# CONFIDENTIAL PATIENT INFORMATION

**Richard A. Ridao, MD**

**PATIENT INFORMATION**

Last Name: _____ First Name:_____ M.I.:____ E-Mail Address:_____

Male ☐ Female ☐ Birth Date: _____ /_____ / _____ Marital Status: Single ☐ Married ☐ Other ☐

Social Security Number: _____ / _____ / _____ Home Telephone number: ( _____ ) _____ - _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Work Telephone Number: ( _____ ) _____ - _____ Cellular Phone: ( _____ ) _____ - _____

**WHO MAY WE THANK FOR REFERRING YOU?** _____

**INSURANCE INFORMATION**

Primary Insurance: _____ Policy Number: _____

Subscriber Name: _____ Subscriber DOB: _____ /_____ / _____

Subscriber Relationship to Patient: _____ Subscriber Sex: Male ☐ Female ☐

Secondary Insurance: _____ Policy Number: _____

Subscriber Name: _____ Subscriber DOB: _____ /_____ / _____

Subscriber Relationship to Patient: _____ Subscriber Sex: Male ☐ Female ☐

Workers' Comp Claim? Yes ☐ No ☐ Automobile Accident? Yes ☐ No ☐ Third Party Claim? Yes ☐ No ☐

Date of Injury: _____ Insurance Carrier: _____

Claim Number: _____ Adjustor's Name / Telephone Number: _____

**RESPONSIBLE PARTY INFORMATION (IF SAME AS PATIENT, CHECK HERE ☐ AND SKIP TO NEXT SECTION)**

Last Name: _____ First Name:_____ M.I.:____ Relationship::_____

Male ☐ Female ☐ Birth Date: _____ /_____ / _____ Marital Status: Single ☐ Married ☐ Other ☐

Social Security Number: _____ / _____ / _____ Home Telephone number: ( _____ ) _____ - _____

**EMERGENCY CONTACT:** Name: _____

Relationship to Patient: _____ Telephone Number: _____

**INSURANCE AND INFORMATION AUTHORIZATION – Please Read and Sign**

I verify that the above information is correct. I hereby authorize Dr. Richard A. Ridao or his agents to furnish to insurance carriers and governmental agencies, including Medicare and CMS, information concerning my illness and treatments and assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for all charges not covered by insurance.

I authorize Dr. Richard Ridao and his agents to disclose and request my unrestricted health information to and from: 1) Any health insurance plan and billing service for the purpose of payment of charges; 2) Physicians, hospitals, and facilities for the purposes of continuity of care; 3) Any insurance company that provides liability insurance coverage for Dr. Richard Ridao or his agents to evaluate clinical performance; 4) Workers' compensation, no-fault, or administrative proceeding for the purpose of evaluating my medical condition.

This authorization covers the period from my first visit until 2 years after the date of my last visit. A photocopy of this authorization will be as valid as the original.

Signature: _____ Date: _____

# CONFIDENTIAL PATIENT HEALTH QUESTIONNAIRE

**Richard A. Ridao, MD**

**Thank you for taking the time to fill out this confidential health questionnaire. This will help us to take better care of you.**

Last Name: _____ First Name:_____ M.I.:____ Age: _____

Male ☐ Female ☐ Birth Date: _____ /_____ / _____ Date of Last Physical Exam: _____

**What is Your Reason For Visiting Us Today?** _____

_____

**SYMPTOMS – PLEASE CHECK OFF SYMPTOMS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST YEAR:**

**GENERAL:**
Dizziness ☐ Fatigue ☐ Fever ☐ Headache ☐ Insomnia ☐ Loss of Appetite ☐ Nervousness ☐ Undesired Weight Loss ☐

**EYES:**
Blurred Vision ☐ Double Vision ☐ Eye Pain ☐ Temporary Blindness ☐ Do You Wear Glasses or Contact Lenses? ☐

**EARS, NOSE, THROAT:**
Bleeding From Gums, Ears, or Nose ☐ Difficulty Swallowing ☐ Earache ☐ Hearing Loss ☐ Ringing in Ears ☐ Sore throat ☐

**CARDIOVASCULAR:**
Chest Pain ☐ Decreased Exercise Tolerance ☐ Fainting Spells ☐ Irregular or Rapid Heart Beat ☐ High Blood Pressure ☐
Low Blood Pressure ☐ Leg Cramps ☐ Poor Circulation ☐ Shortness of Breath ☐ Swelling of the Legs or Ankles ☐

**RESPIRATORY:**
Do You Smoke? ☐ Coughing up Blood ☐ Persistent Cough ☐ Shortness of Breath ☐ Wheezing ☐ Use of Oxygen ☐

**GASTROINTESTINAL:**
Abdominal Cramps ☐ Black or Bloody Stools ☐ Bloating ☐ Bowel Changes ☐ Constipation ☐ Diarrhea ☐ Gas ☐
Heartburn ☐ Hemorrhoids ☐ Loss of Appetite ☐ Nausea ☐ Pain ☐ Vomiting ☐

**GENITOURINARY:**
Bloody Urine ☐ Frequent Urination ☐ Loss of Bladder Control ☐ Nocturia (Night-time urination) ☐ Painful Urination ☐

**MUSCULOSKELETAL:**
Joint Pain or Swelling ☐ Muscle Pain ☐ Muscle Weakness ☐

**SKIN:**
Easy Bruising ☐ Hives ☐ Itching☐ Non-healing Sore ☐ Rash ☐ Recurrent Bleeding ☐ Suspicious Mole or Lesion ☐

**NEUROLOGIC & PSYCHIATRIC:**
Anxiety ☐ Crying Spells ☐ Confusion ☐ Depression ☐ Headaches ☐ Insomnia ☐ Memory Loss ☐ Numbness ☐
Paralysis ☐ Slurred Speech ☐ Weakness ☐ Heavy Alcohol Use ☐ Illegal Drug Use ☐

**ENDOCRINE:**
Excessive Thirst ☐ Excessive Urination ☐ Heat or Cold Intolerance ☐ Hot Flashes

**OTHER:**
Breast Lump, Pain, or Discharge ☐ Difficulty with Intercourse ☐ Discharge From Genitals ☐ Sores on Genitals ☐

| CHRONIC MEDICAL PROBLEMS | HOSPITALIZATIONS & SURGERIES | DATE |
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| MEDICATIONS – Include Dosage and Frequency | ALLERGIES – To Medications and Substances |
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I hereby certify that the above information is accurate and correct to the best of my knowledge. I will not hold Dr. Richard Ridao, his agents, or his staff responsible for any errors, omissions, or misrepresentations, that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed By: _____ Date: _____