

Name: _____ Date of Birth: ____/____/____ Age: ____
 LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Sex: F M Height: _____ Weight: _____

Patient's Marital Status _____ Nearest Relative _____

Patient's Address _____ City _____ Zip _____

Name of Responsible Party if Patient is a Minor _____

Insurance _____ Main subscriber on the insurance _____ DOB _____

SS# _____ Home Phone () _____ Cell() _____

Email _____ Patient's Employer (If minor, Responsible Party) _____

Occupation _____ Work Address _____ Work Tel () _____

Spouse's Name _____ Spouse's Employer _____ Work Tel () _____

Referred here by (check one) Self Family Friend Doctor Other Health Professional

Name of person making referral: _____

Primary Care Physician/Internist: _____ Cardiologist: _____

(Would you like records sent to any of these Doctors? (Yes/No) Please Circle One

Have you had a recent medical evaluation by one of these doctors? _____ Name of Doctor: _____

What is your primary problem for being seen today?

Where is your Pain? **Body Part:** _____ **Right or Left (circle one)**

Date of Injury: _____ **Length of Symptoms:** _____

Describe your injury and symptoms: _____

Does your pain **Radiate** up or down? YES NO (If yes: up down both)

Do you have any **Weakness**? YES NO

Do you have **Numbness and/or tingling**? YES NO

Have you had **Surgery** on this body part? YES NO

If yes, describe the procedure: _____

Date(s) / Surgeon(s): _____

Have you had **Physical Therapy**? YES NO If yes, how many visits _____

Have you had any **Images** taken on this MRI CT EMG Bone Scan Xray (circle all that apply)

body part? **Findings:** _____

Have you had an **Injection**(s)? YES NO If yes, how many _____

What **Pain Medicine** are you taking for this problem? _____

Past Medical History:

In the past 4 weeks, have you had a cough, cold, sore throat or bronchitis that required treatment? _____

List any medical conditions you have: (ex High blood pressure, mitral valve prolapsed)

Drug Allergies: Yes No **List allergies?** _____

Type of Reaction: _____

Current Medications (List any medications you are taking. Include such items as aspirin, vitamins, calcium, **DIET PILLS** ETC)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?	Please Check: Helped?		
			A Lot	Some	Not at All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you used **blood thinners**, such as Coumadin, Heparin, Aspirin, Ibuprofen, or Plavix, with in the past 2 weeks?

Yes/No If yes, please list: _____

Have you ever taken **steroids**, such as Prednisone or Medrol, by mouth? ___ If yes, when and for how long? _____

Do you take medication for Osteoporosis such as Fosamax, Actonel, or Boniva? _____

Date of last **EKG** ___ / ___ / ___ Date of last **Blood draw** ___ / ___ / ___ Date of last **Chest X-ray** ___ / ___ / ___

List All Surgeries

	Date	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Social and Family History

Have you ever smoked? Yes No Quantity/Amount:_____ If quit, how long ago? _____

Do you drink alcohol? Yes No number per week ___Has anyone ever told you to cut down on drinking? Yes No

Do you use recreational drugs, such as marijuana, cocaine, meth? Yes No

If yes, please list _____

Name: _____

LAST

FIRST

MIDDLE INITIAL

MAIDEN

CONSTITUTIONAL	GASTROINTESTINAL	INTEGUMENTARY (SKIN AND/OR BREAST)
<input type="checkbox"/> Recent weight gain amount _____ <input type="checkbox"/> Recent weight loss amount _____ <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Fever Eyes <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Double or blurred Vision <input type="checkbox"/> Itching eyes EARS–NOSE–MOUTH–THROAT <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Runny nose <input type="checkbox"/> Sores in mouth <input type="checkbox"/> Loss of taste <input type="checkbox"/> Dryness of mouth <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Difficulty in swallowing CARDIOVASCULAR <input type="checkbox"/> Pain in chest <input type="checkbox"/> Heart murmurs <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Sudden changes in heart beat <input type="checkbox"/> High blood pressure MUSCULOSKELETAL <input type="checkbox"/> Morning stiffness Lasting how long? <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle tenderness <input type="checkbox"/> Joint swelling List joints affected in the last 6 mos.	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting of blood or coffee ground material <input type="checkbox"/> Stomach pain relieved by food or milk <input type="checkbox"/> Blood in stools <input type="checkbox"/> Jaundice <input type="checkbox"/> Persistent diarrhea <input type="checkbox"/> Black stools <input type="checkbox"/> Heartburn <input type="checkbox"/> Increasing constipation GENITOURINARY <input type="checkbox"/> Difficult Urination <input type="checkbox"/> Pain or burning on urination <input type="checkbox"/> Rash/ulcers <input type="checkbox"/> Blood in urine <input type="checkbox"/> Pus in urine <input type="checkbox"/> Cloudy, “smoky” urine <input type="checkbox"/> Discharge from penis/vagina <input type="checkbox"/> Getting up at night to pass urine <input type="checkbox"/> Sexual difficulties <input type="checkbox"/> Vaginal dryness RESPIRATORY <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty in breathing at night <input type="checkbox"/> Wheezing (asthma) <input type="checkbox"/> Swollen legs or feet <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Easy bruising <input type="checkbox"/> Redness <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Hair loss <input type="checkbox"/> Tightness <input type="checkbox"/> Nodules/bumps <input type="checkbox"/> Color changes of hands or feet in the cold NEUROLOGICAL SYSTEM <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Night sweats <input type="checkbox"/> Sensitivity or pain of hands and/or feet <input type="checkbox"/> Memory loss <input type="checkbox"/> Fainting <input type="checkbox"/> Muscle spasm <input type="checkbox"/> Loss of consciousness HEMATOLOGIC/LYMPHATIC <input type="checkbox"/> Transfusion? When <input type="checkbox"/> Swollen glands <input type="checkbox"/> Tender glands <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency PSYCHIATRIC <input type="checkbox"/> Excessive worries <input type="checkbox"/> Easily losing temper <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty staying asleep ENDOCRINE <input type="checkbox"/> Excessive thirst ALLERGIC/IMMUNOLOGIC <input type="checkbox"/> Frequent sneezing <input type="checkbox"/> Increased susceptibility to infection

Name: _____

LAST

FIRST

MIDDLE INITIAL

MAIDEN

NOTICE TO CONSUMERS

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

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. Insurance Portability and accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of you health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billings records, but not including psychotherapy notes. You must submit your request in writing to our Practice Privacy Officer at 1401 Avocado Ave., Suite 307, Newport Beach, California 92660.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Practice Privacy Officer at 1401 Avocado Ave., Suite 307, Newport Beach, California 92660
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Practice Privacy Officer at (949) 720-1944. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our Practice Privacy Officer at (949) 720-1944.

I hereby acknowledge that I have been presented with a copy of Warren G. Kramer, III, M.D., Inc., and/or Sten Erik Kramer, M.D., Inc., and/or Ryan S. Labovitch, M.D., Inc. and/or Carolyn M. Perry MS, PA-C and/or Robin L. Ray MS, PA-C Notice of Privacy Practices.

Date: _____ Signed: _____

Name: _____

LAST FIRST MIDDLE INITIAL MAIDEN

ASSIGNMENT AND AUTHORIZATION TO PAY PHYSICIAN

For value received, I hereby assign to Warren G. Kramer, III, M.D., Inc., and/or Sten Erik Kramer, M.D.,Inc, and/or Ryan S. Labovitch, M.D and/or Carolyn M. Perry MS, PA-C and/or Robin L. Ray MS, PA-C all sums payable to me under any policy of insurance for any portion of the charge for the diagnosis and treatment described below. I further hereby assign payment directly to Warren G. Kramer, III, M.D., Inc., and/or Sten Erik Kramer, M.D., Inc., and/or Ryan S. Labovitch, M.D., Inc.and/or Carolyn M. Perry MS, PA-C and/or Robin L. Ray MS, PA-C of such sums which would otherwise be payable to me, but not to exceed said charge. I understand that I am financially responsible to the physician for charges not covered by this assignment and authorization.

Date:_____ **Signed:**_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Warren G. Kramer, III, M.D., Inc., and/or Sten Erik Kramer, M.D.,Inc. and/or Ryan S. Labovitch, M.D., Inc., and/or Carolyn M. Perry MS, PA-C and/or Robin L. Ray MS, PA-C to release said insurance company any information regarding my illness and/or injury including laboratory reports, x-rays and diagnosis which is needed by said insurance company to process the claim.

Date:_____ **Signed:**_____

APPOINTMENT AND CANCELLATION POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

CANCELLATION OF AN APPOINTMENT

If it is necessary to cancel your scheduled appointment we require that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. To cancel appointments please call (949) 720-1944. If you do not reach the receptionist you may leave a detailed message with the exchange. We will keep a record of the cancelled appointment in your records.

NO SHOW POLICY

A “no show” is someone who misses an appointment without cancelling in 24 hours in advance. No shows inconvenience those individuals who need access to medical care in a timely manner. Late cancellations will be considered as a “no show”. A failure to be present at the time of a scheduled appointment will be recorded in the medical record as a “no show”. For any “no show” the patient will be sent a letter alerting them to the fact that they have failed to show up for a routine or follow up appointment and did not cancel the appointment. A fee of **\$25.00** will be billed to their account and sent to the patient’s home. For consults, in-office procedures and new patients there will be a fee of **\$50.00**. A copy of the letter will be placed in the patient’s file.

Date:_____ **Signed:**_____

Name: _____

LAST FIRST MIDDLE INITIAL MAIDEN