MECCA INTEGRATED MEDICAL

WELCOME

PATIENT INFORMATION

Date _____

How did you hear of us? _____

Social Security # _____

Patient Name _____

Address _____

City _____ State ____ Zip _____

Email _____

Sex ☐ M ☐ F Birth date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Occupation _____

Employer/School _____

Employer/School Address _____

Employer/School Phone ( )

Primary Care Physician _____

Location _____

Phone ( )

Spouse's Name _____

Birth date _____

Spouse's Employer _____

INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance Co. _____

Member ID _____

Covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth date _____ S.S. # _____

Relationship to patient _____

Insurance Co. _____

Member ID _____

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Mecca Integrated Medical Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Mecca may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize doctor to initiate a complaint to the Insurance Commissioner or my health care provider for any reason on my behalf. Date: _____

Signature of Patient/Guardian: _____

PHONE NUMBERS

Home Phone ( )

Cell Phone ( ) carrier:

Work Phone ( )

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Best phone number to reach them

( )

ACCIDENT INFORMATION

Is this condition due to an accident? ☐ Yes ☐ No

Claim # _____

Date _____

Type of accident ☐ Auto ☐ Work ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Worker's Comp ☐ Other

Adjuster Name/ Attorney Name (if applicable)

_____

Phone ( )

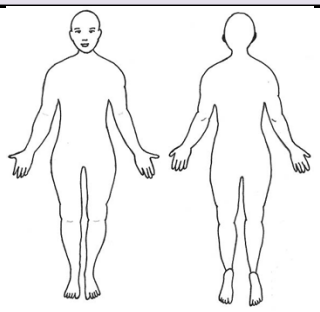
PATIENT CONDITION

Reason for visit _____

When did your symptoms appear _____ _____

Is this condition getting progressively worse? ☐ Yes ☐ No

Mark an X on the picture where you continue to have pain, numbness, or tingling →



Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness

☐ Shooting ☐ Swelling ☐ Aching ☐ Other

How often does this pain occur? _____ Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Check all that are painful to perform: ☐ Sitting ☐ Standing ☐ Lifting ☐ Bending ☐ Walking ☐ Lying Down ☐ Other

MEC CA
INTEGRATED MEDICAL

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Family Doc ☐ Medications
☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Neurology ☐ Pain Management

Date(s) of treatment _____

Name and location of other doctor(s) who have treated your condition _____

Date of Last:

Physical Exam _____ Spinal X-Ray _____ MRI/CT Scan _____
Spinal Exam _____ Blood Test _____ Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Mono	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	MS	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	**Fractures**	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	**Osteoporosis**	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	**Pacemaker**	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	**Heart Disease**	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Bleeding		Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Disorders	☐ Yes ☐ No	**Herniated Disc**	☐ Yes ☐ No	**Prosthesis**	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	High Blood		Rheumatoid	
Bulimia	☐ Yes ☐ No	Pressure	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	STD's	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Chemical		Liver Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Dependency	☐ Yes ☐ No	Measles	☐ Yes ☐ No	**Tumors/Growths**	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No

Other:

EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress	Reason _____
Are you pregnant?	☐ Yes ☐ No	Due Date	

Injuries/Surgeries History

	Description	Date(s)
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Please List: Max Adult Weight: _____ Min. Adult Weight: _____ Ideal Adult Weight: _____

Medications _____

Vitamins/Supplements _____

Allergies