Bassem Said, MD
Otolaryngology - Head & Neck Surgery

1240 Central Avenue, Brentwood, CA 94513
Office: 925-516-4368 Fax: 925-516-4360

PATIENT INFORMATION

Patient Last Name:	MI:	First Name:
Street Address:		
City:	State:	Zip Code:
Home Phone:		Date of Birth:
Daytime / Work Phone:		Cell / Alternate Phone:
CA Drivers License or I.D.#:	Gender: M F	Marital Status: S M Sep D W
Patient Social Security #:	Employer/ School Name ***(for children):***	

SPOUSE / CARE GIVER / Adult accompanying minor

Last Name:	MI:	First Name:
Street Address: ***(if different from patient)***		
City:	State:	Zip Code:
Home Phone:		Date of Birth:
Social Security #:		CA Drivers License #:
Employer Name:		Daytime / Cell / Work Phone:
Employer Address:		

E M E R G E N C Y C O N T A C T

Name:	Relation ship to patient	Home Phone	Daytime / Cell Phone

P H Y S I C I A N I N F O R M A T I O N

REFERRING PHYSICIAN INFORMATION

Referring Physician Name:	Specialty:
Phone:	Fax:

PRIMARY CARE PHYSICIAN (if different from referring physician)

Primary Care Physician Name:	
Phone:	Fax:

I N S U R A N C E I N F O R M A T I O N

PRIMARY POLICY INFORMATION

Insurance Carrier:	
Certificate/ ID/ Subscriber/ Policy Number:	Group Number:
Effective Date:	Insurance Phone:
Subscriber / Policy Holder's **Employer Name and Address:**	
Patient's Relationship to Subscriber / Policy holder: Self / Dependant / Spouse / Domestic Partner / Other: _____	

PRIMARY POLICY HOLDER (if different from guarantor / spouse)

Last Name:	MI:	First Name:
Street Address: ***(if different from patient)***		
City:	State:	Zip Code:
Home Phone:	Gender:	**Date of Birth:**
Social Security #:		Daytime Cell / Work Phone:

SECONDARY POLICY INFORMATION (if applicable)

Insurance Carrier:	
Certificate/ ID/ Subscriber/ Policy Number:	Group Number:
Effective Date:	Insurance Phone:
Subscriber / Policy Holder's **Employer Name and Address:**	
Patient's Relationship to Subscriber / Policy holder: Self / Dependant / Spouse / Domestic Partner / Other: _____	

SECONDARY POLICY HOLDER (if applicable)

Last Name:	MI:	First Name:
Street Address: ***(if different from patient)***		
City:	State:	Zip Code:
Home Phone:	Gender:	**Date of Birth:**
Social Security #:		Daytime Cell / Work Phone:

** I authorize the release of medical information to process this claim.*

** I understand that if the medical insurance provided is not in effect I will be responsible for services rendered.*

** I agree that The information above is true and accurate.*

X ***

Signature **Date**

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First Name Last Name	Age:	Sex:	Height:	Weight:

Referring Physician:

ALLERGIES: Do you have allergies to any medications? **YES NO**

If yes, which ones and what type of reaction do you have?

Reason for Visit (Chief Complaint):

How long have you had this problem and what treatments have you had? (Duration)

PAST MEDICAL HISTORY - List any past or other current medical problems: ___ NONE

PAST SURGICAL HISTORY - List any surgeries you have had, include dates: ___ NONE

MEDICATIONS - List all medications you currently take: ___ NONE

SOCIAL HISTORY:
Occupation:

How many alcoholic drinks do you consume per week?

Do you now or have you previouly smoked? **YES NO** If you quit, When? _____
If yes, how many packs per day _____ and for how many years? _____

PERTINENT FAMILY HISTORY:
check all that apply:

___ Early Onset Hearing Loss ___ Thyroid Cancer ___ Bleeding Disorders
___ Other: _____

FOR CHILDREN:

Does your child attend Day care? **YES NO**

Are there smokers in the hosehold? **YES NO**

REVIEW OF SYSTEMS: Check all that apply

Cardiovascular	Gastrointestinal	Respiratory	Infections	Psychiatric	Hematologic/ Lymphatic
__NORMAL	**__NORMAL**	**__NORMAL**	**__NONE**	**__NORMAL**	**__NORMAL**
__artificial heart valve	__stomach ucler	__asthma	__hepatitis	__depression	__anemia
__pacemaker	__colitis	__emphysema	__HIV/AIDS	__anxiety attacks	__bleeding problems
__hypertension	__liver damage	__other lung problems:	__tuberculosis	__other:_____	__enlarged lymph nodes
__heart attack (when?)	__other GI problems:	_____	__other:_____		__other:_____
_____/_____/_____	_____				

Constitutional Symptoms	Musculosketal	Eyes/Ear/Nose/Throat	Skin	Endocrine	Neurological
__NORMAL	**__NORMAL**	**__NORMAL**	**__NORMAL**	**__NORMAL**	**__NORMAL**
__weight loss	__arthritis	__glaucoma	__abnormal scarring	__diabetic	__stroke
__fever	__artificial joint	__hearing aid	__poor healing	__thyroid	__seizuers
__other:_____	__other:_____	__plastic surgery	__other skin disorder	__kidney disease	__other:_____

MODIFYING FACTORS: Do you have any history of: ___ Smoking ___ Diabetes ___ Radiation Treatments ___ Use of Blood Thinners
___ Immunosuppression ___ Oral Steroid (Prednisone) Use; if so, Why? _____

Reviewed By Bassem Said, MD:

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Patient Responsibility

_____Print Patient's Full Name

Insurance

Health insurance companies routinely purchase contracts with physicians from other insurance companies without notifying the physician. As a result we are not aware of every insurance company that has us listed as a contracted provider. Dr. Said is contracted with the following plans - John Muir, Hill Physicians, Sutter Delta Medical Group, Blue Cross and Blue Shield. If your plan is not listed, it is your responsibility to verify that Dr. Bassem Said is a covered provider for your health plan. Our acceptance of your insurance card and/or copay does not imply that we contract with your health plan. It is your responsibility to verify that your health plan will pay for services provided to you by Dr. Bassem Said. If your health insurance plan fails to pay for services rendered, the responsibility becomes yours. _____ <= ***please initial***

Co-Payments

If you have a managed care plan or PPO plan, your office co-pay is due at the time of service.

_____ <= ***please initial***

Cancellations and Missed Appointment Fees

A 24-hour notice is required for all cancellations. If this amount of time is not given, a missed appointment or cancellation fee of $25 will be due and payable before your next appointment can be scheduled.

_____ <= ***please initial***

Medical Records and Form Fees

Your medical records in this practice are the property of Bassem Said, MD. You have the right to review these records and request copies of them. There is a minimum charge of $15 for the copying of your records. Any form that requires completion by Dr. Said will have a minimum charge of $25. These fees are due at the time of the request. _____ <= ***please initial***

Consent to Treatment

I herby give my permission and consent to Bassem Said, MD to treat me using generally accepted standards of medical care. I am aware that medicine and surgery are not exact sciences. I have not been promised or guaranteed that the outcome will be successful. I am aware that the treatment for my condition is based on the information that I provide. If I have provided inaccurate, incomplete, or misleading information I will accept full responsibility. (The identifying information provided such as address, telephone number, date of birth, etc. is correct and I agree to inform Bassem Said, MD and or staff of any changes.) I understand that if the information provided is inaccurate I may be dismissed from the care of Bassem Said, MD._____ <= ***please initial***

_____ _____

Patient or Guardian's **Signature** Date

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Required to Bill Medical Insurance)

Patient's Name: _____ ID Number (Office use only) _____

I hereby authorize Bassem Said, MD; and his business associates to use and disclose my individually identifiable health information ("Health Information") in the manner described below. I understand that this authorization is voluntary (a signature is required to bill your health insurance directly.)

Any and all of the following Health Information may be disclosed by Bassem Said, MD:

1) Medical Records
2) Claims/Billing Information

This Health Information may be disclosed to / obtained from : Primary care, referring phyisician(s), Dr. Said and his business associates, health insurance carrier(s), and answering machines on home, work or cellular phones...

◯ spouse ◯ significant other ◯ family members ◯ Other *(check all that apply)*

_____.

(list anyone else you would consent to having your Health Information released to)

I understand that if the person or entity authorized above by me to receive my Health Information is not a health plan or health-care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.This Health Information will be used only for the purposes of allowing Bassem Said, MD and his business associates to pursue and receive reimbursement of claims from any and all responsible third parties, as allowed in the members' health plan or insurance policy. I understand that my health care will not be affected if I do not sign this form, however, I may be financially responsible for all services rendered if my insurance company refuses to compensate Dr. Said because he was unable to release my "Health Information". Dr. Said and his business associates will not receive any financial or "in-kind" compensation as payment for disclosing the Health Information described above.

I understand that this authorization is indefinite unless a specific expiration date is listed here: _____. I also understand that I may revoke this authorization at any time by notifying Bassem Said, MD in writing. I understand that my revocation of this authorization will not affect any actions taken by Bassem Said, MD in reliance on this authorization prior to the time he received my revocation. I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received or was offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the Patient Information Binder located in the waiting area (*copies available upon request*) , and that I will be offered a copy of any amended Notice of Privacy Practices upon request at each appointment.

Signed: _____ Date:_____

Print Name: _____ Telephone:_____

If not signed by the patient, please indicate relationship with a checkmark:

- □ Parent or guardian of minor patient (to extent minor could not have consented to the care)
- □ Guardian or conservator of an incompetent patient
- □ Beneficiary or personal representative of deceased patient

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Signed: _____ Date:_____

Print Name: _____ Telephone:_____

Name of Patient if different from above: _____

If not signed by the patient, please indicate relationship with a checkmark:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

OPTIONAL:

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____