PRE VISIT DOCUMENTS

Notice of Privacy Practice and Consent to the Use and Disclosure of Health Information.

Name: _____ Date of Birth: _____SS #: _____

I understand that as part of my healthcare, Dr. Shelby's office originates and maintains health records describing my health history, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication amongst the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

☐ **I request the following restrictions to the use or disclosure of my health information:**

Medical information can be discussed with:

☐ Patient Only

_____

☐ Family member or friend _____

☐ Physician

☐ Other _____

Detailed messages regarding test results can be left on my answering machine/voicemail:

☐ Yes ☐ No ☐ Phone #:

☐ Other Restrictions

_____

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices for Dr. Shelby's Office.

_____ _____

Signature of Patient or Legal Representative Date

PRE VISIT DOCUMENTS

Patient Information Sheet: **Email:** _____

Last Name:_____ First Name: _____ Middle Name:_____

Sex: Male / Female Date Of Birth _____ Age: _____

Social Security #: _____ Driver's License Number: _____

Full Address: _____

Home Phone: _____ Cell: _____Work: _____

IN CASE OF EMERGENCY (Notify): _____Phone: _____

Primary Physician (Required): Referring Physician (Required):

Pharmacy name, address and Phone number: _____

PRIMARY INSURANCE	**SECONDARY INSURANCE:**
Name Of Insurance: _____	Name Of Insurance: _____
Street Address: _____	Street Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: (____) _____	Phone: (____) _____
SUBSCRIBER: _____	**SUBSCRIBER**: _____
Relationship to Patient: _____	Relationship to Patient: _____
SOCIAL SECURITY #: _____	SOCIAL SECURITY #: _____
Date Of Birth: _____	Date Of Birth: _____
POLICY #: _____	POLICY #: _____
GROUP #: _____	GROUP #: _____
EFFECTIVE DATE: _____	EFFECTIVE DATE: _____

CONSENT FOR TREATMENT/INSURANCE AUTHORIZATION I hereby authorize the release of information to my insurance company concerning charges/treatment provided to me by the physician listed above. Transmittal by Fax is authorized. I hereby assign benefits and I understand that payment is due as services are provided, including my deductible, co-payment, coinsurance, or any balance not paid by my insurance (excluding contractual allowances). If, after 60 days, insurance payment has not been received, I understand that the charges are my responsibility and payable immediately. In the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to a maximum of 50% of our outstanding balance at the same time the amount is placed with the agency. Interest of 10% per year will be accrued on the principal balance. Should legal action also be necessary to collect the amount I/we agree to pau the attorney's fees and court fees incurred for collection.

_____ _____

PATIENT'S SIGNATURE DATE

Salim Shelby, MD, A Division of BASS Medical Group **email:ShelbyGIMD@gmail.com**
1320 El Capitan Dr. Ste. 110, Danville, CA 94526 **Phone: (925)2320090** **fax (925)9532371**

PRE VISIT DOCUMENTS

Health Questionnaire

Please fill out completely

Name: _____Were you referred by a friend or family member? _____

Reason for this visit: _____Age: _____Height: _____ Weight: __

Medical Problems/Hospitalizations/Surgeries/Date:

1) _____ 5) _____

2)_____ 6) _____

3)_____ 7) _____

4)_____ 8) _____

Allergies: None OR Allergies to: Latex/Iodine/Shellfish /Anesthetic or Medications Allergy: _____

Medications: (include BCP, calcium, vitamins, aspirin, herbs) and dosage

1) _____ 5) _____

2)_____ 6) _____

3)_____ 7) _____

4)_____ 8) _____

Social History: Occupation _____Are you Married/Single/Widowed/Divorced/Other _____
Are you a Smoker: NO/YES, I smoke approximately _____Pack(s) a Day for_____ Years
Alcohol: None or I have approximately _____ drink(s) a day for _____ Years, Beer OR Hard liquor

Family: Age Medical Problems ?Deceased Age, Medical Problems, ?Deceased

Father_____ M/F Children _____
Mother _____ M/F Children _____

Brothers/Sisters_____ M/F Children _____

Brothers/Sisters _____M/F Children _____

Review of Systems: (Please check all that apply) Last menses: _____Birth control method:_____
Pacemaker/Mastectomy/Dentures/Eyeglasses/Hearing aid or other: _____Diabetes/High BP/Heart Failure/Organ Transplant/Valve Replacement/Blood thinners _____

I have: Past/Current

Fevers	Immune Deficiency	Diarrhea
Weight changes	Cancer	Constipation
Fatigue/Weakness	Arthritis/Joint Pains	Bloody/Black Stools
Headaches	Immune Disorders	Diverticulosis/Diverticulitis
Seizure/Strokes	Eczema/Psoriasis	Abdominal discomfort/pain
Eye Problems	Rashes	Bleeding/Clotting disorders
Hearing/Ear Problems	Prostate Problems	Anemia/Transfusion
Shortness of breath	Urinary Infections	Signature:_____
Asthma/Emphysema	Kidney Stones	**Date:**_____
Pneumonia/Bronchitis/TB	Blood in urine	
Sleep Apnea	Suicide Attempts	
Chest Pains	Drug/Alc Abuse	
Heart Attack	Nausea	
Rheumatic Fever/Murmur	Vomiting	
Antibiotics before dentist	Heartburn/Regurgitation	
Leg swelling or cramps	Difficulty Swallowing	
Blood in urine	Ulcers	
Thyroid Problems	Hepatitis/Jaundice/Liver Dis.	