

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

Name: Last		Middle				Maiden			
Home Address: Street		City					State Zip		
Home Phone:	Cell Ph	Cell Phone:		Birthdate:		Social Security Number:		Sex: M	F
Email Address:)							
Patient Occupation:	Employ	Employment: ☐ Full Time ☐ Part Tim			Employer:		Business Pho	ne:	Ext.
Employer's Address: Street		☐ Unemploy	yed Student City			State		Zip	
Emergency Contact:	Phone Num	nber:	Address:						
			110010		T		1.6.0/:1		
Who referred you to our office?						es es	re before? (circl No	e one)	
FINANCIAL INFOI	RMATI			SIB	LE PART			AME AS ABO	OVE)
Name of responsible party:		Relationship to	o patient:			Birthdate	:		
Address: Street	ddress: Street		City			State Zip			
Home Phone:		Social Securit	y Number	<u> </u>		Drivers I	License Number:	<u> </u> :	
Occupation:	Employ	/ment: □ Full Tim	no. 🏻 Dore	Time	Employer:		Business Phor	201	Ext.
	Employ	Unemploy	/ed □ S	tudent	Employer:				EXI.
Employer's Address: Street			City				State	Zip	
INSURANCE INFO	RMAT	ION (PLEASI	E FILL O	UT AI	L SPACES R	ELATING	TO YOUR C	OVERAGE	E)
CHECK TYPE OF COVER	AGE				PRIMARY	Y INSURAN	CE SECO	ONDARY INS	URANC
		NAME OF THE INSURED							
		NAME OF INSURANCE COMPANY							
☐ INDIVIDUAL PLAN	ВП	BILLING ADDRESS							
	TE	TELEPHONE NUMBER							
□ MEDICARE		SUBSCRIBER ID NUMBER							
	GR	GROUP OR LOCAL NUMBER							
□HMO	SO	SOCIAL SECURITY NUMBER							
	ВП	BIRTHDATE							
☐ INDUSTRIAL ACCIDE									
		ICAL INFOR							
nereby authorize payment directly nancially responsible for charges a ere the original. If it becomes necessall pay the reasonable attorney fe	not covered lessary for the	by this authorizatine account to be re	on. I also	authoriz	e that a photogra	aphic copy	of this authoriza	ation is as if s	
nereby consent and give my permocedures upon me as the doctor d	ission to the	TREA doctor (and the do	TMEN'			acement) to	administer and	perform suc	h
rint name of patient, parent.		andion	<u></u>		of notions no		egal guardian		ATE



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PATIENT QUESTIONNAIRE

Name:	Age	:	Sex: M F	Date:
Which Hand do you WRITE w	/ith : RIGHT	LEFT	Height:	Weight:
Occupation:				
Hobbies:				
Chief Complaint: (Please des	cribe how the	injury occurre	ed, your sympto	oms, and when they began)
For this problem:				EMG/Nerve Conduction
Treatment to Date: S	-		_	
Prior Surgeries: (please included)	de all surgerie	s during your	lifetime):	
Other injuries:				
Medical Conditions: Diabetes	s High Blood	d Pressure	High Choleste	rol Hypo/Hyper Thyroid
Rheumatoid Arthritis Stro	oke Seiz	zure Hep	oatitis A / B / C	Tuberculosis Gout
Heart Disease Heart Atta	ck CO	PD Ast	hma Ulcei	rs Liver Disease
Alcoholism Osteoarthi Other:			cked Arteries	Depression
Allergies to medications: No Please list MEDICATION and				
Current Medications (please	list PRESCRI	BED and OVE	ER THE COUN	TER):
Cigarette use: No C	Quit Whe	n Yes _	Amount	(# per day)
Alcohol use: No C	uit Whe	n Yes _	Amount	(# per week/month)
Last Tetanus Shot:				
Anesthesia Problems: No	Yes	_ Please desc	cribe:	
Bleeding problems after surg	gery: No	Yes Ple	ease describe:	



FINANCIAL RESPONSIBILITY WAIVER

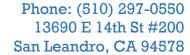
PATIENTS WITH INSURANCE: Although we will bill your Insurance Company/Medical Group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your Health Plan/Medical Group, we will contact you for assistance. 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 policies and I agree to comply with them. I attest that all information give is true and accurate to the best of my knowledge.				
Patient Signature	Date			
I/we wish to accept financial responsibilenamed patient.	ity 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) 297-0550.

Patient name (please print)	Date
Signature		
Parent of Auth	orized Representative (if applicable)	Relationship
	nges (i.e. prescription refills, test results thine: Yes No Phone Numb	<i>O</i> ,
	nation can be discussed with: Patient only (if checked, STOP HERE)	
I	Family Member or Friend (if checked, f	ill in name(s) below)
Name: _	Restrictions*:	Relationship:
Name: _	Restrictions*:	Relationship:
Name: _		Relationship:

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