EastBayHand Medical Center

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:	Social Security Number:	Sex: **M** **F**
Patient Occupation:	Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Student	Employer:	Business Phone: Ext.	
Employer's Address: Street		City	State	Zip
Emergency Contact:	Phone Number:	Address:		
Who referred you to our office?		Have you been treated here before? (circle one) Yes No		

FINANCIAL INFORMATION OF RESPONSIBLE PARTY ☐ (CHECK HERE IF SAME AS ABOVE)

Name of responsible party:	Relationship to patient:	Birthdate:	
Address: Street	City	State	Zip
Home Phone: ( )	Social Security Number:	Driver's License Number:	
Occupation:	Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Student	Employer:	Business Phone: Ext.
Employer's Address: Street	City	State	Zip

INSURANCE INFORMATION (PLEASE FILL OUT ALL SPACES RELATING TO YOUR COVERAGE)

CHECK TYPE OF COVERAGE		PRIMARY INSURANCE	SECONDARY INSURANCE
☐ GROUP PLAN	NAME OF THE INSURED		
	NAME OF INSURANCE COMPANY		
☐ INDIVIDUAL PLAN	BILLING ADDRESS		
	TELEPHONE NUMBER		
☐ MEDICARE	SUBSCRIBER ID NUMBER		
	GROUP OR LOCAL NUMBER		
☐ HMO	SOCIAL SECURITY NUMBER		
	BIRTHDATE		
☐ INDUSTRIAL ACCIDENT	CLAIM NUMBER		

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to East Bay Hand Medical Center of the insurance benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this authorization. I also authorize that a photographic copy of this authorization is as if such copy were the original. If it becomes necessary for the account to be referred to collection agency or an attorney for collection or suit, the undersigned shall pay the reasonable attorney fees and collection expenses.

Worker's Comp Patients are NEVER balance billed and are ONLY responsible for payments if their claim is denied by their WC provider

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Print name of patient, parent, or legal guardian

Signature of patient, parent, or legal guardian DATE

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INITIAL WORKERS COMPENSATION PATIENT QUESTIONNAIRE

Name:____________________________ **Age**:________ **Sex**: M F **Date**: ________________________

Which Hand do you WRITE with: RIGHT LEFT **Height**: _________ **Weight**: ________________

Who referred you to this office? _____________________________ **Date of injury:** ____________________

Date you first noticed symptoms: ____

History of Injury: (Please describe symptoms, how the injury occurred, and when symptoms began)

____

____

Describe your pain (circle): *Dull / Sharp / Aching / Stabbing / Throbbing / Burning*

What doctors have you seen? ____

What treatment have you had? (circle) *Splint / Injection / Medication / Therapy / Surgery*

How many therapy sessions have you had? ____

What tests have you had? (circle) *X-Ray / MRI / CT Scan / EMG (Nerve Study) / Arthrogram*

Name of Employer: ____

Date hired: _______________ If less than 5 years, list prior 2 employers and how long you worked for them:

____

What is your job title? ____

How many hours per week did you work before the pain started? ________________________________

Describe your work duties (*write/type/lift/overhead work*) ____

____

How much time have you taken off work for this problem? _____________________________________

Describe your work modifications (*lifting limit, limited/no use, etc.*) ________________________________

____ **When did modifications begin?** ________________

List any prior Workers Compensation Claims: ____

Current Medications (please list PRESCRIBED and OVER THE COUNTER): __________________________

____

Allergies to medications: No _____ Yes _____ **MEDICATION and REACTION**: _______________________

____

Cigarette use: No ____ Quit ____ When ____ Yes ____ Amount _________ (# per day)

Alcohol use: No ____ Quit ____ When ____ Yes ____ Amount _________ (# per week/month)

Medical Conditions: *Diabetes / High Blood Pressure / High Cholesterol / Hypo/Hyper Thyroid*
Rheumatoid Arthritis / Stroke / Seizure / Hepatitis A / B / C / Tuberculosis / Gout / Heart Disease
Heart Attack / COPD / Asthma / Ulcers / Liver Disease / Alcoholism / Osteoarthritis / Bursitis
Blocked Arteries / Depression / Other: ____

Prior Surgeries: (please include all surgeries during your lifetime): __________________________________

____

____

Highest grade you completed in school (circle one):

Elementary School Jr. High School High School College (# of years_____)

List your hobbies: ____

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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 Authorized Representative (if applicable) Relationship

Detailed messages (i.e. prescription refills, test results, surgery scheduling) may be left on answering machine: Yes ____ No ____ Phone Number: (_____) ___________________

Medical Information can be discussed with:

______ Patient only (if checked, STOP HERE)

______ Family Member or Friend (if checked, fill in name(s) below)

Name: _________________________________ Relationship: __________________
Restrictions*: ____

Name: _________________________________ Relationship: __________________
Restrictions*: ____

Name: _________________________________ Relationship: __________________
Restrictions*: ____

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