New Patient Information

Personal Data

Patients Name		Date of Birth	
Home Address		Soc.Sec.No	
City/St./Zip			
Home Phone			
Emergency Contact			

Employment Information

Employer		Occupation	
Address			
City/St./Zip			
Work Phone			

Referring M.D.

Name	
Address	
City/St./Zip	
M.D. Phone	

Attorney Information

Name	
Address	
City/St./Zip	
Attorney Phone	
Attorney Fax	

☐ Personal Insurance

Carrier	
Address	
City/St./Zip	
Ins. Co. Phone	

☐ Alta Bates Medical Group?

Policy #	
Group #	
Co-pay	
Medicare	Primary Secondary N/A

☐ Worker's Compensation Insurance

☐ *Work-related accident?*

Carrier		Date of injury	
Address		Claim #	
City/St./Zip		Review Co.	
Ins. Co. Phone		Adjuster's name	
		Adjuster's phone	
		Adjuster's fax	

Problem Description

☐ Left
☐ Right

How occurred?	
Previous treatment:	

Interpreter Information
Name:
Phone:
Fax:

Initials (Info taken by) _____
Date

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Dominant Hand: Left Right Ambidextrous Height: Weight:

Place of Birth (Please include country):

Racial or Ethnic background: Caucasian (white) African American Asian

Native American Hispanic East Indian Arabic

Other (please state)

Name: Date: Age:

On which side is your problem? Right Left Both sides

When did you first notice the problem?

Please describe your current problem:

History of Current Problems

What were you doing at the time of your accident/injury?

Where did you first go to be treated?

How long have you had pain or difficulty functioning due to this problem?

Do you have pain or difficulty functioning with: all activities only certain activities

If you have problems sometimes, please describe the types of activities that cause problems.

What makes is worse?

What makes is better?

Below please put a check next to any previous procedures or tests that have been done to diagnose your current

✍	*Previous procedures or tests*	*Where performed*	*When? (Mo/Yr)*
	Splint/Cast		
	Injection		
	X-rays		
	Bone Scan		
	CT or CAT scan		
	MRI		
	EMG (nerve study)		
	Blood tests		
	Surgery		

Any other test or procedures not mentioned above? _____

List any medications you have been on for this current problem: Please indicate any problems or side effects.

Medication	*Problem or Side effect*

Please List any additional information that you think would help the doctor better understand your current problem:_____

_____

CONFIDENTIAL MEDICAL QUESTIONNAIRE

ORTHOPEDIC HISTORY

Prior to this, have you had any injuries or problems with your hands arms or shoulders? YES NO

If so, please list and state whether it is left or right side:

Have you had any fractures or injuries resulting from a previous accident? YES NO

If so, please list, stating left or right side and approximate dates:

WORK HISTORY

What is your present occupation?

For how long?

Are you currently working? YES NO Full Duty Light Duty

Job Description:

Describe the routine activity in your job (for example: lifting, pushing, filing, typing)

Do you do any lifting at work? YES NO If yes, how many pounds?

What is the heaviest object you must lift?

Do you do any overhead work? YES NO Regularly Occasionally Never

Do you do any overhead lifting? YES NO If yes, how many pounds?

If you are not currently working, what was the date that you last worked?

What was your past occupation (if different from above) over the past ten years?

SOCIAL HISTORY

_____Married _____Single _____Living with significant other

Do you live by yourself? _____yes _____no

If any, how many children do you still have living at home? _____

What are your hobbies? _____

_____

_____

Do you smoke? _____yes _____no

Have you ever been addicted to any drug? _____yes _____no

Have you ever been in the Armed Forces? _____yes _____no

If yes, was your discharge medical or non-medical? _____

CONFIDENTIAL MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

Do you have any medical allergies? _____yes _____no Please list if any:

_____

_____

Do you see any other doctors regularly? _____yes _____no If so, please list and indicate any medical problems for which you are currently being treated: _____

Physician	*Type of Doctor*	*Condition being treated for*

Please list any medications that you take on a regular basis: _____

_____

Have you recently been on prednisone or any steroids? _____yes _____no
Is so, when did you need them last? _____
Are you currently on a blood thinner (coumidin/warfarin)? _____yes _____no
Are you pregnant? _____yes _____no
Are you considering getting pregnant in the near future? _____yes _____no
If so, approximately when? _____
When was the date of your last tetanus shot? _____

Do you have now, or have you ever had:

	Heart burn		Bleeding disorder
	Yellow jaundice		Kidney problems
	Bleeding form your stomach		Ulcer
	Swollen ankles		Water on your lungs
	High blood pressure		Liver trouble
	Gastritis/sensitive stomach		Abmormal liver test
	Nervous breakdown		Hepatitis
	Blood transfusion		Diabetes
	Colon problems		Arthritis
	Asthma		Heart trouble
	Epilepsy		Prostate problems
	Poor teeth		Polio
	Dentures		Circulatory problems
	Shortness of breath		Tuberculosis
	Bone/joint disease		Chest pain
	Bursitis		Varicose veins
	Lung trouble		Positive HIV test
	Abnormal vaginal bleeding		Glaucoma
	Thyroid problems		

Did you ever have an operation? _____yes _____no Please list and give approximate dates:

Procedure	*Approximate Date*

Have you ever had a problem with anesthesia? _____yes _____no If yes, please elaborate:

_____

Thank you for your time and attention in filling out this form.

OFFICE PAYMENT POLICY

Payment for office examination and treatment is requested in advance unless other arrangements have been made with the office manager.

We are happy to assist you in submitting your insurance claims, but remember that insurance is a method of reimbursing you, the patient, for fees paid to the physician. It is not a substitute for payment.

Authorization for Release of Medical Information

I hereby authorize the release of any and all information acquired in the couse of my examination and treatment for the purpose of securing payment of benefits from my insurance company. A photocopy of this agreement is to be considered as valid as the original.

Signature _____ Date _____

Assignment of Payments

I hereby assign all surgical and/or medical benefits for services rendered, to be paid directly to the Oakland Office of Dr. Mathias Masem, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature _____ Date _____