

Phone: (510) 297-0550 13690 E 14th St #200 San Leandro, CA 94578

PATIENT INFORMATION (PLEASE PRINT)					Email Address:					
Name: Last First					Middle Maiden					
Home Address: Street				City				State	Zip	
Home Phone:	Cell Phone:			Birthdate:		date:	Social Security Number:		Sex: M	F
Patient Occupation:		Employm	ent: ☐ Full Time ☐ Unemploye			Employer:	Business Pho		ne:	Ext.
Employer's Address: Street	•			City				State	Zip	
Emergency Contact:	Ph	one Numbe	er:	Address:						
ho referred you to our office?					Have you been treated here before? (circle one) Yes No			le one)		
FINANCIAL INFO	RN	IATIO	N OF RE	SPON	SIB	LE PART	Y	HECK HERE IF S	SAME AS AB	OVE)
Name of responsible party:			Relationship to	patient:			Birthdate	»:		
Address: Street				City				State	Zip	
Home Phone:			Social Security	Number:			Drivers I	License Number	:	
Occupation:		Employm	ent: ☐ Full Time ☐ Unemploye			Employer:		Business Phone:		Ext.
Employer's Address: Street				City				State	Zip	
INSURANCE INFO	RI	MATI(ON (PLEASE	E FILL O	UT AI	L SPACES R	ELATING	TO YOUR C	COVERAG	E)
CHECK TYPE OF COVER	AG	E				PRIMAR	Y INSURAN	CE SEC	ONDARY INS	SURANG
GROUP PLAN NAME OF THE II		IE OF THE INSUI	INSURED							
NAME OF INSUR		IE OF INSURANC	JRANCE COMPANY							
☐ INDIVIDUAL PLAN		BILLING ADDRESS								
		TELEPHONE NUMBER								
□ MEDICARE		SUB	SUBSCRIBER ID NUMBER							
		GRO	UP OR LOCAL N	UMBER						
□ НМО		SOCIAL SECURITY NUMBER								
		BIRT	THDATE							
☐ INDUSTRIAL ACCIDENT CLAIM NUMBER			IM NUMBER							
RELEASE	Ol	F MEDI	CAL INFOR	MATI(ON AI	ND ASSIGN	MENT O	F BENEFI'	ΓS	
nereby authorize payment directly nancially responsible for charges ere the original. If it becomes neo all pay the reasonable attorney fe	not o	covered by ary for the	this authorization	on. I also a	authoriz	e that a photogr	aphic copy	of this authoriz	ation is as if	such co
nereby consent and give my permocedures upon me as the doctor d	issio	on to the do	TREA	TMENT			lacement) to	o administer and	d perform suc	ch
rint name of patient, parent.	Or.	legal gu	ardian	Sign	nature	of patient, pa	rent or la	oal guardian	, r	DATE.



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PATIENT QUESTIONNAIRE

Name:			Age:		S	ex: M F	Date	:
Which Hand do y	ou WRITI	E with:	RIGHT	LEFT		Height:		_ Weight:
Occupation:								
Hobbies:								
								nd when they began)
For this problem:								
Treatment		_				_		6/Nerve Conduction Surgery
Prior Surgeries: (please inc	clude all s	urgeries	during	your lif	etime):		
Other injuries:								
Medical Condition	ns : Diabe	etes Hig	h Blood	Pressu	re H	ligh Cholest	erol	Hypo/Hyper Thyroid
Rheumatoid Arthri					•	titis A / B / C	C Tube	erculosis Gout
Heart Disease			COP	D				Liver Disease
Alcoholism Other:			Burs		Block	ed Arteries	Depi	ression
Allergies to medi Please list MEDIC								
Current Medicatio	ons (pleas	se list PR	ESCRIB	ED and	OVER	THE COU	NTER):	
Cigarette use:	No	Quit	When	n \	/es	Amount _		(# per day)
Alcohol use:	No	_ Quit	When	ı \	es	Amount _		_ (# per week/month)
Last Tetanus Sho	ot:							
Anesthesia Probl	ems: No	Ye	s	Please	descri	be:		
Bleeding problen	ns after s	urgery: N	lo `	Yes	Plea	se describe	:	





FINANCIAL RESPONSIBILITY WAIVER

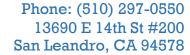
PATIENTS WITH INSURANCE: Although we will bill your Insurance Company/Medical Group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your Health Plan/Medical Group, we will contact you for assistance. Should your Health Plan/Medical Group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

DUAL COVERAGE: **East Bay Hand Medical Center** abides by the California State Insurance Laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information from primary, secondary, and tertiary health plans.

CO-PAY POLICY: Your Health Plan requires that you make your co—payment at the time of visit. However, in an emergency situation, when you are unable to make your copayment, you will be granted a 10-day grace period in which to make payment without penalty.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I authorize the release of any medical information which may have a bearing on the determination and/or payment of my claim. I request that payment be made directly to **East Bay Hand Medical Center**, and acknowledge that I am responsible for payment if this assignment is not honored.

I have read and understand the above polic that all information give is true and accurat	ies and I agree to comply with them. I attest te to the best of my knowledge.
Patient Signature	Date
I/we wish to accept financial responsibility named patient.	for medical expenses incurred by the above-
Gaurantor (Print)	Phone # ()
Gaurantor Signature	Date





ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I further acknowledge that a copy of the current Notice will be provided by the front desk staff.

You may request a copy of the Notice to keep for your records. If you have questions regarding the Notice, please do not hesitate to contact Karen Stein at (510) 297-0050.

Patient name (please print)	Date
Signature		
Parent of Auth	orized Representative (if applicable)	Relationship
answering mac		Its, surgery scheduling) may be left or mber: ()
	Patient only (if checked, STOP HERE	Ε)
I	Family Member or Friend (if checked	, fill in name(s) below)
Name: _	Restrictions*:	Relationship:
Name: _	Restrictions*:	Relationship:
Name: _	Restrictions*:	

^{*}Restriction examples: Appointment Date/Time only, No Prescription information, etc.