

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME NUMBER _____ WORK NUMBER _____ CELL _____
EMAIL ADDRESS _____ SEX (circle): Male Female
EMPLOYER _____ OCCUPATION _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

EMERGENCY CONTACT

EMERGENCY CONTACT _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ PHONE _____
NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE OF INSURED: _____ POLICY # _____ GROUP # _____
SECONDARY INSURANCE _____ PHONE _____
NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE OF INSURED: _____ POLICY # _____ GROUP # _____

FAMILY DOCTOR OR INTERNIST

FAMILY DOCTOR'S NAME _____ PHONE # _____

REFERRING PHYSICIAN

REFERRING PHYSICIAN _____ PHONE # _____

AUTHORIZATION

I hereby authorize the physician to furnish information to insurance carrier regarding this illness/accident, and hereby irrevocably assign to Dr. Penenberg all payments for medical services rendered. A copy of this authorization shall be considered valid as the original.

PATIENT SIGNATURE _____ DATE _____

INSURANCE ACKNOWLEDGEMENT

Patient's Name: _____

Insurance Plan: _____

Please be aware that Dr. Brad Penenberg and Michelle Riley, PA-C are not contracted providers with your insurance. However, as a courtesy to our patients, we will submit a claim for services rendered in our office to your insurance.

Even though we do not participate in your insurance plan, it is usually possible to work out an acceptable financial arrangement.

Please feel free to contact our billing service, Med-Net Billing, at (310) 322-4278 to discuss these arrangements.

X

Patient's Signature

Date

HIPAA COMPLIANCE PLAN/ MEDICAL RECORDS RELEASE FORM FOR
BRAD L. PENENBERG, M.D., INC.

Expiration Date of Authorization

This authorization is effective through ____/____/____ unless revoked or terminated earlier by the patients or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to our practice. You should contact our Privacy Office to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Individual

You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization,

Effect of Refusing Authorization

If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

Treatment Conditioned on Authorization

Printed Name of Patient

X _____
Signature of Patient

Date

Signature of Patient Representative

Relationship to Patient

Information to Be Used or Disclosed

The information covered by this authorization includes

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Name of person/organization

PATIENT NAME: _____ DATE OF BIRTH: _____

1. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practices for the medical practice of Brad L. Penenberg, M.D., Inc. Our practice reserves the right to modify the privacy practices outlined in the notice.

Please initial: x _____

2. AUTHORIZATION TO RELEASE INFORMATION: I agree that my physician and staff may give out written or verbal information concerning my medical records to any insurance carrier or agent that is authorized to have access to and to make copies of my medical records.

Please initial: x _____

3. AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign all medical benefits payable to me to be paid directly to Brad L. Penenberg, M.D., Inc. Any monies payable to Dr. Penenberg will be paid directly to him.

Please initial: x _____

4. NON-CANCELLED APPOINTMENTS: I understand that when I make an appointment and do not cancel within 24 hours of said appointment, I will be charged \$25.00 because another patient could have been given that appointment time.

Please initial: x _____

5. FINANCIAL AGREEMENT: I hereby agree to pay all statements not covered by insurance for services rendered by the physicians and medical staff at the end of each medical service. Any balance not paid within 30 days of receipt of statement will be considered in default, unless financial arrangements have been made with Med-net, our billing service.

Please initial: x _____

6. SPECIAL LETTERS AND FORM COMPLETION: I understand that if I request a letter describing any medical conditions and/or treatments, I will be charged a minimum of \$25.00.

Please initial: x _____

7. DISCLOSURES: I understand that Dr. Penenberg is a consultant for, and receives royalties from, Wright Medical Technology, Inc. for his input on orthopaedic implant design, surgical instrumentation and surgical techniques. Specific implant choice is based on patient specific needs and if I have surgery performed by Dr. Penenberg, I understand that I may receive an implant from this company or another orthopaedic device company to which he has no financial connection. Further details available upon request.

Please initial: x _____

The undersigned certifies that he/she has read the foregoing, receiving a copy if requested thereof, and is the patient or is authorized by the patient's general agent to execute the above and accept its terms.

X _____
Signature

Date

Brad L. Penenberg, M.D.
Michelle Riley, PA-C

FAMILY HISTORY: Have any blood relatives ever had any of the following (or other disease)? Heart disease, high blood pressure, diabetes, cancer, stroke, tuberculosis, gout, bone disease, other? If so, what disease and who?

SURGICAL HISTORY: Please list date, procedure, surgeon, and hospital:

MAJOR ACCIDENTS OR INJURIES: Please list date, type of injury, and treatment:

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE INDICATE BY CIRCLING THE APPROPRIATE ITEM:

GENERAL

fever, sweats
recent marked weight loss or gain

GASTROINTESTINAL

ulcers or gastritis
severe or frequent abdominal pain
tarry black stool
yellow jaundice
coffee ground vomiting

HIV/AIDS

ever exposed to AIDS?
used self-procured IV drugs?
When?
Results?

NEUROLOGICAL

fainting
convulsions
dizziness
shakiness or trembling

VASCULAR

previous phlebitis
leg cramps on exercise
varicose veins

CARDIAC

high blood pressure
history of heart attack
chest pain
shortness of breath
rapid or irregular pulse
ankle swelling

HEAD, EYES, EARS, NOSE

frequent headaches
neck pain or stiffness
glaucoma
eye pain
blurring of vision
double vision
unusual sensitivity to light
discharge from eyes
hearing difficulties
sinus problems

PSYCHIATRIC

under psychiatric care
serious emotional problems
history of substance abuse

WOMEN

pregnant
abnormal/irregular periods
vaginal discharge
date of last period _____
age at which period stopped: _____

ENDOCRINE

diabetes
thyroid disorder
gout

GENITOURINARY

frequent or painful urination
kidney or bladder infection
kidney stones

HEMIC-LYMPHATIC

easy bruising
prolonged bleeding
frequent minor infection

MUSCULOSKELETAL

generalized joint pain
joint swelling
neck or back pain

RESPIRATORY

asthma
chronic cough
sputum producing cough
coughing up blood
positive TB skin test
abnormal chest x-ray