ELIASmedical
A. George Elias, M.D.
9900 stockdale hwy., suite 203
bakersfield, ca 93311
t. 661.663.0300 | f. 661.663.0903
www.eliasmedical.com

I. PATIENT INFORMATION

Name: _____ Age:

Date of Birth: _____ SS #: _____ Drivers License #: _____

Marital Status: Married ‘‘ Single ‘‘ Divorced ‘‘ Widowed ‘‘

Sex: Male ‘‘ Female ‘‘ Race:_____ Ethnicity:_____

Preferred Language:_____
Preferred Communication: I_I Home address mail I_I Cell phone I_I Home phone I_I Email I_I Work Phone

Home Address: _____ City:

State: _____ Zip: _____ Home Telephone #: (___) _____

Mobile/Cell #: (____) _____ E-mail Address: _____

Mailing Address (if different from above): _____

City: _____ State: _____ Zip:_____
Employment status: Employed ‘‘ Retired ‘‘ Unemployed ‘‘ Other ‘‘
Employer (if retired or unemployed, please list last employer): _____

Occupation: _____ Employer’s Telephone #: (____)

Employer’s Address: _____
City: _____ State: _____ Zip:_____

Do you have an “Advanced Directive,” also known as a “Living Will” or a “Durable Power of Attorney for Health Care”? ‘‘ Yes ‘‘ No *(If yes, please provide a copy for your medical record in our office.)*

How did you hear about us?
□ **Google** □ **Yahoo** □ **Yelp** □ **Yellow pages** □ **Person referred-_____** □ **Other-_____**

II. SPOUSE INFORMATION (***or if patient is a minor, enter responsible party information)***
Name: _____ Date of Birth: _____

Home Address: _____ City:

State: _____ Zip: _____ Telephone #: (___) _____ SS #: _____

Employment status: Employed ‘‘ Retired ‘‘ Unemployed ‘‘ Other ‘‘

Employer: _____ Employer’s Telephone # (____)_____

Employer’s Address: _____

City: _____ State: _____ Zip: _____

III. EMERGENCY INFORMATION - Provide information on nearest adult relative, not your spouse, who is **not** living with you.

Name: _____ Relationship: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Telephone #: (_____) _____

IV. INSURANCE INFORMATION *(Our receptionist will scan your insurance card(s))*

Medicare: Yes ‘‘ No ‘‘ **If yes, Medicare Claim Number (HIC #): _____**

Is Medicare your primary insurance? Yes ‘‘ No ‘‘

PRIMARY INSURANCE COMPANY:

Name of Company: _____ Telephone #: (____) _____

ID/Certificate/Policy #: _____ Group #:_____

Claims Address: _____

City: _____ State: _____ Zip: _____

Subscriber’s (Policyholder’s) Name: _____

Subscriber’s Social Security #: _____ Subscriber’s Date of Birth: _____

SECONDAY INSURANCE COMPANY *(or Medicare Supplement)***:** *Check if none* ‘‘

Name of Company: _____ Telephone #: (____)

ID/Certificate/Policy #: _____ Group #:

Claims Address:

City: _____ State: _____ Zip:

Subscriber’s (Policyholder’s) Name:

Subscriber’s Social Security #: _____ Subscriber’s Date of Birth:

V. SIGNATURE

The above information is true and correct to the best of my knowledge.

_____

Signature of Patient or Responsible Party DATE

NAME, STREET AND ZIP CODE OF

PERFERRED PHARMACY:_____

HISTORY & PHYSICAL

Name:_____ **SSN#:**_____ **Date:**_____

Address:_____ **Occupation:**_____

Phone: (home):_____ **(work):**_____ **Date of Birth:**_____ **Age:**_____

Chief Complaint:_____

DRUG ALLERGIES

_____

_____

_____

_____

_____

_____

CURRENT MEDS

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

	Father	Mother	Fathers Parents	Mother Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITAL OR SURGERY

Reason	Date	Reason	Date

Women Only: **Pregnant?** ☐ Yes ☐ No **Planning Pregnancy?** ☐ Yes ☐ No

MEDICAL HISTORY

HABITS

● Smoke: Packs daily:_____ How long: _____ Interested in stoping?

☐ Coffee: Cups daily:_____ Other caffeine:_____

☐ Alcohol: Type:

☐ Sleep Difficulty falling asleep? Continuity disturbances: Snoring:

☐ HEADACHES	☐ LACTOSE INTOLERENCE	☐ DEPRESSION
☐ SHORTNESS OF BREATH	☐ GALLBLADDER DISEASE	☐ GOUT
☐ HEART PALPITATIONS	☐ PROSTATE DISEASE	☐ SCARLET FEVER
☐ HEART MURMUR	☐ BOWEL IRREGULARITY	☐ CHRONIC RASHES
☐ CHEST PAIN	☐ INCONTINENCE	☐ RHEUMATIC FEVER
☐ DIZZINESS/FAINTING	☐ SEXUAL/MENSTRUAL DYSFUNCTION	☐ MUMPS
☐ PERIPHEAL VASCULAR DISEASE	☐ VENEREAL DISEASE	☐ MEASLES
☐ ALLERGIES/HAY FEVER	☐ FREQUENT INFECTIONS	☐ RUBELLA
☐ ASTHMA	☐ HEPATITIS	☐ POLIO
☐ BRONCHITIS	☐ ANEMIA	☐ DIPHTHERIA
☐ PNEUMONIA	☐ ARTHRITIS	☐ TETANUS
☐ ULCER	☐ OSTEOPOROSIS	☐ OTHER
☐ GI DISORDER (STOMACH PAIN AT TIMES)	☐ NERVOUSNESS	☐ OTHER

● Exercise Routine _____ Amount:_____ Early morning awakening:

_____ ☐ Diet: Salt intake:_____ Daytime drowsiness

Fat intake:_____ Other:

HEPATITIS

- **Blood transfusion prior to 1992**
- **Iv drug use (1+ times)**
- ☐ **Contact with blood/bodily fluid**
- ☐ **Tattoos**
- ☐ **Shared razor/toothbrush**
- ☐ **Body piercing**

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Authorization for Release of Medical Information

Patient name_____
Last name first name MI

Address_____

Date of birth_____ Social Security_____

Phone # _____

I hereby request and authorize the following:
Name_____
Address_____
Phone_____

To Release to:
Name_____
Address_____
Phone_____

_____ **A completed copy of all of the above named patient's medical records, including all records relating to mental health, drug or alcohol related conditions**.

_____ **A copy of the above named patient's medical patient's medical records, limited** to the following:

_____ Actual x-rays film or copies: We understand that these films are a part of your permanent records and are released on a loan basis only. We will return the films within thirty (30) days of receipt.

This authorization and request shall be valid until the disclosure is complete or to 90 days after the date below, after which time is shall expire. This authorization may be revoked by contacting **Dr. A. George Elias at (661)663-0300**.

_____ _____
Patient Signature Date signed

_____ _____
Guardian/ Parent Date signed

Financial Policy

Payment for office visits and minor surgical procedures is expected at the time of each visit. To facilitate collection from your insurance company we have designed a combination medical report and insurance form (superbill), which is your receipt upon payment. For surgical procedures that involve a substantial fee, we will usually defer payment and bill your insurance. For certain selected health insurance programs, including Medicare, we accept assignment and will bill the insurance. However, please remember that each patient, not your insurance, is responsible for your payment.

Signature_____ Date _____
(Patient/Legal Guardian)

Assignment and Release: I herby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. If the insurance company has not paid in 60 days, I will pay the bill in full at that time and will be responsible for contacting and follow-up with the insurance carrier. I also authorize the physician to release any information required.

Signature _____ Date_____
(Patient/Legal Guardian)

ELIGIBILITY CERTIFICATION

_____ _____
Subscriber's Name Subscriber's ID Number

_____ _____
Group Name Group Number

(Please Print)

I, _____, understand that I am eligible for benefits through
(Name of member)
_____ on or as of _____through my
(Insurance Carrier) (Effective Date)

_____ employment at _____
(Self/ Spouse's/Parent (Name of employer)

I understand that A. George Elias M.D. is the medical provider for members of the contract under which I am covered. I am aware that if the above is not true I (or the person financially responsible for me) will be held responsible for all charges related to services provided to me. I (or the person financially responsible for me) agree to **PAY IN FULL** all such charges.

_____ _____
Signature of Patient/Legal Guardian Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (661) 663-0300 or by requesting one at this office.

_____ _____

(Date) **(Signature)**

_____

(Print or Type Name)

- **As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.**

_____ _____

(Signature) **(Relationship)**

_____

(Date)

Your medical information can be discussed with the following family members or your POA;

_____

_____

_____

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Dear Patient,

As of July 1, 2008, there will be a charge for the following services:

Missed or broken Doctor Office appointment $25.00

Missed or broken Cosmetic Appointment $50.00

Copy of Medical Records $35.00

Completion of Disability and other Forms $25.00

We also ask that you pay your co-pay and/or deductible at the time of your appointment. We accept Visa, Mastercard, and cash for co-pays. However, we do not accept checks.

If you are requesting a copy of your medical records: Please complete the records release form and allow us 48 hours, as some records have been removed from this office and are in an off-site storage.

An appointment is considered missed or broken when not cancelled prior to 24 hours of the appointment time.

If you will be requiring a refill on your medications please call your pharmacy 3-4 days prior to ensure enough time is available for all approvals to be completed. Allow more time if you will need authorization from your insurance for your medication.

Thank you for your assistance and understanding.

Signature:_____Date:_____