____ Zip _____

**Secondary Insurance Company Name** _____ Subscriber (if other than patient) _____

Insurance ID # _____ Group # _____ Insured's Relation to Patient _____ Date of Birth _____

Insurance Billing Address _____ Suite# _____ City _____ Zip _____

**HMO**

Medical Group/IPA _____ PCP _____

Effective Date _____ Copayment _____

Eligibility verified ☐ online or ☐ telephone call

Name of health plan representative _____

**PPO**

Effective Date _____ Copayment _____

Coinsurance amount _____ % Deductible _____

Deductible amount met _____

I understand that if the information provided above is incorrect or if the patient is not eligible under the stated insurance program or health plan, that I am liable for the charges incurred for services rendered. Additionally, I am liable for charges for services rendered which are considered not medically necessary; are considered cosmetic or not otherwise covered by the stated insurance program or health plan; and services which are not authorized in accordance with my health plan and/or medical group. In such instance, I agree to pay in full for all services rendered and shall do so within thirty days after receipt of invoice from the above-noted medical group or physician.

_____ Signature

_____ Office Personnel Verifying

_____ Date

CADUCEUS
MEDICAL GROUP

**Please PRINT and complete all sections below**

# PATIENT REGISTRATION INFORMATION

## PATIENT'S REFERRAL INFORMATION

Referred by: _____ If referred by a friend, may we thank her or him? ☐ Yes ☐ No

Name(s) of other physician(s) who care for you: _____

_____

_____

## EMERGENCY CONTACT INFORMATION

Name of person _____ Relationship _____

Address _____ City _____ Zip _____

Best number to contact this person _____ Alternate phone number _____

## MEDICAL CONSENT

The undersigned consents to any x-ray examination, anesthesia, laboratory procedure, medical and surgical treatment or hospital service rendered the patient under the general supervision of, or upon the advice of a physician.

### Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Caduceus Medical Group and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance carrier. In the event of default, I agree to pay all costs of collection and reasonably attorney's fees in conjunction with such collection efforts. I hereby authorize Caduceus Medical Group and its agents to release all information necessary to secure the payment for services required. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Signature Date

# HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

| | | |
|---|---|---|
| Measles | No | Yes |
| Mumps | No | Yes |
| Chickenpox | No | Yes |
| Diabetes | No | Yes |
| Strokes | No | Yes |
| Cancer | No | Yes |
| Rheumatic fever or heart disease | No | Yes |
| Tuberculosis | No | Yes |
| Venereal disease | No | Yes |
| Congenital Abnormalities | No | Yes |
| Other serious diseases: _____ | No | Yes |

Adult:

| | | |
|---|---|---|
| Have you had any serious illness? | No | Yes |
| Have you ever been hospitalized or been under medical care for very long? | No | Yes |

If yes, for what reason? _____

Operations:

Have you had any surgery? . . . . . No Yes

List _____

Injuries:

| | | |
|---|---|---|
| Have you had any broken bones? | No | Yes |
| Have you had any head concussions or injuries? | No | Yes |
| Have you ever been knocked unconscious? | No | Yes |

| FAMILY HISTORY: | If Living: Age | Health | If Deceased: Age (at death) & Cause | | Has any blood relative ever had: | | |
|---|---|---|---|---|---|---|---|
| Father | | | | | Cancer | No | Yes |
| Mother | | | | | Tuberculosis | No | Yes |
| Brother/Sister | | | | | Diabetes | No | Yes |
| | | | | | Heart Trouble | No | Yes |
| | | | | | High blood pressure | No | Yes |
| Husband/Wife | | | | | Stroke | No | Yes |
| Son/Daughter | | | | | Convulsions | No | Yes |
| | | | | | Suicide | No | Yes |
| | | | | | Insanity | No | Yes |
| | | | | | Bleeding tendency | No | Yes |
| | | | | | Gout or other arthritis | No | Yes |

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed

| | | |
|---|---|---|
| Are you living with your husband or wife? | No | Yes |
| Is your sex life satisfactory? | No | Yes |
| Do you have dependents at home? | No | Yes |

Alcoholic Beverages: Never _____ Rarely _____ Moderately _____ Daily _____ Ever? _____ . . . . . No Yes

Tobacco: Cigarettes _____ Packs a day _____ Don't Smoke _____ Ever smoked? _____ . . . . . No Yes

Are you employed? Full Time _____ Part Time _____

What is your job? _____

Are you exposed to fumes, dusts or solvents? _____

Education: (Years)

| | |
|---|---|
| Grade School | _____ |
| High School | _____ |
| College | _____ |
| Postgraduate | _____ |

How much time have you lost from work because of your health during the past?

| | |
|---|---|
| Six Months | _____ |
| One Year | _____ |
| Five Years | _____ |

SYSTEMIC REVIEW: Do you have any of the following?

General:

| | | |
|---|---|---|
| Recent weight change? | No | Yes |
| Have you been in good general health most of your life? | No | Yes |

Skin:

| | | |
|---|---|---|
| Skin Disease | No | Yes |
| Jaundice | No | Yes |
| Hives, eczema or rash | No | Yes |
| Frequent infection or boils | No | Yes |
| Abnormal pigmentation | No | Yes |

Head-Eyes-Ears-Nose-Throat:

| | | |
|---|---|---|
| Eye disease or injury | No | Yes |
| Do you wear glasses? | No | Yes |
| Double vision | No | Yes |
| Headaches | No | Yes |
| Glaucoma | No | Yes |
| Itching eyes or nose | No | Yes |

Head-Eyes-Ears-Nose-Throat (cont'd)

| | | |
|---|---|---|
| Sneezing or runny nose | No | Yes |
| Nosebleeds | No | Yes |
| Chronic sinus trouble | No | Yes |
| Ear disease | No | Yes |
| Impaired hearing | No | Yes |
| Dizziness or transient episodes of unconsciousness | No | Yes |

Neck:

| | | |
|---|---|---|
| Stiffness | No | Yes |
| Thyroid trouble | No | Yes |
| Enlarged glands | No | Yes |

Respiratory:

| | | |
|---|---|---|
| URI (cold) now | No | Yes |
| Spitting up blood | No | Yes |
| Chronic or frequent cough | No | Yes |

SYSTEMIC REVIEW:

Respiratory (Cont'd)

| | | |
|---|---|---|
| Asthma or Wheezing | No | Yes |
| Difficulty breathing | No | Yes |
| Any trouble with lungs | No | Yes |
| Pleurisy or Pneumonia | No | Yes |

Cardiovascular:

| | | |
|---|---|---|
| Chest pain or angina pectoris | No | Yes |
| Shortness of breath with walking or lying down | No | Yes |
| Difficulty walking two blocks | No | Yes |
| Heart trouble or heart attacks | No | Yes |
| High blood pressure | No | Yes |
| Swelling of hands, feet or ankles | No | Yes |
| Awakening in the night smothering | No | Yes |
| Heart murmur | No | Yes |

Gastrointestinal:

| | | |
|---|---|---|
| Peptic ulcer (stomach or duodenal) | No | Yes |
| Vomiting blood or food | No | Yes |
| Gallbladder disease | No | Yes |
| Liver trouble | No | Yes |
| Hepatitis | No | Yes |
| Painful bowel movements | No | Yes |
| Bleeding with bowel movements | No | Yes |
| Black stools | No | Yes |
| Hemorrhoids or piles | No | Yes |
| Recent change in bowel habits | No | Yes |
| Frequent diarrhea | No | Yes |
| Heartburn or indigestion | No | Yes |
| Cramping or pain in the abdomen | No | Yes |
| Does food stick in throat | No | Yes |

Genitourinary

| | | |
|---|---|---|
| Loss of urine | No | Yes |
| Frequent urination | No | Yes |
| Night time urinating | No | Yes |
| Burning or painful urination | No | Yes |
| Blood in urine | No | Yes |
| Kidney trouble | No | Yes |
| Kidney stones | No | Yes |
| Bright's Disease | No | Yes |

Gynecological

Age periods started _____

How long do periods last? _____ Days

Gynecological (cont'd)

Number of pregnancies _____

Number of miscarriages _____

Date of last cancer smear and results _____

_____

Frequency of periods, every _____ days.

| | | |
|---|---|---|
| Any pain with your periods | No | Yes |

Number of children _____ Ages _____

Date of first day of last period _____

Locomotor-Musculoskeletal:

| | | |
|---|---|---|
| Varicose veins | No | Yes |
| Weakness of muscles or joints | No | Yes |
| Any difficulty in walking | No | Yes |
| Any pain in calves or buttocks on walking relieved by rest | No | Yes |

Neuro-Psychiatric:

| | | |
|---|---|---|
| Have you ever had psychiatric care? | No | Yes |
| Have you been advised to see a psychiatrist? | No | Yes |
| Do you ever have, or have had, fainting spells? | No | Yes |
| Convulsions | No | Yes |
| Paralysis | No | Yes |

Hematologic:

| | | |
|---|---|---|
| Are you slow to heal after cuts | No | Yes |
| Blood disease | No | Yes |
| Anemia | No | Yes |
| Phlebitis | No | Yes |
| Have you had difficulty with bleeding excessively after tooth extraction or surgery? | No | Yes |
| Have you had abnormal bruising or bleeding? | No | Yes |

Allergic:

| | | |
|---|---|---|
| Any allergies, including medication | No | Yes |

Endocrine

| | | |
|---|---|---|
| Thyroid disease | No | Yes |
| Hormone therapy | No | Yes |
| Any change in hat or glove size | No | Yes |
| Any change in hair growth | No | Yes |
| Have you become colder than before - or skin become dryer | No | Yes |

HEIGHT _____

WEIGHT _____

## ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

| | Circle One | | | What Drug or Food? |
|---|---|---|---|---|
| Penicillin or other antibiotics | Yes | No | Don't know | _____ |
| Morphine, Codeine, Demerol or other narcotics | Yes | No | Don't know | _____ |
| Novocain or other anesthetics | Yes | No | Don't know | _____ |
| Aspirin, empirin or other pain remedies | Yes | No | Don't know | _____ |
| Sulfa drugs | Yes | No | Don't know | _____ |
| Tetanus antitoxin or other serums | Yes | No | Don't know | _____ |
| Adhesive tape | Yes | No | Don't know | _____ |
| Iodine or merthiolate | Yes | No | Don't know | _____ |
| Any other drug or medication | Yes | No | Don't know | _____ |
| Any foods, such as egg, milk or chocolate | Yes | No | Don't know | _____ |

2. Drugs Recently Taken: Within the past six months has patient taken:

| | | | |
|---|---|---|---|
| Cortisone | Yes | No | Don't know |
| ACTH | Yes | No | Don't know |
| Anticoagulants | Yes | No | Don't know |
| Tranquilizers | Yes | No | Don't know |
| Hypotensives (high blood pressure medicines) | Yes | No | Don't know |
| Has the patient ever received treatment for: | | | |
| Asthma, rheumatism or rheumatic fever? | Yes | No | Don't know |
| Aspirin | Yes | No | Don't know |

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Doctor _____ Date _____ Signature of patient _____

CADUCEUS
MEDICAL GROUP

Name: _____

D.O.B. _____

Who is your primary care physician/family doctor?

_____

*Office Use Only*

Blood Pressure: _____
Heart Rate: _____
Temperature: _____
Weight: _____

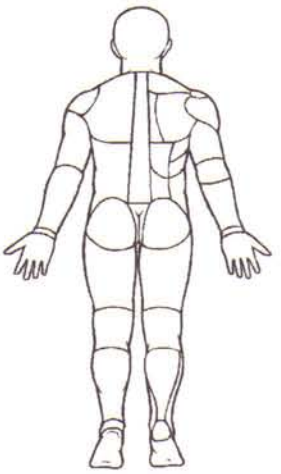
What is the major reason you are coming to see the doctor (chief complaint):

_____

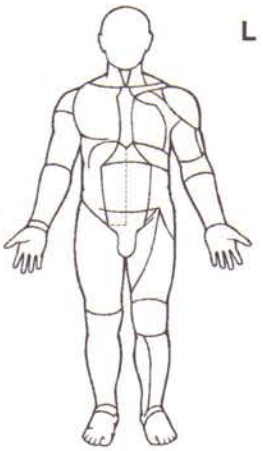
_____

_____

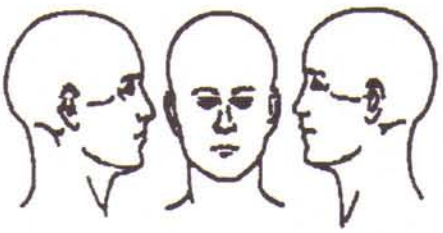
**Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.**



R



L



**How long does the pain last?**

☐ Constant ☐ Intermittent

**Quality Of Pain:**

Please mark all that apply:

| | | | | |
|---|---|---|---|---|
| ( ) Throbbing | ( ) Cramping | ( ) Gnawing | ( ) Aching | ( ) Shooting |
| ( ) Stabbing | ( ) Sharp | ( ) Hot-burning | ( ) Heavy | ( ) Tender |
| ( ) Splitting | ( ) Sickening | ( ) Tiring-Exhausting | ( ) Fearful | |
| ( ) Punishing-Cruel | ( ) Other_____ | | | |

**Intensity of Pain:**
On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain, how would you rate your pain?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| At Worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At Best: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Average: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**What makes your pain worse?** Mark all that apply.
( ) Bending ( ) Lifting ( ) Coughing ( ) Sneezing
( ) Defecation ( ) Prolonged Sitting ( ) Walking ( ) Prolonged Standing
( ) Other, please explain _____

**What makes your pain better?** Mark all that apply.
( ) Rest ( ) Activity/physical therapy ( ) Massage ( ) Heat
( ) Cold ( ) Lying in a fetal position ( ) Lying on your back
( ) Lying on back w/ pillows under your legs ( ) Medication, please list _____
( ) Other, please explain _____

**Which of the following tests have you undergone prior to your arrival here today?**
( ) X-rays ( ) CAT scan ( ) MRI scan ( ) EMG test
( ) Discogram ( ) Myelogram

## REVIEW OF SYSTEMS

*Please place a checkmark if you currently have any of the following symptoms. (Disregard the bold headings)*

**• Constitutional**
( ) No Problems ( ) Fever ( ) Weight Loss ( ) Fatigue

**• Cardiovascular**
( ) No Problems ( ) Chest Pain/Angina ( ) Irregular Heart Beat ( ) Fainting
( ) Limb Swelling ( ) Limb Pain on Walking

**• Genitourinary**
( ) No Problems ( ) Incontinence ( ) Pain on Urination ( ) Blood in Urine

**• Musculoskeletal**
( ) No Problems ( ) Muscle Pain ( ) Muscle Cramp ( ) Neck Pain ( ) Back Pain
( ) Joint Swelling ( ) Joint Pain ( ) Joint Stiffness ( ) Muscle Twitches

**• Neurologic**
( ) No Problems ( ) Headache ( ) Weakness ( ) Tremors ( ) Seizures
( ) Trouble with Memory/Concentration ( ) Blackouts ( ) Face Numbness/Pain

**• Psychiatric**
( ) No Problems ( ) Hallucinations ( ) Feeling Down ( ) Trouble Sleeping
( ) Suicidal Thoughts ( ) Inappropriate Crying/Laughing

**• Hematologic/Lymphatic**
( ) No Problems ( ) Abnormal Bleeding ( ) Anemia ( ) Lumps/Swellings

# ADVANCED DIRECTIVES ACKNOWLEDGEMENT FORM

Patient Name: _____ Date:_____

_____ I ***do have*** an Advanced Directive / Living Will / Durable Power of Attorney for medical or health care decisions.

_____ I ***do not have*** an Advanced Directive / Living Will / Durable Power of Attorney for medical or health care decisions.

_____ Date: _____
Patient's Signature

---

**FOR ADMINISTRATIVE USE ONLY**:

_____ Written information regarding Advanced Directives ***was provided***.

If the patient has an Advanced Directive, has it been placed in the Medical Record?:

_____ Yes _____ No

Comments:

Staff Signature: _____ Date: _____

# ADVANCED DIRECTIVES

**Definition**
Advanced Directives can protect your right to refuse or accept medical care if you ever become mentally or physically unable to choose or communicate your wishes due to an illness or injury.

**Why have an "Advanced Directive"?**
This protects your right to make medical choices that can affect your life. It helps your family by allowing them to avoid the responsibility and stress of making difficult decisions. It helps your physician by providing guidelines for your care.

**What kind of situation might cause me to need an Advanced Directive?**
*IF YOU EVER*:

1. Have irreversible brain damage or brain disease, which can affect your ability to think as well as communicate.
2. Have a permanent coma or other unconscious state which can leave you without hope of recovery.
3. Have a terminal illness in which you are expected to die within a short period of time.

**What kinds of things can Advanced Directives Discuss?**

1. **CPR** – A procedure is used to restore stopped breathing or heartbeat.
2. **IV Therapy (intravenous)** – This is used to provide food, water, and/or medication through a tube placed in a vein.
3. **Feeding Tubes** – Are inserted through the nose, throat or through a hole in the abdomen (stomach wall) to provide liquid food/nutrition when you cannot eat, chew or swallow yourself.
4. **Respirators** – machines used to keep a patient breathing when they are unable to breathe on their own. (Previously called "iron lungs").
5. **Dialysis** – a method of cleansing the blood by a machine when kidneys are no longer working properly.

Advanced Directives allow you to state whether you choose any of these procedures or wish to refuse them.

**How do I get an "Advanced Directive"?**
You can make a **"Living Will"** or a **"Durable Power of Attorney"** for health care. You can contact an attorney to get one of these forms, or you can simply put your wishes in writing: be as specific as possible, then sign the document and have it witnessed and notarized.

Give a copy of your advanced directive to your physician's office as part of your medical record, and inform your family that you have done so. You can also make special requests or statements regarding organ donations, etc.

**Where can I get more information or help in preparing Advanced Directives?**

- Any family lawyer or attorney
- The State Attorney General's office
- The Internet
- Local hospitals
- Local hospice agencies
- Local home health agencies
- Long term care facilities, such a local nursing homes

# NUTRITION RELATED HISTORY

**Patient Name:**_____ **Date:** _____/_____/_____

Age: _____ Date of Birth: _____/_____/_____ Sex: M ☐ F ☐ Ethnicity: _____

Phone Number: _____ Referring Clinician: _____

Reason for Visit: _____

Personal Goal(s) with Nutrition: _____

_____

Recent weight change (gain/loss in what time frame): _____

Possible Reason for Weight Change: _____

Current Exercise Schedule: _____

Disabilities: _____

Appetite: Excellent ☐ Good ☐ Fair ☐ Poor ☐ Dentures: Yes ☐ No ☐

Difficulty swallowing/chewing? (if yes, describe): _____

Recent nausea, vomiting, constipation, diarrhea: (if yes, describe): _____

Cultural or religious food preferences: _____

Motivation level for change: No motivation 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Very Motivated

Have you seen a dietitian before? If so for what?: _____

**Past Medical History:** (check off all current (C) or resolved (R) conditions)

| | | |
|---|---|---|
| C ☐ R ☐ High Cholesterol | C ☐ R ☐ Pre-Diabetes | C ☐ R ☐ Gastrointestinal Disorders (IBS, Celiac Disease, GERD, Gastric Bypass etc.) |
| C ☐ R ☐ High Triglycerides | C ☐ R ☐ Diabetes | If so, describe:_____ |
| C ☐ R ☐ High Blood Pressure | C ☐ R ☐ Cancer | _____ |
| C ☐ R ☐ Overweight/Obesity | C ☐ R ☐ Underweight | C ☐ R ☐ Other: _____ |

**Lifestyle:** Employed? Yes ☐ No ☐ Occupation: _____

Sources of stress: _____

Work schedule: _____

Barriers to eating healthy when at work: _____

_____

_____

Barriers to eating healthy when at home: _____

_____

_____

Barriers to eating healthy on the weekends: _____

_____

**Please start thinking about how you eat on a regular basis before you come in for the consult. Thank you!**

CADUCEUS
MEDICAL GROUP

# PATIENT FINANCIAL POLICY

Caduceus Medical Group is dedicated to providing optimal care and service to our patients. This policy has been developed to clarify matters that frequently arise between our patients and medical office(s). If you have any questions regarding the financial policy, please discuss them with our operations officer.

Benefits and Coverage Limitations – It is the responsibility of the patient/guarantor to understand the terms and conditions of their insurance coverage, including; in-network providers, co-payment and coinsurance responsibilities, and lifetime maximums. Caduceus Medical Group will be held harmless from any fees resulting from the failure to understand any of the terms and conditions regarding the patient's coverage policy which results in non-payment by the health plan, and is the sole responsibility of the patient/guarantor.

Non-covered Benefit – In the event that your health plan (insurance) determines a service to be a non-covered benefit, or if the procedure is considered to be elective and not medically necessary, you will be responsible for payment of the total charges related to that visit. For services rendered to minors, the parent/guardian, and/or policy holder accompanying the minor will be responsible for payment of all expenses incurred.

Time of Payment – Payment for services is due at the time services are rendered. This would include co-payments, co-insurance (patient responsibility), non-covered services, and deductibles. Outstanding balances are also due at the time of service.

Credit Balances – If a credit balance exists on an account, Caduceus is authorized to apply the credit balance to any unpaid or future balance.

Past Due Balance – For any past due balance in excess of 45 days, a monthly finance charge of 1.5% will be assessed and added to the balance due.

Collection of Unpaid Accounts – Statements requesting payment for balance due, when determined as patient responsibility, are sent at 30, 60, and 90 days. The statement at 90 days is the final notice. Unpaid balances over 120 days will be referred to an outside collection agency and/or an attorney which may result in legal action and reporting to credit bureaus. All legal expenses and costs incurred by Caduceus will be the responsibility of the undersigned.

Payment Plans – Payment plans for unpaid balances must be in writing and can only be approved by the Management Services Office or Executive Board. Physicians/providers are not authorized to offer or create any payment plans.

Special Physical and Form Fees – For special physicals and/or forms that may be required, e.g., DMV, Schools, Camps, Employers, and Sports Teams – the patient/guarantor is responsible for any fees related to the service, unless documented to be a covered benefit by the health plan.

Returned Check or Insufficient Funds – In the event that a check is returned, for any reason, or if there are insufficient funds, a fee in the amount of $25 will be assessed and added to the account.

I have read and understand the Patient Financial Policy of Caduceus Medical Group and accept all the terms maintained, herein.

Signature: _____ Date: _____

Name (Print): _____

# PATIENT FINANCIAL POLICY

Caduceus Medical Group is dedicated to providing optimal care and service to our patients. This policy has been developed to address questions often asked by our patients.

**Benefits and Coverage Limitations**

It is the responsibility of the patient/guarantor to understand the terms and conditions of his/her insurance coverage including: in-network providers, co-payment and co-insurance responsibilities, and benefit maximums. Caduceus Medical Group will be held harmless from any fees resulting from the failure to understand any of the terms and conditions regarding the patient's coverage policy which results in non- payment by the health plan. Any such fees shall be the sole responsibility of the patient/guarantor.

**Non-Covered Benefits**

In the event that your health plan (insurance) determines a service to be a non-covered benefit or if the procedure is considered to be elective and not medically necessary, you will be responsible for payment of the total charges related to that visit. For services rendered to minors, the parent/guardian and/or policy holder accompanying the minor will be responsible for payment of all expenses incurred.

**Payment**

Payment for services is due at the time services are rendered. This would include co-payments, co-insurance, yearly deductible, and amounts for non-covered services. Outstanding balances are also due at the time other services are being provided. If a credit balance exists on an account, Caduceus is authorized to apply the credit balance to any unpaid or future balance.

**Past Due Balances**

For any past due balance in excess of 45 days, a monthly finance charge of 1.5% will be assessed and added to the balance due.

**Collection of Unpaid Accounts**

Statements for balances due are sent at 30, 60, and 90 days. The statement at 90 days is the final notice. Unpaid balances over 120 days will be referred to an outside collection agency and/or an attorney, which may result in legal action and reporting to credit bureaus. All legal expenses and costs incurred by Caduceus related to collection of any balance will be the responsibility of the undersigned.

**Payment Plans**

Payment plans for unpaid balances must be in writing and must be approved by the Management Services Officer or the Executive Board. Physicians/providers are not authorized to offer or create any payment plans.

**Special Physical and Form Fees**

For special physicals and/or forms that may require completion by a physician, e.g. DMV, school, sports, camp, etc., the patient/guarantor is responsible for any fees related to the service unless documented to be a covered benefit by third-party payer.

**Returned Check or Insufficient Funds**

In the event that a check is returned for any reason or if there are insufficient funds, a fee in the amount of $25 will be assessed and added to the account balance.

I have read and understand the Patient Financial Policy of Caduceus Medical Group and accept all of the terms stated herein.

_____ _____

Print Name Signature

Date _____

CADUCEUS
MEDICAL GROUP

**Authorization to Use or Disclose Health Information**

Patient Name:_____ Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below:

   _____ is authorized to make the disclosure, indicate office below:

   - ❑ Caduceus Imperial 18300 Yorba Linda Blvd, Suite 204, Yorba Linda, CA 92886
   - ❑ Caduceus Specialty 18200 Yorba Linda Blvd, Suite 104, Yorba Linda, CA 92886
   - ❑ Caduceus4Kids, 18200 Yorba Linda Blvd, Suite 108, Yorba Linda, CA 92886
   - ❑ Caduceus Jamboree, 19724 MacArthur Blvd, Suite 100, Irvine, CA 92612
   - ❑ Caduceus on Thalia, 333 Thalia, Laguna Beach, CA 92 xxx

2. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

   - ❑ Problem list
   - ❑ Medication list
   - ❑ List of allergies
   - ❑ Immunization records
   - ❑ Most recent office notes
   - ❑ Most recent hospitalization
   - ❑ Lab/ Xray results (please describe the dates or types of lab tests you would like disclosed)_____
   - ❑ Consultation reports from (please supply doctors' names)_____
     _____
   - ❑ Other (please describe)_____

3. I understand that the information in my health record may include information relating to sexually-transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to the following individuals or organization(s) listed here.

   Name:_____

   Address:_____

5. This information for which I'm authorizing disclosure will be used for the following purpose:
   - ❑ My personal records
   - ❑ Changing doctors
   - ❑ Appointment with a specialist
   - ❑ Moving
   - ❑ Legal case
   - ❑ Other (please describe)_____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless I specify differently, this authorization will expire: Date:_____
   If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

8. I understand that once the above information is disclosed to the designated party, it may be re-disclosed by that party and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

_____ _____
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of Witness Date

CADUCEUS
MEDICAL GROUP

**Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided; and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to receive a copy of the *Notice of Information Practices* which provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and, prior to implementation, will post and make available, the revised notice at physical practice site(s). I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

○ I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

○ I also authorize the disclosure of my health information to the following family members or person(s):

_____

_____

_____

○ I wish to be contacted regarding any test results or treatment plans by the methods indicated:

Please circle: **Home Phone** Yes/No **Cell Phone** Yes/No **Work Phone** Yes/No **Voice Mail** Yes/No

**Fax** Yes/No **E-Mail** Yes/No **US Mail** Yes/No

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Birth Date | Signature of Patient or Legal Representative |
| _____ | _____ | _____ |
| Relationship to Patient (if patient is a minor) | Date | Witness |

**OFFICE USE ONLY:**

○ Accepted

○ Denied

| _____ | _____ | _____ |
|---|---|---|
| Signature | Title | Date |

CADUCEUS
MEDICAL GROUP

Name: _____

D.O.B. _____

Who is your primary care physician/family doctor?

_____

*Office Use Only*

Blood Pressure: _____
Heart Rate: _____
Temperature: _____
Weight: _____

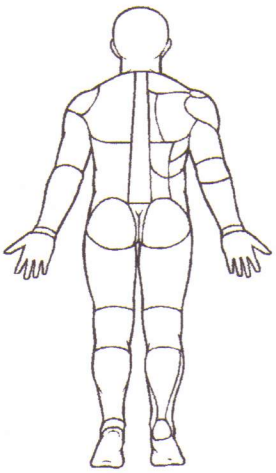
What is the major reason you are coming to see the doctor (chief complaint):

_____

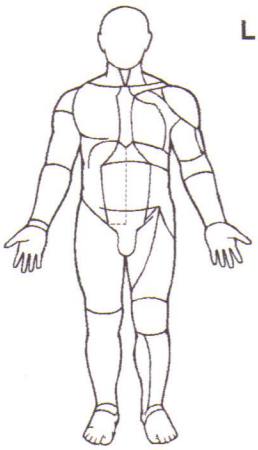
_____

_____

**Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.**

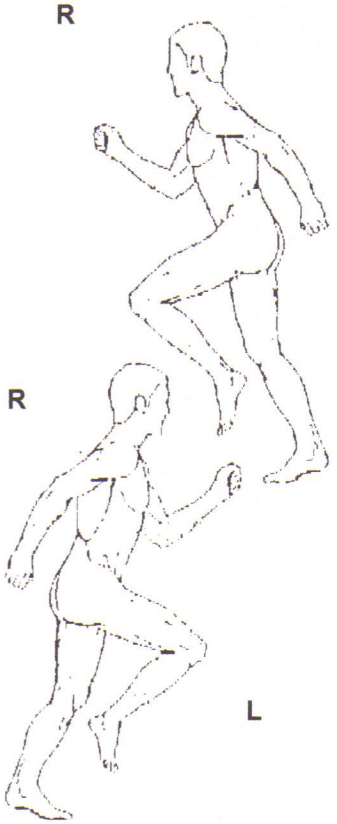


R



L

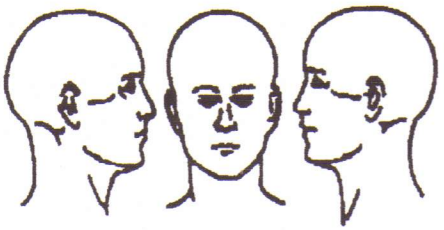
R

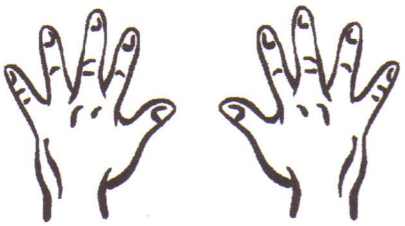


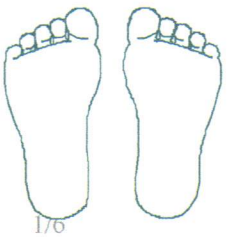
L

R

L







How long have you had this pain? _____

When did it start? _____

What were you doing when the pain first started? _____

_____

How long does the pain last?

- ☐ Constant
- ☐ Intermittent

**QUALITY OF YOUR PAIN:**

Please mark all that apply:

( ) Throbbing ( ) Cramping ( ) Gnawing ( ) Aching ( ) Shooting
( ) Stabbing ( ) Sharp ( ) Hot-burning ( ) Heavy ( ) Tender
( ) Splitting ( ) Sickening ( ) Tiring-Exhausting ( ) Fearful
( ) Punishing-Cruel ( ) Other_____

**Intensity of Pain**

On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain, how would you rate your pain?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| At Worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At Best: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Average: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**What makes your pain worse?** Mark all that apply.

( ) Bending ( ) Lifting ( ) Coughing ( ) Sneezing
( ) Defecation ( ) Prolonged Sitting ( ) Walking ( ) Prolonged Standing
( ) Other, please explain _____

**What makes your pain better?** Mark all that apply.

( ) Rest ( ) Activity/physical therapy ( ) Massage ( ) Heat
( ) Cold ( ) Lying in a fetal position ( ) Lying on your back
( ) Lying on back w/ pillows under your legs ( ) Medication, please list _____
( ) Other, please explain _____

**Are there other symptoms/problems associated with the pain?**

( ) Difficulty sleeping ( ) Feel "blue" all the time
( ) Other(s), please describe _____

**In what time period is your pain worst?**

( ) early morning ( ) late evening

## TREATMENT HISTORY

How many times have you visited a professional caregiver (of any kind) for this *current* pain?

( ) 0-5 ( ) 6-10 ( ) Can't Remember ( ) Too many to count

Which of the following types of caregivers have you visited prior to your arrival here?

( ) Family Physician (includes general practitioner, internist, gynecologist, etc.)

( ) Sports Medicine ( ) Orthopedic/Spine Surgeon ( ) Neurologist

( ) Rheumatologist ( ) Occupational Medicine ( ) Anesthesiologist

( ) Rehabilitation Medicine ( ) Pain Management ( ) Chiropractor

( ) Osteopathic Physician ( ) Acupuncturist ( ) Biofeedback

( ) Alternative medicine ( ) Physical Therapist

( ) Other, please list _____

Which of the following tests have you undergone prior to your arrival here today?

( ) X-rays ( ) CAT scan ( ) MRI scan ( ) EMG test

( ) Discogram/Discography ( ) Myelogram

Please check the medications that you have tried for your pain in the past and their effectiveness. (0=no help, 10=very helpful)

| | **Tried Medication** | | |
|---|---|---|---|
| **Name of medication** | Yes | No | **Effectiveness (0-10)** |
| Tylenol/acetaminophen | | | |
| NSAID's: Motrin/Advil/Ibuprofen, etc | | | |
| Opioids: Vicodin/Norco/Oxycodone, etc | | | |
| Oral Steroids/Medrol dose pack | | | |
| Amitriptyline(Elavil), Nortriptyline(Pamelor), etc | | | |
| Muscle relaxants/Flexaril | | | |
| Neurontin/Topamax/Tegretol, etc | | | |
| Marijuana/Cocaine/Heroine/Other illicit drugs | | | |
| Xanax/Ativan/Valium,etc | | | |
| Others, please list | | | |

Have you had any of the following interventions done for your pain?

( ) TENS/nerve stimulator ( ) ultrasound ( ) Heat ( ) Cold

( ) Nerve block injections (not steroids)

If so, how many times? ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

( ) Trigger point injections

If so, how many times? ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

( ) Other, please list _____

## PAST MEDICAL HISTORY

**Drug and Food Allergies:**

_____

**Please list the medications you are currently taking:**

| Name | Dosage | How Often? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List all **MEDICAL** problems:

_____

_____

_____

_____

List all **SURGERIES** and their dates:

_____

_____

_____

_____

## SOCIAL HISTORY

**Any use of tobacco** (type and for how long?)

_____

**Any use of alcohol** (type and for how long?)

_____

**Any use of recreational drugs** (type and for how long?)

_____

**Any exposure to toxins/poisonous substances at work or with hobbies?**

_____

**What type of work do you do?**

_____

**Are you currently on disability:** **( ) Yes** **( ) No**

**Education:**
Grade School High School College Post-Graduate Vocational Training

**Marital Status:**
Single Married Divorced Separated Widowed

## FAMILY HISTORY

Mother: ☐ Living ☐ Deceased Age(s) _____ Health issues: _____

Father: ☐ Living ☐ Deceased Age(s) _____ Health issues: _____

Brother(s):
#_____ ☐ Living ☐ Deceased Age(s) _____ Health issues: _____

Sister(s):
#_____ ☐ Living ☐ Deceased Age(s) _____ Health issues: _____

## REVIEW OF SYSTEMS

*Please place a checkmark if you currently have any of the following symptoms. (Disregard the bold headings)*

- **Constitutional**

( ) No Problems ( ) Fever ( ) Weight Loss ( ) Fatigue

- **Eyes**

( ) No Problems ( ) Blurred Vision ( ) Eye Redness ( ) Double Vision
( ) Vision Loss ( ) Eye Dryness ( ) Eye Pain

- **Ear/Nose/Throat**

( ) No Problems ( ) Trouble Hearing ( ) Ringing in the ear ( ) Loss of Balance
( ) Dizziness/Vertigo ( ) Ear Discharge ( ) Ear Pain

- **Cardiovascular**

( ) No Problems ( ) Chest Pain/Angina ( ) Irregular Heart Beat ( ) Fainting
( ) Limb Swelling ( ) Limb Pain on Walking

- **Respiratory**

( ) No Problems ( ) Trouble Breathing ( ) Chronic Cough ( ) Coughing Blood

- **Gastointestinal**

( ) No Problems ( ) Indigestion ( ) Nausea ( ) Vomiting ( ) Diarrhea
( ) Heart Burn ( ) Constipation ( ) Bloody Stools ( ) Abdominal Pain

- **Genitourinary**

( ) No Problems ( ) Incontinence ( ) Pain on Urination ( ) Blood in Urine

- **Musculoskeletal**

( ) No Problems ( ) Muscle Pain ( ) Muscle Cramp ( ) Neck Pain ( ) Back Pain
( ) Joint Swelling ( ) Joint Pain ( ) Joint Stiffness ( ) Muscle Twitches

- **Skin & Breast**

( ) No Problems ( ) Numbness ( ) Hair Loss ( ) Discoloration ( ) Tingling
( ) Sweating Change ( ) Nail Change

- **Neurologic**

( ) No Problems ( ) Headache ( ) Weakness ( ) Tremors ( ) Seizures
( ) Trouble with Memory/Concentration ( ) Blackouts ( ) Face Numbness/Pain

- **Psychiatric**

( ) No Problems ( ) Hallucinations ( ) Feeling Down ( ) Trouble Sleeping
( ) Suicidal Thoughts ( ) Inappropriate Crying/Laughing

- **Hematologic/Lymphatic**

( ) No Problems ( ) Abnormal Bleeding ( ) Anemia ( ) Lumps/Swellings

- **Allergic/Immunologic**

( ) No Problems ( ) Rash ( ) Joint Pain ( ) Dry Eyes +/- Mouth

- **Endocrinologic**

( ) No Problems ( ) Excessive Thirst ( ) Excessive Urination ( ) Heat/Cold Intolerance

Person completing this questionnaire_____

Relationship to Patient_____

---

**For office use**: This questionnaire may be completed by the patient, relatives or ancillary staff provided that it is signed and dated by the treating physician. Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent changes.

Physician's Signature_____Date_____

# Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

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- a basis for planning my care and treatment
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○ I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____

○ I also authorize the disclosure of my health information to the following family members or person(s):

_____

_____

_____

○ I wish to be contacted regarding any test results or treatment plans by the methods indicated:

Please circle: **Home Phone** Yes/No **Cell Phone** Yes/No **Work Phone** Yes/No **Voice Mail** Yes/No

**Fax** Yes/No **E-Mail** Yes/No **US Mail** Yes/No **None of the above** Yes/No

_____ Patient Name

_____ Birth Date

_____ Signature of Patient or Legal Representative

_____ Date

_____ Witness

_____ Relationship to Patient (if patient is a minor)

---

**OFFICE USE ONLY:**

○ Accepted

○ Denied

_____ Signature

_____ Title

_____ Date

CADUCEUS
MEDICAL GROUP

# Return Patient Visit Form

| *Office Use Only* | |
|---|---|
| Blood Pressure: | _____ |
| Heart Rate: | _____ |
| Temperature: | _____ |
| Weight: | _____ |

**A.** Reason for your visit today:
( ) Medication refill
( ) Follow up after a procedure
( ) Routine follow-up
( ) Other, please explain _____

**B.** Has your pain changed since the last visit: ( ) Yes ( ) No

**C.** ***Nature of Pain:*** ( ) Constant ( ) Intermittent

***Intensity of Pain:*** On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain; how would you rate your pain?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| At Worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At Best: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Average: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

***What makes your pain worse?***
( ) Bending ( ) Lifting ( ) Coughing ( ) Sneezing ( ) Defecation
( ) Prolonged Sitting ( ) Prolonged Standing ( ) Walking
( ) Other, please explain _____

***What makes your pain better?***
( ) Rest ( ) Activity/physical therapy ( ) Massage ( ) Heat ( ) Cold
( ) Lying in a fetal position ( ) Lying on your back ( ) Medication
( ) Other, please explain _____

**D.** Have you had any new medical problems or hospitalizations since your last clinic visit?
( ) Yes ( ) No
If yes, please explain: _____

**E.** Have you started any new medication(s) not prescribed by my office since the last clinic visit?
( ) Yes ( ) No
If yes, please list the name(s) and dose(s) of the medication(s):
_____

**F.** Have you noticed any side effects from medications: ( ) Yes ( ) No
If yes, please explain: _____

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**G.** Have you had any of the following since the last visit:

| | | | |
|---|---|---|---|
| 1. | Nausea/Vomiting | ( ) Yes | ( ) No |
| 2. | Fever | ( ) Yes | ( ) No |
| 3. | Constipation | ( ) Yes | ( ) No |
| 4. | Urinary retention | ( ) Yes | ( ) No |
| 5. | Flu-like symptoms | ( ) Yes | ( ) No |

**H.** Who is your primary care doctor/family doctor? _____

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# Appointment Materials

Please remember to bring the following information, if applicable, with you to your appointment:

- ☐ MRI and x-ray images along with the official reports
- ☐ The names and addresses of your primary care physician and the referring physician
- ☐ List of all the medications you are taking including herbal medications
- ☐ Complete the initial patient questionnaire we have sent you
- ☐ If you are transferring your care to us, please bring a copy of your old medical records

Failure to follow these guidelines may result in **delay** or rescheduling of your appointment. Once again, thank you for selecting us as your provider of choice. We look forward to taking care of all your pain care needs.