

Please provide us with the following personal and other pertinent information requested.

Today's date \_\_\_\_\_

Name \_\_\_\_\_ Nick-name preferred: \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female Soc.Sec # \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Address : \_\_\_\_\_

City, St, Zip \_\_\_\_\_

Were you referred by  Yourself  Friend  Insurance Carrier  Primary physician  Other physician

Name of person who referred you: \_\_\_\_\_ Their telephone # \_\_\_\_\_

If different from above, who is your family physician? \_\_\_\_\_ Phone # \_\_\_\_\_

FINANCIAL :	PRIMARY INSURANCE	SECONDARY PAYER OR RESPONSIBLE PARTY
NAME		
ADDRESS		
CITY,ST.ZIP -		
POLICY #		
INSURED NAME		
RELATION		
SOC. SEC. #		
BIRTH-DATE		
GROUP #		
EMPLOYER NAME		

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **French Medical Group, Ltd**

Effective November 1, 2007

Please be aware that due to scheduling concerns, we will have to charge a 50.00 cancellation fee for any missed appointments or any schedule changes less than 24 hours notice. We have this policy to ensure that all of our patients are able to receive the best care possible. Scheduling changes less than 24 hours notice does not allow us to schedule patients properly and we want all of our patients to receive the best quality healthcare possible.

Thank you so much for your understanding and adherence to this new policy.

Yours in Health,

The Administrative Staff  
**French Medical Group, Ltd.**

I have read the above policy: \_\_\_\_\_ Date: \_\_\_\_\_

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\* You May Refuse to Sign This Acknowledgement \*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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## For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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MedCorp Services, Inc.

#### ASSIGNMENT OF INSURANCE BENEFITS:

I the undersigned hereby grant permission for contact with my insurance carrier to determine benefits and assign all available medical and/or surgical benefits, to include major medical benefits, private insurance and any other health plans to which I am entitled to the physician and/or practice listed above. This assignment will remain in effect until revoked by me in writing. I authorize a photocopy or facsimile of this assignment to be considered to be as valid as an original. I understand that I am financially responsible for all charges not covered by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

#### MEDICARE ASSIGNMENT

I hereby request payment of authorized Medicare benefits be made to me or on my behalf to \_\_\_\_\_ for any services furnished me by that physician.

I hereby authorize any holder of medical information about me to release information to the Health Care Financing Administration or its agents any information needed to determine all benefits payable. This assignment will remain in effect until revoked by me in writing.

I authorize a photocopy of this assignment to be considered to be as valid as an original.

In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and such non-covered services as may be explained and agreed to by me.

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

WHEN DID THIS PROBLEM START?

WHAT CAUSED THE PROBLEM?

IF YOU WERE INJURED WAS IT:

- AT HOME
- AT WORK
- AUTO ACCIDENT
- OTHER PERSONAL INJURY

DID YOUR PAIN COME ON:

- SUDDENLY
- GRADUALLY

ARE YOU ABLE TO:

- |                     | YES                      | NO                       |
|---------------------|--------------------------|--------------------------|
| SLEEP NORMALLY      | <input type="checkbox"/> | <input type="checkbox"/> |
| DO DAILY ACTIVITIES | <input type="checkbox"/> | <input type="checkbox"/> |
| CARE FOR YOURSELF   | <input type="checkbox"/> | <input type="checkbox"/> |
| FUNCTION NORMALLY   | <input type="checkbox"/> | <input type="checkbox"/> |

IS THE PAIN:

- CONSTANT
- ON AND OFF

Have you had this problem before

- NO
  - YES
- WHEN?

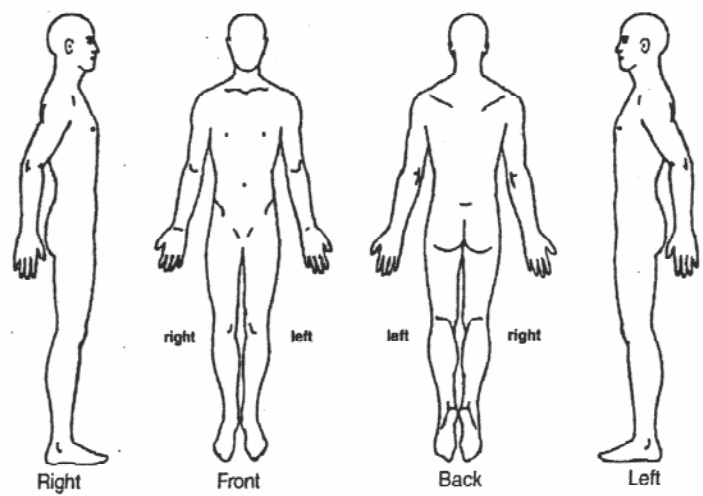
Who treated your last occurrence?

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

- +++ Burning
- ... Pins & needles
- /// Stabbing
- XXX No feeling

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time.

AREA 1 pain is (1-10) \_\_\_\_\_  
 AREA 2 pain is (1-10) \_\_\_\_\_  
 AREA 3 pain is (1-10) \_\_\_\_\_



**Which words describes your pain MOST of the time?**

<input type="checkbox"/> Constant	<input type="checkbox"/> Tingling
<input type="checkbox"/> On and Off	<input type="checkbox"/> Burning
<input type="checkbox"/> Occasional	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Only at night	<input type="checkbox"/> Deep, stabbing
<input type="checkbox"/> Only on exertion	<input type="checkbox"/> Deep Achy
<input type="checkbox"/> Dull Ache	<input type="checkbox"/> Sharp recurring pain

**How would you describe your current mobility?**

<input type="checkbox"/> Self Mobile	<input type="checkbox"/> Need Walker
<input type="checkbox"/> Need Cane	<input type="checkbox"/> Need Wheelchair

**Which best describes your current employment?**

<input type="checkbox"/> Working	<input type="checkbox"/> full time	<input type="checkbox"/> Part time
<input type="checkbox"/> Unemployed		
<input type="checkbox"/> On sick leave		
<input type="checkbox"/> On temporary disability		
<input type="checkbox"/> On permanent disability		
<input type="checkbox"/> Retired		

If on temporary or permanent disability or sick leave  
 Last full day of work was \_\_\_\_\_

			<b>BRIEF HISTORY &amp; SYMPTOMS</b>
PATIENT	ID#	DATE	© MedCorp Services 1999 Form BHX-109

If you previously had any of the following procedures, please list the date and place they were performed.

PROCEDURE	DATE	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		

**CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.**  
(Prescription and over the counter)

Name of medication and Strength	# of doses per day

**HOSPITALIZATION and SURGERY**

PLEASE LIST ALL SURGERY AND PERIODS OF HOSPITALIZATION


**WHAT MEDICATIONS ARE YOU ALLERGIC TO ?**

**DO YOU HAVE IMPLANTS?**  Yes  No **PACEMAKER**  Yes  No **DEFIBRILLATOR**  Yes  No

<b>WOMEN ONLY</b>	Can you become pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Please provide the date or approximate date of your last:
If not, why?			
Date of last period:	Normal?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mammagram
Are you now or could you be pregnant ?		<input type="checkbox"/> YES <input type="checkbox"/> NO	Pap Smear

**DO YOU NOW OR HAVE YOU EVER :** This is confidential information we need to treat you properly.

Smoke ?  YES  NO  Stopped Packs per day?  
 Use Alcohol?  YES  NO Type and amount?  
 Drink Coffee / Caffeine?  YES  NO Type and amount?  
 Use recreational drugs?  YES  NO Type and frequency?

**PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE PAST.**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Severe headaches     | <input type="checkbox"/> Chest pain / Angina        | <input type="checkbox"/> Kidney Stones               | <input type="checkbox"/> Digestive problems       |
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Heart palpitations         | <input type="checkbox"/> Renal disease               | <input type="checkbox"/> Gout                     |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Heart murmur.              | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Arrhythmia                 | <input type="checkbox"/> Endocrine disease           | <input type="checkbox"/> HIV / AIDS               |
| <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Congenital heart disease   | <input type="checkbox"/> Urinary or genital problems | <input type="checkbox"/> Claudication             |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Rheumatic or Scarlet fever | <input type="checkbox"/> Prostate problems           | <input type="checkbox"/> Ulcer                    |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Gall Stones                | <input type="checkbox"/> Sexual dysfunction          | <input type="checkbox"/> Venereal disease         |
| <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Pancreatitis               | <input type="checkbox"/> Menstrual dysfunction       | <input type="checkbox"/> Mental illness           |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Liver disease              | <input type="checkbox"/> Ovarian cysts               | <input type="checkbox"/> Alcohol or Drug problems |

**FAMILY HISTORY:** Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had

condition	who?	condition	who?
Heart Disease		Epilepsy	
Hypertension		Glaucoma	
Stroke		Bleeding disorders	
Cancer		Kidney disease	
Diabetes		Thyroid disease	

			<b>PAGE 2</b>
PATIENT	ID#	DATE	<b>BRIEF HISTORY &amp; SYMPTOMS</b>