Dr. Patrick O'Shea

11468 Sorrento Valley Road, Suite A •San Diego, CA 92121 • (858)457-3545 • Fax (858) 457-0976 •
www.advancedsofttissuecare.com

PATIENT INFORMATION

☐ New Patient ☐ Old Patient Returning

Referred By	Physician's Name	Date

Patient Name (Last, First, Initial)			Email Address		
Home Address			City	State	Zip
Home Phone		Work Phone	Ext.	Cell Phone	
Sex M F	SS# - -	Birthdate	Drivers License #		

Primary Insurance	Name of Insured	Relationship
Secondary Insurance	Name of Insured	Relationship

Check the appropriate box:

☐ Work Related Injury ☐ Auto Accident ☐ Reoccuring Injury ☐ Other

☐ Private Injury ☐ Student Athletic Injury ☐ On-campus Injury ☐ Surgery

Patient Employer	City
Is Patient a Student? Y N Full Time ☐ Part Time ☐	School Name

In case of emergency please notify:		Phone		Relationship
Address		City	State	Zip
If patient is a minor, name of responsible person		Phone of responsible person		

________ INITIAL — I hereby authorize Dr. O'Shea to release any information acquired in the course of my evaluation or treatment for billing purposes.

________ INITIAL — I hereby authorize Dr. O'Shea to release any information regarding my medical condition to the attending or referring medical practitioner.

________ INITIAL — I direct that payments be made directly to Dr. O'Shea. I understand that I am financially responsible for all charges not paid by my insurance. I also understand that all payments made directly to me are to be forwarded to this office.

Signature of Patient or Responsible Party	Date

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POLICIES

Name: ___________________________ Date: _____________________

Welcome!   We look forward to serving you. As a new patient with our office, we would like you to be familiar with our office policies concerning your scheduling and account while you are with us. Please feel free to ask any questions regarding the following.

1. We require a 24-hour notice to change or cancel a scheduled appointment. <u>If you fail to show or cancel your appointment without a 24-hour notice you will be charged $60.00</u>. Payment is due before your next appointment. These charges are the patient's responsibility and cannot be billed to your insurance company or work comp carrier.

2. Our office is happy to courtesy bill your insurance. We will also courtesy call your insurance to verify your Chiropractic benefits. <u>As your insurance will make no guarantee of payment until the claim is received and processed, you will be financially responsible for all services unpaid by your insurance after 60 days.</u> Your insurance company may require authorization or pre-certification for certain procedures and services. As a courtesy, we will contact your insurance company on your behalf. It always remains your responsibility to understand what your insurance policy covers and confirm directly that you have authorization and coverage for the services you receive. We may request your direct involvement in following up on authorization requests and delayed payments if your insurance becomes unresponsive to our inquiries. Direct intervention on the part of the patient often results in a more timely approval of services, prevents delays in treatment and expedites payment for your services.

3. The patient's personal portion will be due at every visit and is collected at the front desk. ***Please be advised we are estimating your personal portion***. This is based on the information received when benefits were quoted by your insurance. Final balances will be determined once your insurance finishes processing. At that time, outstanding balances will be collected or overpayments will be refunded.

4. In the event any action is taken to enforce collection of this account, the presiding party will be entitled to recovery of all legal fees incurred.

The undersigned certifies that he/she has been informed and has read the foregoing and is the patient, or is duly authorized by the patient's general agent to execute the above and accept its terms.

Signature ____ Date ________________________

Witness ____ Date ________________________

Patient Intake Questionnaire

Date: ____________________

Patient's Name: ______________________________

Age: ___________ Sex: ____________

DR. PATRICK O'SHEA, D.C.
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About your current complaint:

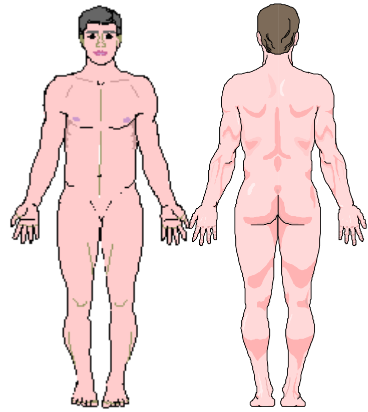
1. What is the complaint that brought you here? ____
2. When did this complaint begin, or recently become worse? Approximate Date: _______________________________
3. What caused this complaint? ____
4. Does this complaint affect your activity choice, tolerance, efficiency or effectiveness: ☐ Yes ☐ No

   If "Yes", what activities? ____
5. What makes this complaint better? ____
6. Does this complaint affect your comfort, mood, or ability to sleep? ☐ Yes ☐ No
7. What symptoms are you experiencing with this complaint?

   ☐ Swelling ☐ Loss of balance or coordination

   ☐ Loss of motion ☐ Numbness ☐ Pain: Draw pain areas on body diagrams ->

   ☐ Weakness ☐ Tingling ☐ Other (Specify)



8. How frequent are the symptoms experienced? ☐ Constant ☐ Intermittent
9. How much pain are you experiencing?

   ☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
10. What tests have you had for this complaint?

    ☐ X-ray ☐ CT Scan ☐ MRI ☐ Myelogram ☐ Bone Scan
11. What treatment have you had for this complaint? ☐ Physical Therapy ☐ Occupational Therapy

    ☐ Athletic Training ☐ Chiropractic ☐ Alternative Medicine-(Specify): ______________________________
12. Is this complaint work related? ☐ Yes ☐ No

    If "Yes", your employer's name: ______________________________ Your Occupation: ___________________________

    Work Status: ☐ Full Time ☐ Part Time ☐ Working ☐ Medical Restrictions ☐ Medical Leave Last Date Worked: ________
13. Is this complaint auto related? ☐ Yes ☐ No

About your general health:

14. Please check all medical conditions that you have, or have had.

    ☐ Arthritis ☐ Heart Disease ☐ Stomach Disorder ☐ Headaches ☐ Pace Maker

    ☐ Cancer ☐ High Blood Pressure ☐ Anxiety ☐ Dizziness ☐ Other: _________

    ☐ Diabetes ☐ Lung Disease ☐ Depression ☐ Metal Implants

    ☐ Stroke/Seizure ☐ Thyroid Problems ☐ Panic Attacks ☐ Morning Stiffness
15. Please check all of the following items that currently apply to you.

    ☐ Hearing Problem ☐ Visual Problems ☐ Learning Problems

    ☐ Pregnant ☐ Bowel or bladder control ☐ Smoker ☐ Recent weight loss
16. Please list surgeries: ____
17. Please list allergies: ____
18. Please list medications you are currently taking: ____

____

19. What goals do you want to achieve through your treatment Dr. O'Shea?_______________________________

____

Please use the back of page for additional writing space as needed.