

# PINNACLE MEDICAL GROUP

## Therapy & Wellness Center

4110 Manatee Ave. W. • Bradenton, FL 34205 • Tel: 941-748-8383

Marc S. Kallins, M.D. David S. Tsai, M.D.

### PATIENT INFORMATION

Please Print and Complete All Blanks

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

SSN#: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Email: \_\_\_\_\_

Race:  American Indian or Alaska Native  Asian  
 Native Hawaiian or Other Pacific Islander  White  
 Black or African American  Unreported/Refused to Report

Employer's Name/Address: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer's Phone: \_\_\_\_\_

Spouse's DOB: \_\_\_\_\_ Spouse's SSN#: \_\_\_\_\_

#### OUT OF STATE ADDRESS (if applicable)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

#### EMERGENCY CONTACT

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

### INSURANCE INFORMATION

Do You Have Medicare?  Yes  No Medicare Number: \_\_\_\_\_

Is The Visit Related To A Motor Vehicle Accident?  Yes  No Date of Accident: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Claim Representative: \_\_\_\_\_

Is This Visit Related To A Worker's Comp Accident?  Yes  No Date of Accident: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Claim Representative: \_\_\_\_\_

Do You Have An Attorney Handling Your Case?  Yes  No Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

Are You Now Or Have You Ever Been On Disability?  Yes  No

#### PLEASE PRESENT YOUR INSURANCE CARD(S) WHEN REGISTERING

I hereby authorize the release of medical information to insurance carriers concerning my condition and treatment, and I hereby assign to the doctor all payments for medical services rendered. I understand that *I am responsible for any amount not covered by insurance.*

Patient/Responsible Party's Signature \_\_\_\_\_

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**PATIENT HISTORY AND PHYSICAL**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

Allergies: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Please check all that apply

Heart Disease

Heart Attack

High Blood Pressure

Diabetes

Lung Disease

Kidney Disease

Peptic Ulcer Disease

Stroke

Thyroid Disease

Peripheral Vascular

Gout

Joint Replacement(s): \_\_\_\_\_

Fractures(s): \_\_\_\_\_

Anxiety/Depression

Cervical Discomfort

Extremity Discomfort

Loss of Sensation

Numbness \_\_\_\_\_

Trouble Walking

Falls

Kidney Stones

Hepatitis/Liver Disease

Osteoporosis

Gall Bladder Surgery

Abdominal Surgery

Hernia Surgery

Trauma

Other – Please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Names Of All Physicians, Including Therapists and Chiropractor, Seen In Last 3 Years

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SURGICAL/PROCEDURE HISTORY:**

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**PATIENT HISTORY AND PHYSICAL**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL HISTORY:**

Occupation (Past/Present): \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Children \_\_\_\_\_

Alcohol:  Never  Yes If "Yes" \_\_\_\_\_ drinks per \_\_\_\_\_

Quit:  No  Yes If "Yes" how many years? \_\_\_\_\_

If "Yes" have you ever been treated for alcohol abuse?  Yes  No

Tobacco:  Never  Yes If "Yes" packs per day? \_\_\_\_\_

Quit:  No  Yes If "Yes" how many years? \_\_\_\_\_

Recreational

Drugs:  Never  Yes If "Yes"  Oral  IV

Quit:  No  Yes If "Yes" how many years? \_\_\_\_\_

If "Yes" have you ever been treated for Narcotics abuse?  Yes  No

Coffee:  Never  Yes If "Yes" cups per day? \_\_\_\_\_

**FAMILY HISTORY:**

Rheumatoid Arthritis \_\_\_\_\_

Osteo Arthritis \_\_\_\_\_

Gout \_\_\_\_\_

Cancer \_\_\_\_\_

Osteoporosis \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Heart Disease \_\_\_\_\_

Diabetes \_\_\_\_\_

Stroke \_\_\_\_\_

Lupus \_\_\_\_\_

Polymyalgia Rheumatica \_\_\_\_\_

Use Braces/Medical Devices  Yes  N

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

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**PATIENT CONTROLLED SUBSTANCE DISCLOSURE**

Please list all types of controlled substance medication you have taken in the last 6 months; including prescribing physician and pharmacy where prescription was filled. Medications in this category include any taken for sleep, anxiety, pain and depression.

Drug	Dosage	Physician	Pharmacy

The physicians will only write for the types of medications described above, if you are not receiving prescriptions from other providers.

Medications will only be renewed when you are eligible based on appropriate usage. No early refills will be given under any circumstance, this includes if the prescription(s) are lost, stolen, or destroyed. Please note you are responsible for keeping your medications safe.

Seeking prescriptions for the above medications from other sources, including but not limited to, walk-in clinics and emergency rooms, without notifying this office is a violation of office policy and could result in discharge from this practice. Please notify the office of changes in medication usage, as well as any side effects you may experience.

It is the patient’s responsibility to anticipate the need for any prescription refills. Prescription refills are to be requested during normal office hours only. Please note, you must allow 1 business day for requests to be processed. Written prescription requests will not be taken on Fridays. Office hours are Monday - Thursday 8:30 am - 4:30 pm and Friday 8:30 am - 12:00 pm.

Please provide the office with the pharmacy location and phone number you will use when filling prescriptions provided by this office. You must notify the office if you change pharmacies.

Please note this office uses random drug screening to monitor medication and dosing compliance. You may be asked at anytime to participate in this screening process.

The above rules constitute an agreement between the patient, \_\_\_\_\_ and Pinnacle Medical Group. Any violation of this agreement may result in discharge from the practice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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**Patient Consent to Receive Mail, Telephone  
and/or E-mail Message**

DOB: \_\_\_\_\_  
Please print (Last Name) (First Name) (M.I.)

**Do we have permission to?**

Send a yearly appointment card to your home? Yes  No

Send test results to your home? Yes  No

Send test results to your email? Yes  No

Email address: \_\_\_\_\_

**Leave the following information on your home answering machine/voice mail/email:**

Appointment information Yes  No

Billing information Yes  No

Medical information Yes  No

**Leave the following information on your work answering machine/voice mail:**

Appointment information Yes  No

Billing information Yes  No

Medical information Yes  No

**I give permission to share appointment information with the person named below:**

Name: \_\_\_\_\_

**I give permission to share medical information (including biopsy/lab results, prescriptions, etc.) with the person(s) listed below:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

**I give permission to share billing information with the person listed below:**

Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

*For internal purposes only - Account No:*