

PATIENT DATABASE FORM

Last Name: _____ First Name: _____

Date: ____/____/____

Referring MD: _____ Primary Care MD: _____

DOB ____/____/____

Reason for referral to the Neurologist: _____

Your Age: _____ Right Handed Left Handed

Past Medical History: Place a check mark beside the following medical disorders you have.

___ Systemic lupus	How Long? ___	___ Asthma	How Long? ___
___ High blood pressure	How Long? ___	___ Prior Stroke	How Long? ___
___ Diabetes	How Long? ___	___ Rheumatoid arthritis	How Long? ___
___ Coronary artery disease	How Long? ___	___ Thyroid disorder	How Long? ___
___ Elevated cholesterol	How Long? ___	___ Other _____	

Prior Surgeries:

1. _____ Year: _____
2. _____ Year: _____
3. _____ Year: _____
4. _____ Year: _____

List Your Current Medications:

	Drug Name	Mg Size	# Tablets/Times a Day
1.	_____		
2.	_____		
3.	_____		
4.	_____		
5.	_____		
6.	_____		
7.	_____		
8.	_____		

List Any Medication Allergies:

None Other: _____

Social History: Marital Status: (Circle) Single Married Divorced Widowed

Currently living with: Self Spouse Children Other: _____

Number of Children: _____ **Ages:** _____

Do you currently smoke? Yes No If so, how many packs per day (1/2, 1, 1.5, 2)

If smoked in past, list year when quit: _____

Current Alcohol Consumption: ___ None ___ Drinks per day ___ Drinks per week

If previously drank but quit, list year that you quit: _____

Occupation: _____ **Prior Occupation if retired:** _____

(If retired, list year of retirement: _____)

Current Weight: _____ **Current Height:** _____

David A. Gehret, M.D.

Diplomate American Board of Neurology and Psychiatry
Clinical Neurology & Electromyography

Protected Health Information (PHI) Disclosure Authorization (HIPAA) Form

Patient Name: _____ DOB ____/____/____

Please check the following ways Dr. Gehret may contact you:

Earliest time of day we may contact you by phone: ____AM
Latest time of day we may contact you by phone: ____PM

*If you have already filled out your phone #'s on one of the other forms, **do not** fill them out again—just check the ways we may contact you.*

<input type="checkbox"/> Residence Telephone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Written Correspondence	<input type="checkbox"/> Other (specify)
Number: (____) _____	Number: (____) _____	Number: (____) _____	<input type="checkbox"/> Mail/Delivery Service	
<input type="checkbox"/> Leave call back # only; Do not leave message.	<input type="checkbox"/> Leave call back # only; Do not leave message.	<input type="checkbox"/> Leave call back # only; Do not leave message.	<input type="checkbox"/> Fax: (____) _____	
<input type="checkbox"/> Okay to leave detailed message with person	<input type="checkbox"/> Okay to leave detailed message with person	<input type="checkbox"/> Okay to leave detailed message with person	<input type="checkbox"/> Email at residence:	
<input type="checkbox"/> Okay to leave detailed message on answering machine	<input type="checkbox"/> Okay to leave detailed message on answering machine	<input type="checkbox"/> Okay to leave detailed message on answering machine	<input type="checkbox"/> Email at work:	

Please list family members and/or friends WE MAY speak to:

Name of Person	Relationship
	<input type="checkbox"/> Daughter, <input type="checkbox"/> Son, <input type="checkbox"/> Spouse, <input type="checkbox"/> Sibling, <input type="checkbox"/> Parent, <input type="checkbox"/> Significant Other, <input type="checkbox"/> Friend, <input type="checkbox"/> Other
	<input type="checkbox"/> Daughter, <input type="checkbox"/> Son, <input type="checkbox"/> Spouse, <input type="checkbox"/> Sibling, <input type="checkbox"/> Parent, <input type="checkbox"/> Significant Other, <input type="checkbox"/> Friend, <input type="checkbox"/> Other
	<input type="checkbox"/> Daughter, <input type="checkbox"/> Son, <input type="checkbox"/> Spouse, <input type="checkbox"/> Sibling, <input type="checkbox"/> Parent, <input type="checkbox"/> Significant Other, <input type="checkbox"/> Friend, <input type="checkbox"/> Other
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	<input type="checkbox"/> Daughter, <input type="checkbox"/> Son, <input type="checkbox"/> Spouse, <input type="checkbox"/> Sibling, <input type="checkbox"/> Parent, <input type="checkbox"/> Significant Other, <input type="checkbox"/> Friend, <input type="checkbox"/> Other

Please list anyone specifically WE SHOULD NOT speak with and check their relationship.

Name of Person	Relationship
	<input type="checkbox"/> Daughter, <input type="checkbox"/> Son, <input type="checkbox"/> Spouse, <input type="checkbox"/> Sibling, <input type="checkbox"/> Parent, <input type="checkbox"/> Significant Other, <input type="checkbox"/> Friend, <input type="checkbox"/> Other
	<input type="checkbox"/> Daughter, <input type="checkbox"/> Son, <input type="checkbox"/> Spouse, <input type="checkbox"/> Sibling, <input type="checkbox"/> Parent, <input type="checkbox"/> Significant Other, <input type="checkbox"/> Friend, <input type="checkbox"/> Other
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	<input type="checkbox"/> Daughter, <input type="checkbox"/> Son, <input type="checkbox"/> Spouse, <input type="checkbox"/> Sibling, <input type="checkbox"/> Parent, <input type="checkbox"/> Significant Other, <input type="checkbox"/> Friend, <input type="checkbox"/> Other

Patient Signature: _____ Date: _____

DAVID A. GEHRET M.D. REGISTRATION FORM
Priority One Billing Service
Patient Data Entry Sheet

Patient Information

Name: _____ Sex: M F Marital Status: S M D W

Address: _____ City: _____ ST: _____ Zip _____

Home Phone: (____) _____ Cell: (____) _____ Driver's License: _____

Date of Birth ____/____/____ Age: _____ Soc Sec #: _____

Employer: _____ Work #: (____) _____

Address: _____ City: _____ ST: _____ Zip _____

Insurance Information

Primary Carrier: _____ Type: PPO EPO HMO POS Phone #: _____

Policy Holder: _____ ID: _____ Group: _____

Secondary Carrier: _____ Type: PPO EPO HMO POS Phone #: _____

Policy Holder: _____ ID: _____ Group: _____

Financial Responsibility / Assignment of Benefits / Release of Information

I hereby attest that I am an eligible member of the insurance carrier(s) listed above and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all deductible, co-insurance, and services not covered by insurance. I hereby authorize my insurance carrier(s) to make direct payment of medical benefits to the physician for services rendered. I understand and fully agree that payment is due at the time of services and/or upon receipt of statement and that all charges are the direct responsibility of the patient. I hereby authorize release of information to other physicians and insurance carriers upon request for the purpose of payment of medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. I hereby acknowledge that I have read, understand, and agree to the policies of David A. Gehret, MD and Janice S. Young, MD and hereby give my consent for treatment.

X _____
Patient or Guardian Signature Date

X _____
Physician Staff Signature Date

NAME _____

David A. Gehret M.D.

REVIEW OF SYSTEMS

Constitutional Symptoms

- Good general health today
- Recent weight change
- Fever/chills
- Fatigue
- Fever

Eyes

- Eye disease/Injury
- Wear glasses/contact lenses
- Blurred or double vision
- Glaucoma

Ears, Nose, Mouth, Throat

- Hearing tones or ringing
- Earaches or discharge
- Chronic sinus problem or tinnitus
- Nose bleeds
- Mouth sores
- Bleeding gums
- Bad breath or bad taste
- Sore throat or voice change
- Swollen glands in neck

Cardiovascular

- Heart trouble
- Chest pain or angina pectoris
- Palpitations
- Shortness breath w/ walking/lying flat
- Swelling of feet, or ankles

Respiratory

- Chronic or frequent coughs
- Spitting up blood
- Shortness of breath
- Asthma or wheezing

Gastrointestinal

- Loss of appetite
- Change in bowel movements
- Nausea or vomiting
- Frequent diarrhea
- Painful bowel movements, constipation
- Recent bleeding or blood in stool
- Abnormal pain or heartburn
- Peptic ulcer (stomach or duodenal)

Genitourinary

- Frequent urination
- Painful or burning urination
- Blood in urine
- Change in force or strain when urinating
- Incontinence or dribbling
- Kidney stones
- Sexual difficulty
- Male testicular pain
- Female pain with periods
- Female irregular periods
- Female vaginal discharge
- Female pregnancies () miscarriages ()
- Female date of last pap smear ()

Musculoskeletal

- Joint pain
- Joint stiffness or swelling
- Weakness of muscles or joints
- Muscle pain or cramps
- Back pain
- Cold extremities
- Difficulty walking

Skin

- Rash or itching
- Change to skin color
- Change to hair or nails
- Varicose veins
- Breast pain
- Breast lump
- Breast discharge

Neurological

- Frequent or recurring headaches
- Light-headed or dizziness
- Convulsions or seizures
- Numbness or tingling sensations
- Tremors
- Paralysis
- Stroke
- Head injury

Psychiatric

- Memory loss or confusion
- Nervousness
- Depression
- Insomnia

Endocrine

- Glandular or hormone problem
- Thyroid disease
- Diabetes
- Excessive thirst or urination
- Heat or cold intolerance
- Skin becoming drier
- Change in hat or glove size

Hematological/Lymphatic

- Slow to heal cuts
- Bleeding or bruising tendency
- Anemia
- Phlebitis
- Past transfusion
- Enlarged glands

Allergic/Immunologic

History of skin reaction
or other reaction to:

- Penicillin or other antibiotics
- Morphine or other narcotics
- Novocain or other anesthetics
- Aspirin or other pain remedies
- Tetanus or other serums
- Iodine or Shellfish
- Other drugs/medications
- Known food allergies

David A. Gehret. YID Inc.
401 Old Newport Blvd Ste 201
Newport Beach, CA 92663
(949) 999-2977

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards, and our internal policies and procedures.

Attached is your personal copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties, and our privacy practices. It also describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

For your convenience, the following is a summary of the information discussed in the notice:

1. Our Pledge
2. Your Personal Information
3. Our Privacy Practices
4. How We May Use or Share Your Information for:

- Treatment
- Payment
- Health Care Operations
- Notifications
- Marketing
- Research
- Special Circumstances and the Law

5. Your Written Permission
6. Other Restrictions
7. Your Rights
8. Changes
9. Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number shown at the top of this page to receive our copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements.

If, after reviewing the notice, you decide that you do not want to retain your paper copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices:

X _____
Signature

Printed Name

Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It Is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were Improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings, Both parties to this contract, by entering into It, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It Is the Intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children,

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated Including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action In any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not Including counsel fees or witness fees, or other expenses Incurred by a party for such party's own benefit. The parties agree that the arbitrators have the Immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This Immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shag have the absolute right to arbitrate separately the Issues or liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder In this arbitration of any person or entity which would otherwise be a proper additional party In a court action, and upon such Intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator,

Article 4: **General Provisions:** All claims based upon the same Incident, transaction or related circumstances shall be arbitrated In one proceeding. A claim shall be waived and forever barred If (1) on the date notice thereof is received, the claim, If asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant falls to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It Is the Intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it Is signed (including, but not limited to, emergency treatment) patient should Initial below:

Effective as of the date of first medical services

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain In full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Authorized Representative's Signature (Date)

By: _____
Patient's or Patient Representative's Signature (Date)

Newport Doctors Medical Group, Inc.

By: _____
Print Patient's Name

Print or stamp Name of Physician, Medical Group or Association Name

(If Representative, Print name and Relationship to Patient)