EastBayHand Medical Center

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

PATIENT INFORMATION (PLEASE PRINT)

Name: Last	First	Middle	Maiden	
Home Address: Street	City	State	Zip	
Home Phone: ( )	Cell Phone: ( )	Birthdate:	Social Security Number:	Sex: **M** **F**
Email Address:				
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:	Drivers 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.

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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PATIENT QUESTIONNAIRE

Name:_____ **Age**:_____ **Sex**: M F **Date**: _____
Which Hand do you WRITE with: RIGHT LEFT **Height**: _____ **Weight**: _____
Occupation: _____
Hobbies: _____
Chief Complaint: (Please describe how the injury occurred, your symptoms, and when they began)

_____

_____

_____

For this problem:

Diagnostic Studies: X-Ray CT Scan MRI Arthrogram EMG/Nerve Conduction
Treatment to Date: Splint Medication Therapy Injection Surgery

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

_____

_____

Other injuries: _____
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: _____

Allergies to medications: No _____ Yes _____
Please list MEDICATION and REACTION: _____

_____

_____

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

_____

_____

Cigarette use: No ____ Quit ____ When ____ Yes ____ Amount _____ (# per day)
Alcohol use: No ____ Quit ____ When ____ Yes ____ Amount _____ (# per week/month)
Last Tetanus Shot: _____
Anesthesia Problems: No _____ Yes _____ Please describe: _____
Bleeding problems after surgery: No ____ Yes ____ Please describe: _____

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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 co-payment, 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 responsibility for medical expenses incurred by the above-named patient.

Gaurantor (Print) _____ Phone # (____) _____

Gaurantor Signature _____ Date _____

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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) 297-0550.

_____ _____
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.