

WEST COAST SURGICAL SPECIALISTS

PLEASE PRINT CLEARLY

Whom can we thank for referring you to us: _____

Patient Name: _____

Patient Status: single married employed retired student

Gender: male female

Birthdate: _____

Social Security #: _____

Address: _____

Home Phone: _____ Work Phone: _____

Parent/Guardian (if minor): _____

Primary Insurance: _____

Employer or Group Providing Insurance: _____

Insured's Name if not patient: _____ DOB: _____

Social Security #: _____

ID/Subscriber #: _____ Group #: _____

Secondary Insurance: _____

Employer or Group Providing Insurance: _____

Insured's Name if not patient: _____ DOB: _____

Social Security #: _____

ID/Subscriber #: _____ Group #: _____

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CONSENT TO TREATMENT

The undersigned consents to the patient's medical and/or surgical treatment. The undersigned acknowledges that services have been adequately explained, and that all questions have been answered.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be provided to the patient, he/she individually obligates himself/herself to pay the account of patient.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment directly to Allen K. Chan, MD/Tommy Dinh, MD/Patrick Moore, MD./Frank Torres, MD of the insurance benefits to which I may be entitled. Requested information may be released to the insurance carrier.

NOTICE TO MANAGED CARE PATIENTS

Managed care insurances generally require that a representative, often a Primary Care Physician, authorize medical and/or surgical treatment provided by a Specialist before the plan will accept financial responsibility. Your signature below indicates that you agree to be responsible for payments if you receive services that are not authorized as required by your plan.

MEDICARE PATIENTS

Medicare Authorization (for signature on file): I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment (i.e. Allen K. Chan, MD/Tommy Dinh, MD/Patrick Moore, MD/Frank Torres, MD).

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

Relationship if not Patient's Signature: _____

**Acknowledgement of Receipt of Notice of Privacy Practices
WEST COAST SURGICAL SPECIALISTS**

I hereby acknowledge that I have been offered a copy of Allen K. Chan, MD/Tommy Dinh, MD/Patrick Moore, MD/Frank Torres, MD Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, on our website, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship: _____

Name of patient: _____

Yo reconozco que me han ofrecido una copia del aviso sobre la Practicas de Privacidad de Allen K. Chan, MD/Tommy Dinh, MD/Patrick Moore, MD/Frank Torres, MD. Tambien reconozco que hay una copia del aviso en la sala de espera, y que si hay cambios con el aviso de las Practicas sobre la Privacidad me ofreceran una copia en cada visita.

Firma: _____ Fecha: _____

Nombre: _____

Si no es firmado por el paciente, favor indique: _____

Nombre del paciente: _____

For Office Use Only:

Date received: _____ Processed by: _____

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain: _____

Reasons for refusal: _____

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

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Name: _____ DOB: _____ Gender: _____

Reason for visit today: _____

Medical History: (circle all that apply)

(Do you currently have or had the following conditions?)

High Blood Pressure

Diabetes

High Cholesterol

Kidney Failure

Heart Disease

Liver Disease

Stroke

Lung Disease

Asthma

Bleeding Disorder

Clotting Disorder

Cancer

Hepatitis

Immune Deficiency

Varicose Veins

Poor Leg Circulation

Aneurysms

Stomach Ulcer

Others: _____

Surgery History: (list all surgeries you had)

Date: _____ Procedure Done _____

Date: _____ Procedure Done _____

Date: _____ Procedure Done _____

Date: _____ Procedure Done _____

Social History:

Do you currently smoke or had smoked tobacco? Y / N

If yes, about how many years did you smoke tobacco? _____

How much alcohol do you drink per day on the average? _____

What medical conditions are present in your parents/brothers/sisters?
