EAST BAY BRAIN & SPINE
MEDICAL GROUP

PATIENT INFORMATION

Patient Last Name:	Patient First Name:	Patient Middle Name:
Is this your legal name? YES NO	If not, what is your legal name?	Former Name:
Circle One: Mr. Mrs. Ms. Miss	Sex: Male Female	Social Security Number:
Patient DOB:	Marital Status: Single Married Divorced Separated Widowed	
Patient Street Address:		
City:	State:	Zip:
Patient Home Phone:	Patient Cell Phone:	
Patient Email Address:		
Occupation	Employer:	Work Phone:
Language Preference:	Race:	Ethnicity
Primary Care Provider:	Referring Provider:	

INSURANCE INFORMATION

PLEASE BRING A COPY OF YOUR INSURANCE CARD WITH YOU TO YOUR APPOINTMENT.

PRIMARY Insurance Carrier:		circle one: Health Insurance Workers' Comp Lien
ID#:	Group ID:	Group Name:
Co-Pay:	Issued:	Phone:
Claims Address:		
Subscriber's Name:	Subscriber's DOB:	Relationship (circle one): Self Spouse Child Other: _____

SECONDARY Insurance Carrier (if applicable):		circle one: Health Insurance Workers' Comp Lien
ID#:	Group ID:	Group Name:
Claims Address:		
Subscriber's Name:	Subscriber's DOB:	Relationship (circle one): Self Spouse Child Other: _____

IN CASE OF EMERGENCY

Name of local friend/relative:	Relation to patient:	Contact Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be pain directly to the physician. I understand that I am financially responsible for any balance. I also authorize East Bay Brain & Spine Medical Group or insurance company to release any information required to process my claim.

Notice to consumers:
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322 www.mbc.ca.gov

_____ _____ _____

Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party | *Date/Time* | *Relationship to Patient*

EAST BAY BRAIN & SPINE
MEDICAL GROUP

PROTECTED HEALTH INFORMATION (PHI) PERMISSIONS

This form gives East Bay Brain & Spine Medical Group permission to discuss your protected health information (PHI) with others.

Patient Name:	Patient DOB:

Please list below the individuals you give us permission to discuss your medical/health information (PHI) with.

Individual Name:	Relationship to you:	Phone Number:
1.		
2.		
3.		
4.		

I hereby gran East Bay Brain & Spine Medical Group and anyone employed by it, permission to discuss my medical/health information (PHI) with any of the individuals listed above. Any and all prior designations are hereby revoked.

_____	_____	_____
Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*

EAST BAY BRAIN & SPINE
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COMMUNICATION PREFERENCES

This form lets us know the best telephone numbers to contact you, numbers you authorize us to be able to leave detailed personal Protected Health Information (PHI), and addresses and faxes to which we can send your PHI if needed.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (HJPI). The individual is also provided the right to request confidential communications or alternative means of communicating PHI, such as sending correspondence to the individual office instead of their home.

Patient Name:	Patient DOB:

CONTACTING YOU BY TELEPHONE

	Ok to leave a detailed message that might include PHI	Ok to leave a message with callback number only
Home Phone Number:	Yes No	Yes No
Cell Phone Number:	Yes No	Yes No
Work Telephone Number:	Yes No	Yes No
Other Number:	Yes No	Yes No

CONTACTING YOU IN WRITING

OK to mail correspondence containing PHI information to my **home address**:	Yes No
OK to mail correspondence containing PHI information to my **work/office address** below:	Yes No
OK to **fax correspondence** containing PHI information to this number:	Yes No

Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*

EAST BAY BRAIN & SPINE
MEDICAL GROUP

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFOMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and Records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

Patient Name:	Patient DOB:	Date:

AUTHORIZATION

I hereby authorize EAST BAY BRAIN & SPINE MEDICAL GROUP to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

This form gives EAST BAY BRAIN & SPINE MEDICAL GROUP permission to discuss your protected health information (PHI) with others for healthcare purposes.

This authorization is:

_____ Unlimited
(all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/ Treatment)

_____ Limited to the following medical information

- _____ History & Physical Progress Notes
- _____ Lab Reports
- _____ Medication Records
- _____ Operative/Hospital Reports
- _____ Radiology Reports
- _____ Other (X-ray/ MRI/MRA/ CT or Bone Scan films)

I also consent to the specific release of the following records:

Patient Initials

_____ Drug/Alcohol/ Substance Abuse

_____ Psychiatric Mental Health

_____ Tests for Antibodies to HIV

_____ HIV Diagnosis/Treatment

_____ Genetic Information

DURATION

This authorization shall be effective immediately and remain in effect
☐ indefinitely or ☐ until: _____ (date).

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____	_____	_____
Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*
_____	_____	_____
Printed Name of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Witness Signature*	*Date/Time*

EAST BAY BRAIN & SPINE
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HEALTH HISTORY

Patient Name:	Patient DOB:	Height:	Weight:

REVIEW OF SYSTEMS

Please review the following conditions. Indicate all conditions that currently apply to you.

- ☐ Unexpected weight loss/gain
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Cough
- ☐ Sore throat
- ☐ Nasal congestion
- ☐ Abdominal pain
- ☐ Pain upon urinating
- ☐ Urinary incontinence
- ☐ Bowel incontinence
- ☐ Confusion
- ☐ Nausea/vomiting
- ☐ Headache
- ☐ Blurry vision
- ☐ Double vision
- ☐ Memory loss
- ☐ Skin rash
- ☐ Joint swelling
- ☐ Leg swelling
- ☐ Enlarged lymph nodes
- ☐ Easy bleeding

MEDICATIONS

Please list all medications and dosage you are currently taking, including over the counter medications. Please also include the length of time you have been taking any narcotic medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List all allergies and associated reactions.

_____

_____

_____

PHARMACY

Please provide the name and phone number of your preferred pharmacy so that we may keep this information on file if needed.

Pharmacy Name: _____ Pharmacy Phone Number: _____

PERSONAL HISTORY

Do you have a history of:			*Month/Year*	*Description*
Asthma	Yes	No	_____	_____
Bleeding disorder	Yes	No	_____	_____
High Blood Pressure	Yes	No	_____	_____
COPD	Yes	No	_____	_____
Diabetes Mellitus or Pre-Diabetes	Yes	No	_____	_____
Heart Disease	Yes	No	_____	_____
Kidney Disease	Yes	No	_____	_____
Psychiatric Condition	Yes	No	_____	_____
Osteoporosis	Yes	No	_____	_____
Strokes	Yes	No	_____	_____
Seizures	Yes	No	_____	_____
Blood Transfusions	Yes	No	_____	_____
Other	Yes	No	_____	_____

SURGICAL HISTORY

Please use this space for explanation of medical conditions not listed and for previous surgeries/dates.

_____

_____

_____

ANESTHESIA

Have you ever had a problem with anesthesia? Yes No
If yes, please explain.

_____

_____

TOBACCO USE

Have you ever smoked? Yes No If yes, how many years? _____ Currently? Yes No
How many packs per day? _____

ALCOHOL USE

How much alcohol do you drink each week?
Wine: _____ glasses per week Beer: _____ bottles/cans per week Liquor: _____drinks per week
Have you ever had an issue with heavy drinking? Yes No

DRUG USE

Do you use any recreational drugs (marijuana, cocaine, etc.)? Yes No
If yes, which ones? _____

EMPLOYMENT

Current or past occupation: _____
Current work status: Actively working Work at Home Retired Care-taking Disabled Unemployed

SOCIAL HISTORY

Who do you live with? _____

Relationship status: Single Married Partnered Widowed Separated Divorced

If married or partnered, how many years have you been in the relationship? _____

Do you have children? _____ If so, how many? _____

FAMILY HISTORY

Do you have a family history of any of the following conditions?

☐ Arthritis	☐ Peripheral Vascular Disease	☐ Diabetes Mellitus
☐ Heart Attack	☐ Hypertension	☐ Stroke
☐ Heart Disease	☐ High Cholesterol	☐ Cancer