

ELLY S. LAROCQUE, M.D.
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Confidential Intake Form

(To safeguard your information, please do not e-mail this form to us)

Contact Information

| | | |
|-----------------------------------|---|--|
| LAST NAME | FIRST NAME (ANY INITIALS; NAME YOU GO BY) | MR. <input type="checkbox"/> MS. <input type="checkbox"/> MRS. <input type="checkbox"/> DR. <input type="checkbox"/> OTHER/NONE <input type="checkbox"/> |
| ADDRESS | HOME TELEPHONE | CELL |
| | WORK TELEPHONE | FAX |
| OCCUPATION | DATE OF BIRTH | AGE |
| EMPLOYER | EMPLOYER ADDRESS | |
| EMPLOYER TELEPHONE | | |
| FULL NAME OF SPOUSE | SPOUSE'S EMPLOYER | |
| SPOUSE'S CONTACT TELEPHONE NUMBER | SPOUSE'S WORK NUMBER | |
| OTHER EMERGENCY CONTACT PERSON | OTHER EMERGENCY CONTACT PERSON'S NUMBER | |

Referral Information

| | |
|----------------------------|---------------------|
| REFERRED BY | PRIMARY CARE DOCTOR |
| REFERRING DOCTOR'S ADDRESS | |

Reason for Visit (and Related Information)

| | | | |
|---|----------------------------------|---|--|
| WHICH PART OF THE BODY DOES THIS CONCERN? | | RIGHT SIDE <input type="checkbox"/> | LEFT SIDE <input type="checkbox"/> |
| IS THIS AN ILLNESS? | IS THIS AN INJURY? | HOW LONG HAVE YOU HAD THIS ISSUE? (DATE OF ONSET OR INJURY) | |
| IF THIS IS AN INJURY, IT HAPPENED . . . | | | |
| AT WORK <input type="checkbox"/> | AT HOME <input type="checkbox"/> | DURING A SPORTS ACTIVITY <input type="checkbox"/> | AS THE RESULT OF AN AUTOMOBILE ACCIDENT <input type="checkbox"/> |
| NAME(S) AND CONTACT INFORMATION OF ANY OTHER DOCTOR(S) YOU HAVE SEEN FOR THIS | | | |
| ARE ANY RELATED RECORDS AVAILABLE? | | X-RAYS <input type="checkbox"/> | MRI <input type="checkbox"/> |
| | | CT <input type="checkbox"/> | EMG <input type="checkbox"/> |
| PURPOSE OF APPOINTMENT | | CONSULTATION ONLY <input type="checkbox"/> | CONSULTATION AND TREATMENT <input type="checkbox"/> |
| | | SECOND OPINION <input type="checkbox"/> | |

Insurance Information

—PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST—

| | | |
|--------------------------------------|---|----------------|
| NAME OF PRIMARY INSURANCE PROVIDER | ID NUMBER | |
| NAME OF SUBSCRIBER | GROUP NUMBER | EFFECTIVE DATE |
| YOUR RELATIONSHIP TO SUBSCRIBER | CONTACT TELEPHONE NUMBER FOR PRIMARY INSURANCE PROVIDER | |
| SUBSCRIBER'S SOCIAL SECURITY NUMBER | SUBSCRIBER'S DATE OF BIRTH | |
| NAME OF SECONDARY INSURANCE PROVIDER | ID NUMBER | |
| NAME OF SUBSCRIBER | GROUP NUMBER | EFFECTIVE DATE |
| YOUR RELATIONSHIP TO SUBSCRIBER | CONTACT TELEPHONE NUMBER FOR SECONDARY INSURANCE PROVIDER | |
| SUBSCRIBER'S SOCIAL SECURITY NUMBER | SUBSCRIBER'S DATE OF BIRTH | |

I hereby assign medical and/or surgical payments—including major medical benefits to which I am entitled, private insurance, and proceeds from any other health plan—to Elly LaRoque, M.D., for services she provides. This assignment shall remain in effect until I submit a written revocation to her. I understand that I am financially responsible for all charges for the provided services, whether or not they are paid for by such insurance. I hereby authorize assignee to release any of the above information to secure payment. A copy of this assignment shall be as valid as the original.

Date: _____

Patient Acknowledgment: _____