

New Patient Information Sheet

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

Name: _____ Date: _____ Age: _____

Dominant Hand: Left Right Ambidextrous Height: _____ Weight: _____

Place of Birth (Please include country): _____

Racial or Ethnic background: Caucasian (white) African American Asian

Native American Hispanic East Indian Arabic

Other (please state)

HISTORY OF THE CURRENT PROBLEM

On which side is your problem? Right Left Both sides

When did you first notice the problem? _____

Please describe your current problem: _____

What were you doing at the time of your accident/injury? _____

Where did you first go to be treated? _____

How long have you had pain or difficulty functioning due to this problem? _____

Do you have pain or difficulty functioning with: all activities only certain activities

If you have problems sometimes, please describe the types of activities that cause problems. _____

What makes is worse? _____

What makes is better? _____

Below please put a check next to any previous procedures or tests that have been done to diagnose your current problem. Please write where these were done next to the test name.

✓	Previous procedures or tests	Where performed	When? (Mo/Yr)
	Splint/Cast		
	Injection		
	X-rays		
	Bone Scan		
	CT or CAT scan		
	MRI		
	EMG (nerve study)		
	Blood tests		
	Surgery		

Any other test or procedures not mentioned above? _____

List any medications you have been on for this current problem: Please indicate any problems or side effects.

Medication	Problem or Side effect

Please List any additional information that you think would help the doctor better understand your current problem: _____

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 _____

PATIENT FINANCIAL POLICY

The following financial policy is effective as of January 1, 2006. All patients, new and returning, must sign and date this agreement prior to seeing their provider.

We apologize for any inconvenience this new policy may create for you. However, after careful consideration, we have determined that this new policy is necessary in order to bring you quality care.

It is the patient's responsibility to provide the office with current, complete, and accurate insurance information. Any delay in providing this information may result in a denied claim, as there might be a time limit on submitting claims. In the event of a denied claim, the patient would be held responsible for the entire bill. The patient must also immediately inform the office of any change in their insurance coverage.

The patient is responsible for knowing his or her insurance coverage. It is the patient's responsibility to find out if the physician that they are seeing is within their particular insurance plan network or HMO. It is also the patient's responsibility to know if their insurance company requires a pre-authorization to see a physician here. If this is the case, it is the responsibility of the patient to obtain an authorization PRIOR to any visits.

OUT OF NETWORK PRIVATE PATIENTS

If the physician you are seeing here is out of network for your plan, we will submit claims to your insurance company as a courtesy. However, we will not take any additional adjustments, as required under a PPO contract, and you will be responsible for all unpaid charges that are not covered by your plan. Should your account become overpaid, i.e. a negative balance, a refund check will be issued.

IN-NETWORK PRIVATE PATIENTS

Please be prepared to pay your co-pay at each visit. You may also be asked to bring any owing co-pays to make your account current. We accept Visa and Mastercard. We will bill your insurance for you, if we are a participating provider with your plan. You will be responsible for any amounts deemed to be your responsibility by your insurance plan.

ALL INJURED PATIENTS

Any patient seeing a provider in this office as a result of either an industrial injury or a personal injury, i.e. a motor vehicle accident or slip/fall type injury, must provide this office with complete and accurate details of the injury, including date, time, place, and how the injury occurred. Patients must also respond to any inquiries their insurance company might have regarding our claim in a timely fashion.

We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, etc.

PATIENTS WITH INDUSTRIAL INJURIES

If you are here because you were injured at work, this office must have written prior authorization from your employer's workers compensation carrier to see you. This is done by having the claims adjuster handling your case fax us the necessary information. Additionally, if we are aware that you were injured at work and that a claim has been filed, we can not bill your private insurance, as they will not cover medical expenses for active industrial claims.

I have read and agree to the above financial policy.

Signed: _____ Date: _____
Printed Name: _____