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:	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) 297-0550.

_____ _____
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.