

New Patient Information

Personal Data

Patients Name		Date of Birth	
Home Address		Soc.Sec.No	
City/St./Zip			
Home Phone			
Emergency Contact			

Employment Information

Employer		Occupation	
Address			
City/St./Zip			
Work Phone			

Referring M.D.

Name	
Address	
City/St./Zip	
M.D. Phone	

Attorney Information

Name	
Address	
City/St./Zip	
Attorney Phone	
Attorney Fax	

Personal Insurance

Carrier	
Address	
City/St./Zip	
Ins. Co. Phone	

Alta Bates Medical Group?

Policy #	
Group #	
Co-pay	
Medicare	Primary Secondary N/A

Worker's Compensation Insurance

Work-related accident?

Carrier	
Address	
City/St./Zip	
Ins. Co. Phone	

Date of injury	
Claim #	
Review Co.	
Adjuster's name	
Adjuster's phone	
Adjuster's fax	

Problem Description

- Left
 Right

How occurred?
 Previous treatment:

Interpreter Information

Name:
 Phone:
 Fax:

Initials (Info taken by) _____
 Date _____

CONFIDENTIAL MEDICAL QUESTIONNAIRE

ORTHOPEDIC HISTORY

Prior to this, have you had any injuries or problems with your hands arms or shoulders? YES NO

If so, please list and state whether it is left or right side:

Have you had any fractures or injuries resulting from a previous accident? YES NO

If so, please list, stating left or right side and approximate dates:

WORK HISTORY

What is your present occupation?

For how long?

Are you currently working? YES NO Full Duty Light Duty

Job Description:

Describe the routine activity in your job (for example: lifting, pushing, filing, typing)

Do you do any lifting at work? YES NO If yes, how many pounds?

What is the heaviest object you must lift?

Do you do any overhead work? YES NO Regularly Occasionally Never

Do you do any overhead lifting? YES NO If yes, how many pounds?

If you are not currently working, what was the date that you last worked?

What was your past occupation (if different from above) over the past ten years?

SOCIAL HISTORY

____Married ____Single ____Living with significant other

Do you live by yourself? ____yes ____no

If any, how many children do you still have living at home? ____

What are your hobbies? _____

Do you smoke? ____yes ____no

Have you ever been addicted to any drug? ____yes ____no

Have you ever been in the Armed Forces? ____yes ____no

If yes, was your discharge medical or non-medical? _____

CONFIDENTIAL MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

Do you have any medical allergies? _____yes _____no Please list if any:

Do you see any other doctors regularly? _____yes _____no If so, please list and indicate any medical problems for which you are currently being treated:

<i>Physician</i>	<i>Type of Doctor</i>	<i>Condition being treated for</i>

Please list any medications that you take on a regular basis: _____

Have you recently been on prednisone or any steroids? _____yes _____no

If so, when did you need them last? _____

Are you currently on a blood thinner (coumidin/warfarin)? _____yes _____no

Are you pregnant? _____yes _____no

Are you considering getting pregnant in the near future? _____yes _____no

If so, approximately when? _____

When was the date of your last tetanus shot? _____

Do you have now, or have you ever had:

Heart burn	Bleeding disorder
Yellow jaundice	Kidney problems
Bleeding form your stomach	Ulcer
Swollen ankles	Water on your lungs
High blood pressure	Liver trouble
Gastritis/sensitive stomach	Abmormal liver test
Nervous breakdown	Hepatitis
Blood transfusion	Diabetes
Colon problems	Arthritis
Asthma	Heart trouble
Epilepsy	Prostate problems
Poor teeth	Polio
Dentures	Circulatory problems
Shortness of breath	Tuberculosis
Bone/joint disease	Chest pain
Bursitis	Varicose veins
Lung trouble	Positive HIV test
Abnormal vaginal bleeding	Glaucoma
Thyroid problems	

Did you ever have an operation? _____yes _____no Please list and give approximate dates:

<i>Procedure</i>	<i>Approximate Date</i>

Have you ever had a problem with anesthesia? _____yes _____no If yes, please elaborate:

Thank you for your time and attention in filling out this form.

OFFICE PAYMENT POLICY

Payment for office examination and treatment is requested in advance unless other arrangements have been made with the office manager.

We are happy to assist you in submitting your insurance claims, but remember that insurance is a method of reimbursing you, the patient, for fees paid to the physician. It is not a substitute for payment.

Authorization for Release of Medical Information

I hereby authorize the release of any and all information acquired in the course of my examination and treatment for the purpose of securing payment of benefits from my insurance company. A photocopy of this agreement is to be considered as valid as the original.

Signature _____ Date _____

Assignment of Payments

I hereby assign all surgical and/or medical benefits for services rendered, to be paid directly to the Oakland Office of Dr. Mathias Masem, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature _____ Date _____