PLEASE FILL OUT AND RETURN TO RECEPTIONIST WITH YOUR INSURANCE CARDS AND PHOTO ID

PLEASE PRINT ONLY **TODAY'S DATE: _____**

Patient's Name: _____

Address: _____City:_____Zip:_____

Home Phone#:_____ Cell Phone #:_____

CAN APPOINTMENT REMINDER MESSAGES BE LEFT ON YOUR ANSWERING MACHINE? YES / NO

Referring Physician: _____

Address: _____

Phone #: _____

Sex: Male / Female **Marital Status:** Married / Single / Widowed / Divorced / Separated

Patient's Data: **Spouse's Data:**

Patient's Social Security# _____ Spouse's Name_____

Patient's Date of Birth: _____ Spouse Social Security#_____

Patient's Employer: _____Spouse Date of Birth_____

Address: _____Spouse Employer_____

Phone: _____Phone: _____

EMERGENCY CONTACT:

PRIMARY:

Name: _____Phone#:_____Relationship to you: _____

SECONDARY:

Name: _____Phone#:_____Relationship to you: _____

PLEASE GIVE A NUMBER THAT WE MAY USE IF YOU ARE NOT AVALIABLE – **DO NOT GIVE YOUR HOME PHONE #**

I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY THAT ALL CHECKS FOR MY MEDICAL SERVICES PROVIDED BY FARABI HUSSAIN, M.D. AND/OR JOHN CULHANE, M.D. AND/OR MILTON RETAMOZO, M.D. BE PAYABLE AND MAILED TO:

ARROWHEAD COMMUNITY SURGICAL MEDICAL GROUP, INC.
P.O. BOX 670
REDLANDS, CA 92375

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I AUTHORIZE FARABI HUSSAIN, M.D. AND/OR JOHN CULHANE, M.D. AND/OR MILTON RETAMOZO, M.D. TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSONER FOR ANY REASON ON MY BEHALF.

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OR CHARGES THAT ARE NOT COVERED FOR MY ACCOUNT FOR ALL PROFESSIONAL SERVICES RENDERED. I HEREBY AUTHORIZE PAYMENT TO ARROWHEAD COMMUNITY SURGICAL MEDICAL GROUP, INC. FOR SURGICAL AND/OR MEDICAL BENEFITS. I HAVE READ AND COMPLETED ALL THE INFORMATION ON THIS FORM. I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES IN MY STATUS ON THE ABOVE INFORMATION.

PATIENT'S SIGNATURE: _____DATE:_____

WITNESS' SIGNATURE: _____DATE:_____

MEDICATION

Please include prescriptions, over-the-counter medications, and vitamins (Or provide a list to be photocopied):

Name: _____ Dosage:_____Frequency:_____

Name: _____ Dosage:_____Frequency:_____

Name: _____ Dosage:_____Frequency:_____

Name: _____ Dosage:_____Frequency:_____

Name_____ Date of Birth_____ Date_____

ALLERGIES

Any allergies or adverse reactions to the following? (please list type of reaction)

Local anesthesia	Y	N	General anesthesia	Y	N
Aspirin	Y	N	Latex	Y	N
Anti-inflammatory	Y	N	Tape/Adhesives	Y	N
Penicillin	Y	N	Lodine	Y	N
Sulfa	Y	N	Betadine	Y	N
IVP dye	Y	N	Codeine	Y	N
Tetanus	Y	N	Steroids	Y	N

Other antibiotics (name)_____

Other medications(name)_____

_____

Preferred Pharmacy:_____ Pharmacy phone#:_____

SURGICAL AND HOSPITALIZATION HISTORY

Please list previous surgeries and hospitalizations with approximate dates (year):

_____

_____

_____

_____

SOCIAL HISTORY

Your Occupation: _____

Do you smoke?	Y	N	How many pack/day?_____
Did you smoke previously?	Y	N	Packs/day?_____ How many years?_____
Do you drink alcohol?	Y	N	If so, how much:_____ How often?_____

Age: _____ Height: _____ Weight: _____

FAMILY HISTORY

Family history (mother, father, grandparents, or siblings) of: WHO?

Heart Disease……	Y	N	_____
Diabetes……	Y	N	_____
High Blood Pressure…….	Y	N	_____
Stroke……..	Y	N	_____
Varicose Veins……	Y	N	_____
Gout……	Y	N	_____
Arthritis……	Y	N	_____
Neuropathy……	Y	N	_____
Bleeding Disorder……..	Y	N	_____
Foot Problems……	Y	N	_____

Mother: Living_____ Age_____ Cause_____
Deceased_____ Age_____

Father: Living_____ Age_____ Cause_____
Deceased_____ Age_____

Brother(s): Living_____ Age_____ Cause_____
Deceased_____ Age_____

Sister(s): Living_____ Age_____ Cause_____
Deceased_____ Age_____

Name_____ Date of Birth_____ Date_____

MEDICAL HISTORY

PLEASE CIRCLE YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING

AIDS/HIV	Y	N	Depression	Y	N	Liver Disease	Y	N
Anemia	Y	N	Diabetes	Y	N	Low Blood Pressure	Y	N
Anxiety	Y	N	Type___ How Long___			Mental Illness	Y	N
Arthritis	Y	N	Emphysema	Y	N	Neuropathy	Y	N
Type_____			Eye Problems	Y	N	Pacemaker	Y	N
Artificial Heart Valve	Y	N	Fibromyalgia	Y	N	Paralysis	Y	N
Artificial Joint	Y	N	Foot Cramps	Y	N	Phlebitis	Y	N
Asthma	Y	N	Gastric Reflux	Y	N	Psoriasis	Y	N
Back Problems	Y	N	Gout	Y	N	Rheumatic Fever	Y	N
Bleeding Disorder	Y	N	Headaches	Y	N	Schizophrenia	Y	N
Bipolar Disorder	Y	N	Heart Attack	Y	N	Shortness of Breath	Y	N
Blood Clot/DVT	Y	N	Heart Murmur	Y	N	Stroke	Y	N
Bypass Surgery	Y	N	Heart Failure	Y	N	Thyroid Problems	Y	N
Cancer	Y	N	Hemophilia	Y	N	Type_____		
Type_____			Hepatitis	Y	N	Tuberculosis	Y	N
Chemical Dependency	Y	N	High Blood Pressure	Y	N	Ulcers (Stomach)	Y	N
Chest Pain	Y	N	Kidney Problems	Y	N	Varicose Veins	Y	N
Circulatory Problems	Y	N	Leg Cramps	Y	N	Wt. Loss, unexplained	Y	N

WOMEN, are you…….Pregnant? Y N Breastfeeding? Y N

SYMPTOMS

Check (√) Conditions your currently have or have had in the past year

GENERAL
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of Sleep
Loss of weight
Nervousness
Numbness
Sweats

MUSCLE/JOINT/BONE
Pain/weakness/numbness in:
Arms
Back
Feet
Hands
Hips
Legs
Neck
Shoulders

GENITO-URINARY
Blood in urine
Frequent urination

GASTROINTESTINAL
Appetite poor
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

CARDIOVASCULAR
Blood Clots
Chest pain
High blood pressure
Irregular heart beat
Low blood pressure
Murmur
Poor circulation
Rapid heart beat
Swelling of ankles
Varicose veins

EYE/EAR/NOSE/THROAT
Bleeding gums
Blurred vision
Crossed eyes
Difficulty swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing ears
Sinus problems
Vision – Flashes
Vision – Halos

SKIN
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal

MEN only
Breast lump
Erection difficulties
Lump in testicles
Penis discharge
Sore on penis

WOMEN only
Abnormal Pap Smear
Bleeding between periods
Breast Lump
Extreme menstrual pain
Hot flashes
Nipple discharge
Vaginal discharge
Date of last period_____
Date of last Pap Smear_____
Have you had a Mammogram?_____
Are you Pregnant?_____
Number of children_____

Arrowhead Community Surgical Medical Group, Inc.
1800 Western Ave Suite 309 San Bernardino, CA 92411

Name_____ Date of Birth_____ Date_____

CONDITIONS

Check (√) Conditions your currently have or have had in the past year

Epilepsy/Seizure	Stroke	Appendicitis	Diabetes
Multiple Sclerosis	Asthma	Crohn's Disease	Goiter
Migraine Headaches	Bronchitis	Hepatitis	Thyroid Problems
Alcoholism	Emphysema/COPD	Hernia	Anemia
Psychiatric Care	Pneumonia	Irritable Bowel	Bleeding Disorder
Cataracts	Tuberculosis	Liver Disease	Breast Lump
Glaucoma	Heart Disease	Ulcerative Colitis	Cancer _____
Blood Clots	Heart Attack	Ulcers, Stomach	Herpes
Congestive Heart Failure	High Blood Pressure	Prostate Problems	HIV Positive
Pulmonary Embolism	High Cholesterol	Kidney Failure	Arthritis
Rheumatic Fever	Pacemaker	Kidney Stones	Gout

Hospitalizations/ Surgeries/ Pregnancies

Year	Hospitalization or serious Illness/Injuries	Reason for Outcome
Year of Birth	Sex of Birth	Complication if any

Health Habits

Check (√) Which substances you use and describe how much you use.

	Caffeine	
	Alcohol	_____ How Much? ____How Often?
	Drugs	
	Tobacco Year Quit____	____How many Years? ____Packs per day?

Occupational

Check(√) Which substances you use and describe how much you use.

	Stress	Hazardous Substances
	Heavy Lifting	Hazardous Substances
	Other	

What is (was) your Occupation?

Have you ever had a blood Transfusion?

Yes No

If yes, Please give approximate dates

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any error or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

CONSENT FOR PROCEDURE

Name of Patient: _____

1. I hereby request and authorize Doctor_____and/or such assistants as may be selected by him/her, and aided by such associates, assistants and practice personnel as may directed by him/her to perform the procedure listed below (also see procedure site identification diagram on back):

_____

_____(If applicable:

Right Left

2. I fully understand that in preparation for, during and following the contemplated procedure, conditions may be revealed or discovered that in the judgment of the physician and others referred to above, make necessary or advisable a different procedure or extension of the originally contemplated procedure. I, therefore, request and authorize the physician and others referral to above to perform these additional procedures.
3. I hereby authorize ARROWHEAD COMMUNITY SURGICAL MEDICAL GROUP, INC. , to undertake its appropriate services and care necessary, attendant to and in conjunction with those procedure undertaken to alleviate my condition or conditions.
4. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that risks, consequences and complications may be associate with the procedure to be undertaken and that no guarantees have been made to me concerning the results of these.
5. I consent to the administration of such medications and anesthetics as may be considered necessary or advisable by the physician responsible for this service with the exception of those to which I am allergic or to which I object as follow. _____
6. I have had the opportunity to ask questions about the procedure listed above and about the risks and benefits of the proposed procedure, as well as alternative forms of treatment. My questions have been answered to my satisfaction. I may withdraw my consent at any time.

_____ _____

(Witness) Date Signature of Patient Date

The undersigned hereby consents to the foregoing for the patient, who is a minor or is unable to sign because:

_____

_____ _____

(Witness) Date (Closest Relative or Legal Guardian) Date

I hereby certify that in my opinion the patient's consent is an informed.

_____

(Witness) Date