VITAL TOTAL HEALTH Medical Group, Inc.
710 S Broadway, Suite 212, Walnut Creek, CA 94596
Phone and Fax (925) 388-9800

INTAKE FORM

Patient name: _____ Gender: _____

Street Address:_____
City: _____ State: _____ Zip: _____

Email: _____
Cell Phone: _____ Work Phone:_____
Home Phone: _____

Date of Birth: _____ Social Security Number:_____
Driver's License: _____ State: _____

Employer: _____
Address: _____
___ Retired ___Disabled ___On Social Security Disability ___On Work Comp Disability

Primary Care Doctor:
Doctor: _____
Address: _____
Telephone: _____ Fax: _____

Emergency Contact:
Name: _____
Address: _____
Phone: _____ Relationship: _____

HOW DID YOU FIND US:
___ Internet: ___Google ___Microsoft ___Yelp ___Facebook ___YouTube
___ Print: ___Ad ____ Yellow Pages ___ Post Card ____ Mailer ___Other: _____
___ Your Insurance Book ___ Family or Friend _____

REFERRED BY:

___ Doctor: _____ City: _____

Telephone: _____

___ Attorney: _____

Address: _____

Telephone: _____

___ Insurance Co: _____

Telephone: _____ Contact Person: _____

INSURANCE POLICIES:

___ Self-Pay

(We do not accept Medi-Cal. Write your Medi-Cal info at Ins #1, they accept our med, x-ray, lab orders)

___ Medicare Primary: Medicare Number _____

(Please note, we accept straight Medicare, but we are <u>not</u> on any HMO plans).

Commercial/Private Insurances: (eg. Aetna, Cigna, United Healthcare, Blue Cross, Sutter, etc.)

Insurance 1: _____

Insurance Telephone Number: _____

Subscriber ID #:_____

Group #: _____ Plan: _____

Insurance 2: _____

Insurance Telephone Number: _____

Subscriber ID #: _____

Group #: _____ Plan: _____

___ Work Comp: Employer _____ Date of Injury _____

Your Work Compensation or Auto Insurance Co:_____

Claims Adjustor: _____ Telephone _____

Claim Number: _____

Your Attorney Name: _____ Telephone_____

___ Auto / Personal Injury: Date of Accident: _____ Where occurred: _____

Your Auto Insurance Co: _____ Telephone_____

Other Parties' Insurance Co: _____Telephone _____

Claims Adjustor: _____ Telephone _____

Claim Number: _____

Your Attorney Name: _____ Telephone _____

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS
AND FINANCIAL RESPONSIBILITY, and
RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and other health plans, to VITAL TOTAL HEALTH MEDICAL GROUP, INC. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Vital Total Health Medical Group, Inc., to use, to disclose, and to release any of my personal and healthcare information to secure payment. I authorize Vital Total Health Medical Group, Inc. to release my medical information to any physicians and healthcare providers as well as adjustors, case managers, vocational counselors, and pharmacists. I further authorize any physicians and healthcare providers to release my medical, laboratory, x-ray and diagnostic, pharmaceutical, and psychiatric records to Vital Total Health Medical Group, Inc.

I acknowledge that I have been informed of my rights under the Health Information Protection and Portability Act (HIPAA), I understand that I may request copies of this information and rights any time.

Signature: _____

Printed Patient Name: _____

Date: _____