MARKO BODOR, M.D., Inc.
Queen of the Valley Wellness Center

3421 Villa Lane, Suite 2B ~ Napa, CA 94558 ~ 707.255.5454 Fax: 707-255-5411

PLEASE COMPLETE & BRING TO YOUR APPOINTMENT

ON: _____ THANK YOU!

PATIENT INFORMATION SHEET

PATIENT'S NAME: _____ □ Male □ Female
FIRST INITIAL LAST

Mailing Address: _____

City: _____ State: _____ Zip: _____

PHONE-Home: _____ Business: _____ Cell: _____

Birth date: _____ Age: _____ Social Security #: _____

Email: _____ Employer: _____ Occupation: _____

SPOUSE'S OR PARENT'S NAME: _____ Contact Number: _____

PERSON RESPONSIBLE FOR BILL (If under 18 years):

Name: _____ Phone: _____

Relationship: _____ Address: _____

EMERGENCY CONTACT: Name: _____ Phone: _____

Relationship: _____ Address: _____

REFERRING PHYSICIAN: _____ Phone: _____ City: _____

PRIMARY PHYSICIAN: _____ Phone: _____ City: _____

▶Was this a Work Comp or Auto Accident injury? □ Yes □ No If YES, provide following:

WORK COMP INJURY	**MOTOR VEHICLE ACCIDENT** (We do not bill third party auto claims.)
Claim Number: _____	Claim Number: _____
Date of Injury: [month/day/year] _____	Date of Injury: [month/day/year] _____
Ins. Carrier Name: _____	Your PIP Ins. Co.: _____
Claim Manager's Name: _____	Claim Adjustor's Name: _____
Claim Manager's Phone #: _____	Claim Adjustor's Phone #: _____

▶HEALTH PLAN INFORMATION: FILL IN COMPLETELY USING YOUR INSURANCE CARD.

PRIMARY INSURANCE: _____	**SECONDARY INSURANCE:** _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber DOB: _____	Subscriber DOB: _____
I.D. # _____	I.D.# _____
Does your insurance require a referral? □ YES □NO (If YES, you must bring a copy with you to your appointment.)	Does your insurance require a referral? □ YES □ NO (If YES, you must bring a copy with you to your appointment.)

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

Assignment, Release and Financial Agreement: I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize the physician to release any information to referring/consulting physicians or other health care providers as your physician deems appropriate to facilitate my/our care. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have also been informed of the $35.00 fee on checks returned. In the event it should become necessary to place for collection an unpaid balance due for services rendered to me or my family, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and any other costs.

Patient's Signature/Parent's Signature **Date**

YEARLY UPDATE

- I certify that I have reviewed the information on this form in its entirety, and there are no changes.

_____ _____

Patient's Signature/Parent's Signature Date

- I certify that I have reviewed the information on this form in its entirety, and there are no changes.

_____ _____

Patient's Signature/Parent's Signature Date

YEARLY UPDATE

- I certify that I have reviewed the information on this form in its entirety, and there are no changes.

_____ _____

Patient's Signature/Parent's Signature Date

- I certify that I have reviewed the information on this form in its entirety, and there are no changes.

_____ _____

Patient's Signature/Parent's Signature Date

New Patient Questionnaire
Marko Bodor, MD

Name: _____ Date: _____

Height: _____ Weight: _____ Age: _____ Pain Rating: _____
(Pain Scale of 1 to 10, with 10 being extreme pain)

Chief Complaint:

What is the main problem that brings you in today?

History of Present Illness:

Please describe your symptoms, including any numbness, pain or weakness.

When did your symptoms begin and how have they progressed?

Are they the result of an acute injury or accident?

Which doctors have you seen for this problem?

Which diagnostic studies have you had? What has been your diagnosis?

Which treatments have helped? What makes your symptoms better or worse?

Has surgery been mentioned for this problem?

Are you seeing an attorney for this problem?

Past Medical History:

Please list any current and past medical conditions or problems.

Have you had any surgeries or fractures?

Please list all food and drug allergies:

Medications (may attach separate list):

Social and Family History:

Are you married, single, widowed or divorced?

How many children do you have?

Did anyone in your family have similar symptoms?

Which activities are impaired by your symptoms?

Which activities make your symptoms worse?

Which favorite activity would you like to be able to do?

Are you on Workmen's Compensation?

If so, how well are you getting compensated compared to before?

Alcohol/Drugs: **What is your approximate weekly use of alcoholic beverages?**

- **____ I don't drink alcohol.**
- **____ Less than 1-2 drinks a week.**
- **____ 3-6 drinks a week.**
- **____ Drink some alcohol on a daily basis.**

Have you or a parent ever had a problem with:

- **Alcoholism: ____You ____ Parent ____ No Drug Abuse: ___ You ___ Parent ___ No**
- **Tobacco: What is your approximate daily use of tobacco?**

____ I don't smoke ____ 1 pack per day ___ More than 2 packs per day

____ ½ pack per day ____ 1-2 packs per day

Review of Systems:

Please circle or place an "x" next to any of the following conditions you might have now or before.

___ Taking blood thinners
___ Arthritis
___ Diabetes
___ Infections
___ Chemical exposures
___ Thyroid disorders
___ Lupus
___ Insomnia
___ Depression
___Anger
___ Weight loss or gain
___ Eye, ear, nose, throat, lung, heart, stomach, kidney or skin disorders (please circle)
___ Stroke
___ Neuropathy
___ Headaches
___ Family dysfunction
___ Fibromyalgia
___ Nausea
___ Vomiting
___ Chills
___ Problems with sexual function
___ Loss of sensation around groin or buttocks
___ Unexplained fevers
___ Night sweats
___ Loss of appetite
___ Excessive fatigue
___ Decreased concentration
___ Memory difficulties
___ Unusual stress in home life
___ Unusual stress in work life
___ Trouble breathing with exercise
___ Trouble breathing lying flat
___ Stomach pain
___ Swollen ankles
___ Joint pain or swelling
List joints: _____
___ Muscle tenderness
___ Generalized morning stiffness
___Blood in stool
___ Pain or burning when urinating
___ Blood in urine
___ Need to urinate more at night
___ Persistent eye redness
___ Dry eyes or mouth
___ Skin rashes

Gastrointestinal: Do you have ulcers? ____ Yes ____ No Has your ulcer bled? ___Yes ____No

Do you have reflux, hiatal hernia or GERD? ____ Yes ____ No

Check all of those that apply to you:

1. Bowel Function: __ Normal __ Loss of control or accidents __ Constipation
2. Bladder Function: __ Normal __ Loss of control or accidents __ Difficulty starting or stopping urination __ Sense of urgency
3. Leg/Foot: __ Normal __ Weakness (Right/Left)
4. Arm/Hand: __ Normal __ Weakness (Right/Left)

It is normal for patients faced with daily pain to experience emotional reactions such as worry, frustration and sadness. Please circle the appropriate number to indicate the extent that you are troubled by the following:

	NONE ←										**→ SEVERE**
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10

I currently take medications for anxiety or depression: _____ Yes _____ No
I have received counseling for anxiety or depression: _____ Yes _____ No

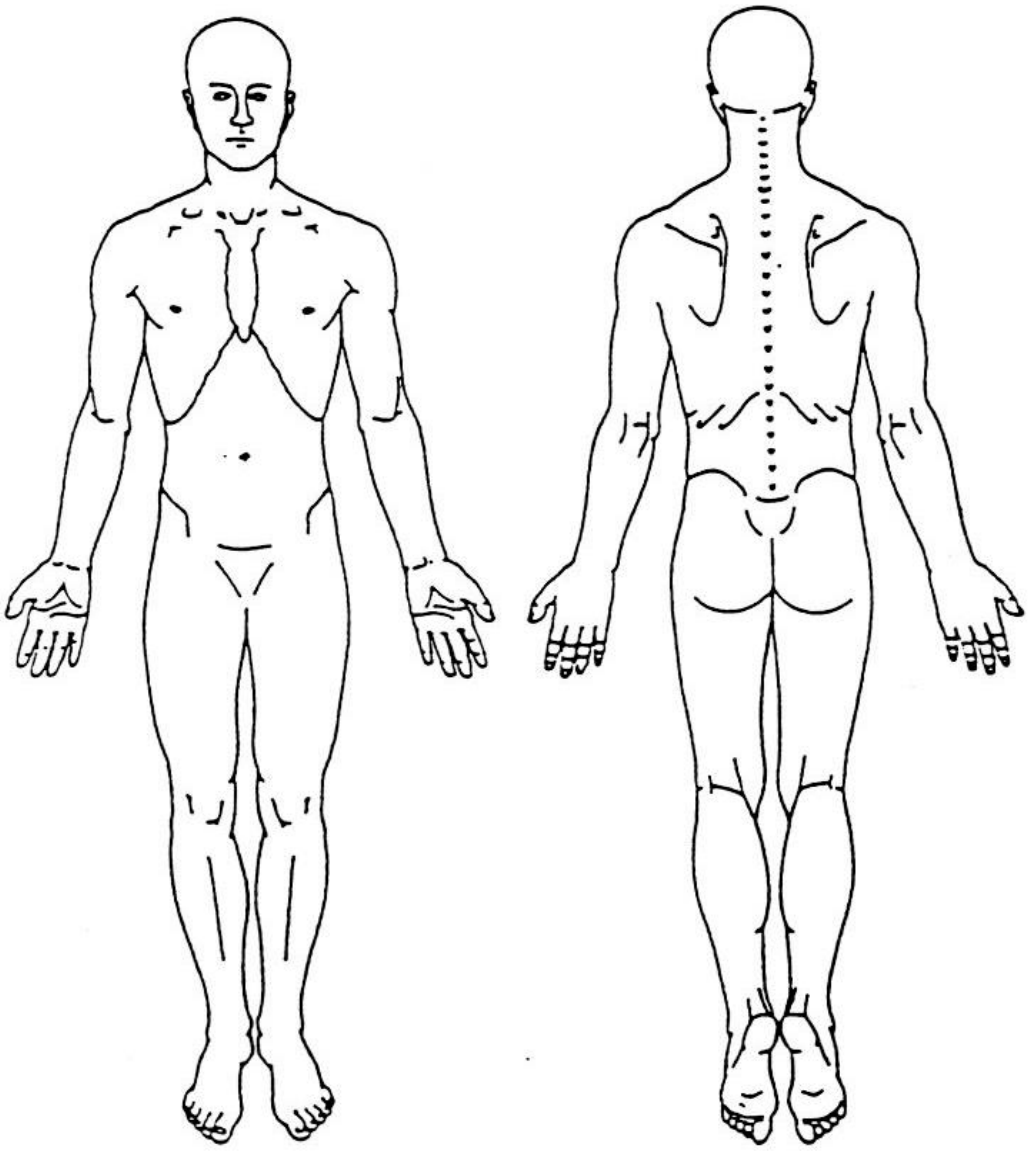
Which of the following have you had for your low back/mid-back/neck?				Did the treatment make you:		
	Low Back	**Mid-Back**	**Neck**	**Better**	**No Change**	**Worse**
Physical Therapy						
Occupational Therapy						
Chiropractic / Osteopathic						
Regular X-rays						
MRI Scan						
CT Scan						
EMG / NCV						

Note the location of your pain on these drawings.

(If the back of your neck is painful, mark the drawing on the back of the neck, etc.)

If you feel any of the following symptoms, please indicate where you feel them by placing the symbols on the diagrams.

Numbness	========	Pins and needles	oooooooooo	Ache	^^^^^^^^^^
	========		oooooooooo		^^^^^^^^^^
Burning	XXXXXXXX	Stabbing	//////////////		
	XXXXXXXX		//////////////		



Social: What are some of your usual recreational activities that you had participated in the **YEAR BEFORE** your current problem? **Place an "X" in front of those you currently cannot perform.**

[____] _____ [____] _____

[____] _____ [____] _____

Education: ***(Circle highest level attained)*** Did Not Finish High School / High School / College / Post Graduate

Primary Care Physician: Name: _____

Address: _____

Please inform me if any portion of the physical examination that I will perform causes you pain. Please do not perform any motion that causes your symptoms to worsen. An initial evaluation will occasionally increase your symptoms since painful structures are being evaluated.

Please sign and date this form.

_____ _____ _____ _____

Patient's Signature Date Physician's Signature Date

Record Review: Yes/NO **X-Ray Review: Yes/NO**

UPDATES:

_____ _____ _____ _____

Patient's Signature Date Physician's Signature Date

Record Review: Yes/NO **X-Ray Review: Yes/NO**

_____ _____ _____ _____

Patient's Signature Date Physician's Signature Date

Record Review: Yes/NO **X-Ray Review: Yes/NO**

_____ _____ _____ _____

Patient's Signature Date Physician's Signature Date

Record Review: Yes/NO **X-Ray Review: Yes/NO**

_____ _____ _____ _____

Patient's Signature Date Physician's Signature Date

Record Review: Yes/NO **X-Ray Review: Yes/NO**

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

I, _____ understand that as part of my health care, Marko Bodor, M.D., Inc., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment including phone message notifications to you about appointments;
- 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 and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Marko Bodor, M.D., Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations.

I further understand that Marko Bodor, M.D., Inc. reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Marko Bodor, M.D., Inc. change their notice, I will receive a revised notice at the next visit.

I wish to have the following restrictions to the use or disclosure of my health information:

I wish to have the following exceptions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax or electronically.

I fully understand and accept / decline the terms of this consent.

Patient's Signature: _____

Date: _____

FOR OFFICE USE ONLY

I Consent received by _____ on _____

I Consent refused by patient, and treatment refused as permitted

I Consent added to patient's medical record on ___ _____

If this is work-related injury, please answer the following questions:

Work:

Employer:_____

Job Title:_____

Date last worked:_____

Work status at the time of:	**Injury Onset**	**Currently**
On disability	_____	_____
Regular: full-time	_____	_____
Regular: part-time	_____	_____
Permanent light duty	_____	_____
Temporary light duty	_____	_____
Temporarily totally disabled (not working)	_____	_____
Retired	_____	_____

How physically demanding is your job?

_____ Very heavy (frequently lifting > 100 pounds)
_____ Heavy (frequently lifting > 60 pounds)
_____ Moderate (frequently lifting > 30 pounds)
_____ Light (frequently lifting < 30 pounds)
_____ Sedentary (essentially no lifting)

How satisfied are you with your job?

_____ Very satisfied
_____ Satisfied
_____ Dissatisfied
_____ It is the worst job I've ever had