Bassem Said, MD
1240 Central Blvd, Ste. A2
Brentwood, CA 94513
Phone: 925-516-4368 Fax: 925-516-4360

PATIENT INFORMATION

Patient's Last Name:		First Name:			Middle:
Marital Status: S M Sep D W	Gender: M F	Age:	Date of Birth:	Preferred Language:	
Address:		City:		State:	Zip:
Home Phone:	Work Phone:	Cell Phone:		Email:	
Name of Insurance Subscriber: (If different than patient)		Date of Birth of Insurance Subscriber: (If different than patient)			

EMERGENCY CONTACT

Name & Relationship:	Cell Phone:	Other Phone:

PHYSICIAN INFORMATION

Primary Care Physician:	Phone:
Referring Physician:	Phone:

Consent for Treatment, Insurance Authorization, Release of Medical Information & Ambient Listening Services:

I hearby authorize the release of medical or other information to my insurance company and/or my referring or primary care physicians concerning charges/treatment provided to me by Dr. Said.

I hearby assign benefits and I understand that payment is due as services are provided, including my deductible, co-payment, coinsurance, or any other balance not paid by my insurance company.

I hereby authorize Dr. Said and his staff to perform diagnostic tests and provide necessary treatment for medical evaluation and healthcare using generally accepted standards. I am aware that medicine and surgery are not exact sciences. I have not been promised or guaranteed that the outcome will be successful. I am aware that the treatment for my condition is based on the information that I provide. If i have provided inaccurate, incomplete, or misleading information, I will accept full responsibility. I understand that primary medical care is the responsibility of the referring physician or another physician of my choice, and is not the responsibility of Dr. Said.

To help your provider focus more on your care, our clinic may use a secure, HIPPA-compliant AI system that listens to the visit and creates a clinical note in real time. The audio is not stored, and the system is used only for documenting the visit. Participation is voluntary, and you may opt out at any time.

I hearby acknowledge that I received or was offered a copy of this medical practice's Notice of Privacy Practices. The current notice is available in the Patient Information Binder located in the waiting area (copies available upon request), and that I will be offered a copy of any amended Notice of Privacy Practices upon request at each appointment.

X _____ _____

Signed (Patient or Parent/Guardian if Minor) **Date**

ONLY COMPLETE THIS SECTION IF PATIENT IS A MINOR

Person Responsible For Account:		Date of Birth:	Phone:
Relationship to Patient:	Address: (If Different from Above)		

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HEALTH HISTORY

Todays Date:

Patient's Last Name:	First Name:	Sex:	Age:	Date of Birth:	Height:	Weight:

Reason for Visit (Chief Complaint): How long have you had this issue, and what treatments have you had?

Allergies to Medications: If Yes, which medications are you allergic to? What type of reaction do you have?
YES NO

Medications - List all patient currently takes:
NONE ◊

Medical History - List past and current medical issues:
NONE ◊

Surgical History - List with dates:
NONE ◊

Alcohol Use? YES NO
If Yes, how many per week?

Occupation:

Exposure to Loud Noise
YES NO

Do you now or have previously used Tobacco products? YES NO
Packs per day? How many years? If you quit, when?

Family History: Which Family Member: Which Family Member:
Early Onset Hearing Loss? Y N _____ Bleeding Disorders? Y N _____
Thyroid Cancer? Y N Other? Y N

If patient is a CHILD, do they attend Daycare? Y N Are there Smokers in the household? Y N

Pharmacy Name and Location:

Accompanied by/Translated by: Relationship:

Review of Systems - To be Completed by Patient:

Cardiovascular	Gastrointestinal	Respiratory	Infections	Psychiatric	Hematologic/Lymphatic
___ NORMAL	___ NORMAL	___ NORMAL	___ NORMAL	___ NORMAL	___ NORMAL
___ Artificial Heart Valve	___ Stomach Ulcer	___ Asthma	___ Hepatitis	___ Depression	___ Anemia
___ Pacemaker	___ Colitis	___ Emphysema	___ HIV/AIDS	___ Anxiety Attacks	___ Bleeding Problem
___ Hypertention	___ Liver Damage	___ Other Lung	___ Tuberculosis	___ Other	___ Enlarged Lymph Node
___ Heart Attack (when?)	___ Other GI Problem	_____	___ Other	_____	___ Other: _____

Constitutional Symptoms	Musculoskeletal	Eyes/Ears/Nose/Throat	Neurological	Endocrine	Skin
___ NORMAL	___ NORMAL	___ NORMAL	___ NORMAL	___ NORMAL	___ NORMAL
___ Weight Loss	___ Arthritis	___ Glaucoma	___ Stroke	___ Diabetic	___ Abnormal Scarring
___ Fever	___ Artificial Joints	___ Hearing Aid	___ Seizures	___ Thyroid	___ Poor Healing
___ Other	___ Other	___ Plastic Surgery	___ Other:	___ Kidney Disease	___ Other Skin Disorder

Modifying Factors: ___Smoking ___Diabetes ___Blood Thinners ___Radiation Trmt ___Immunosuppressants ___Oral Steroid (Prednisone)
Why?

Reviewed by Bassem Said, MD