

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

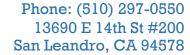
PATIENT INFOR	MATI	ON (PLEAS	SE PRI	NT)	Email Address	3:				
Name: Last First				Middle Maiden						
Home Address: Street			City				State		Zip	
Home Phone:	Cell Pho	Cell Phone: Birtho			late: Social Security Number: Sex: M			I F		
Patient Occupation:	( Employe	( ) Employment: □ Full Time □ Part			Employer:		Busines	ss Dhon	0:	Ext.
-	Employment: ☐ Full Time 1			tudent	Employer.		Dusines	88 1 11011	С.	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 INFOR	MATI(			SIB	LE PART			RE IF SA	AME AS AI	BOVE)
Name of responsible party:		Relationship to	patient:			Birthdate	<b>:</b> :			
Address: Street	Address: Street			ty		State			Zip	
Home Phone:		Social Security	Number:			Driver's	License N	Number		
Occupation:	Employr	nent: □ Full Time □ Unemploye	e 🗆 Part	Time tudent			Busines	iness Phone: Ext.		
Employer's Address: Street			City			State		Zip		
INSURANCE INFOR	RMATI	ON (PLEASE	FILL O	UT AI	L SPACES R	ELATING	то yо	UR CO	OVERAG	E)
CHECK TYPE OF COVERAGE					PRIMARY	PRIMARY INSURANCE SECONDAR'S		NDARY IN	SURANCE	
☐ GROUP PLAN  NAME OF THE INSU		RED								
NAME OF INSU		ME OF INSURANC	NSURANCE COMPANY							
□ INDIVIDUAL PLAN		BILLING ADDRESS								
		TELEPHONE NUMBER								
□ MEDICARE		SUBSCRIBER ID NUMBER								
		GROUP OR LOCAL NUMBER								
□ НМО		SOCIAL SECURITY NUMBER								
	BIR	THDATE								
☐ INDUSTRIAL ACCIDENT CLAIM NUMBER										
		CAL INFOR								
I hereby authorize payment directly to financially responsible for charges no were the original. If it becomes neces shall pay the reasonable attorney fees **Worker's Comp Patients are NEVI	ot covered by ssary for the and collect	y this authorizatio account to be refion expenses.	n. I also a erred to c	uthoriz ollectio	e that a photogran on agency or an a	aphic copy attorney for	of this au collection	thorizat n or sui	ion is as if t, the unde	such copy rsigned
I hereby consent and give my permiss	sion to the d	TREA				acement) to	adminis	ter and	perform su	ch
procedures upon me as the doctor dec			5 4551			, K				



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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	symptom	s, how the i	njury occurred,	and when symptoms began)	
Describe your pain (circle): Dull / What doctors have you seen?	•	•	•	•	
What treatment have you had? (c	ircle) Spl	int / Injecti	on / Medicatio	n / 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 les	ss than 5 y	ears, list p	rior 2 employers	and how long you worked for them:	
What is your job title?					
How many hours per week did yo	u work b	efore the p	ain started? _		
Describe your work duties (write/	type/lift/ov	erhead wor	rk)		
How much time have you taken o	ff work fo	or this prob	nlem?		
•		_			
•			-	ications begin?	
List any prior Workers Compensa				_	
				ITER):	
Allergies to medications: No	Yes _	MEDI	CATION and R	EACTION:	
Cigarette use: No Quit	Wh	en Ye	es Amount	(# per day)	
Alcohol use: No Quit	Wh	en Ye	s Amount	(# per week/month)	
Medical Conditions: Diabetes / Hi	igh Blood	Pressure / I	High Cholesterd	ol / Hypo/Hyper Thyroid	
Rheumatoid Arthritis / Stroke / Seiz	ure / Hepa	atitis A / B /	C / Tuberculosi	s / Gout / Heart Disease	
Heart Attack / COPD / Asthma / Uld	ers/ L	iver Diseas	se / Alcoholism /	/ Osteoarthritis / Bursitis	
Blocked Arteries / Depression / Oth	er:				
Prior Surgeries: (please include all	surgeries	during you	ır lifetime):		
Highest grade you completed in s		-	History C. L.	Oallans (# 1	
Elementary School Ji List your hobbies:	r. High Sc		High School	College (# of years)	





## 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*:	

<sup>\*</sup>Restriction examples: Appointment Date/Time only, No Prescription information, etc.