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:

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 understand that I am responsible for providing a referral from my primary care physician if required by my insurance company. In the event that such a referral has not been provided to Dr. Said, I agree to pay for services at the time they are rendered.

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.

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