902 Santa Fe

902 Santa Fe Avenue, Albany, CA 94706

Christopher Brown, DO

(510) 526-5256 • fax (510) 526-5547
www.christopherbrowndo.com
902santafe@gmail.com

Patient's Last Name: _____ First Name: _____

Address: _____

City: _____ State_____ Zip_____

Phone: (Home)_____ (Work): _____ (Cell): _____

Age_____ Date of Birth ____/_____/_____ Email: _____

*Occupation*_____

Referred by: _____

Patient's condition: _____

_____ Duration of Problem: _____

Doctor: _____ Doctor's Telephone: _____

No. in household _____

If Child: Parent or guardian: _____

Parent 1 Occupation: _____ *Parent 2 Occupation:* _____

Siblings _____

Emergency Contact (other than parent) (name & phone):

_____

Fees:

- **New patient**: Adult - $300, Child under 14 - $200
- **Follow-up**: Adult - $170, Child under 14 - $150

Office Policies:

- 48-hours (2 business days) cancellation notice
- For "no-shows" and late cancellations, you are charged half of treatment fee
- We do not bill insurance directly
- We do not take Medicare/Medical nor Workman's Comp
- Payment is required at the time of your visit. We accept cash, check or credit

I have read and agree to honor all office policies.

Signed_____ Date _____

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HEALTH QUESTIONNAIRE

FAMILY HISTORY – Did any blood relative suffer any of the following? Please highlight and indicate which relative:

○ Epilepsy	○ Thyroid	○ Osteoporosis	○ Alcoholism
○ Migraine	○ Hayfever	○ Arthritis	○ Hepatitis
○ Mental Illness	○ Asthma	○ Heart disease	○ Cancer
○ Glaucoma	○ Anemia	○ Hypertension	_____
○ Diabetes	○ Bleeds easily	○ High cholesterol	_____

HOSPITAL ADMISSIONS	YEAR	ILLNESS or OPERATION	YEAR	ILLNESS or OPERATION
Medications/ Supplements		**ALLERGIES**	**VACCINE**	**TEST EXAM**
			Tetanus/TD____	○ Rectal/Stool _____
			Flu _____	○ Cholesterol _____
			Pneumonia ____	○ Eye Exam _____
			Hepatitis _____	○ TB Test _____
				○ Hepatatis _____

MEDICAL HISTORY

❒ Decreased hearing
❒ Ringing in ear
❒ Ear infections
❒ Dizzy or fainting spells
❒ Failing vision or eye pain
❒ Double or blurred vision
❒ Nose bleeds – recurrent
❒ Sinus trouble
❒ Sore throats – frequent
❒ Hoarseness – prolonged
❒ Hayfever /Allergies
❒ Pneumonia / Pleurisy
❒ Bronchitis / Chronic cough
❒ Asthma / Wheezing
❒ Shortness of breath
❒on exertion ❒lying flat
❒ Chest pain
❒ High blood pressure
❒ Heart murmur
❒swollen ankles
❒irregular pulse ❒palpitations
❒ Leg pain 🚶 when walking
❒ Varicose veins / Phelebitis
❒ Cold numb feet
❒ Loss of appetite - recent
❒ Difficulty swallowing
❒ Heartburn ❒Peptic ulcer
❒ Persistent Nausea / Vomiting
❒ Abdominal Pain - chronic
❒ Gallbladder trouble
❒ Jaundice / Hepatitis
❒ Diarrhea ❒Constipation
❒ Diverticulosis ❒Crohn's / Colitis
❒ Inflammatory Bowel Syndrome
❒ Bloody or tarry stool
❒ Hemorrhoids ❒Hernia
❒ Urination / Overactive bladder
❒Overnight more than twice
❒More than 8 times / 24 hrs
❒Urgency to urinate
❒with leakage
❒ Decrease in force/flow ❒ painful
❒ Stress incontinence – urine leakage with exercise /movement
❒ Blood in urine ❒Kidney stones
❒ Urine infections – frequent
❒ Sexually transmitted diseases
❒ Sexual problems
❒ Weight loss ❒Gain – recent
❒ Anemia ❒Bruise easily
❒ Blood transfusions
❒ Cancer ❒Chronic fatigue
❒ Diabetes ❒Thyroid disease
❒ Seizures ❒Stroke
❒ Tremor / hands shaking
❒ Numbness / tingling sensations
❒ Headaches – frequent
❒ Arthritis / Rheumatism
❒ Back pain – recurrent
❒ Bone fracture / joint injury
❒ Osteoporosis
❒ Foot pain ❒Gout
❒ Rashes ❒Hives
❒ Psoriasis ❒Eczema
❒ Any type of sleeping difficulty
❒ Depression ❒Nervousness
❒ Agitation ❒Memory loss
❒ Moodiness ❒ Suicidal thoughts
❒ Phobias ❒Mental illness
❒ Feelings of worthlessness
❒ Rheumatic fever ❒Scarlet fever
❒ Chickenpox ❒Polio ❒Mumps
❒ Measles ❒German measles
❒ Tuberculosis ❒Herpes
❒ AIDS / HIV
❒ Alcohol ____ oz/week
❒ Coffee / Tea ____cups per day
❒ Smoking _____cig/day
years ____ year quit_____
❒ Exercise _____
❒ Street drugs _____
❒ Acupuncture / tattoos
❒ Hair loss _ progressive _ recent

MALES: ❒ Prostate problems

FEMALES *Please complete:*

Menstrual Flow:
❒Regular ❒ Irregular ❒ Pain/Cramps
Days of flow _____ Length of cycle ____
Date of 1st day of last period _____
❒Pain / Bleeding during or after sex
Number of Pregnancies _____
Abortions _____ Miscarriages _____
Live Births _____
Birth control method _____
❒ Flushing / Menopause
Date of last PAP test _____
❒Normal ❒Abnormal
Date of last mammogram _____
❒Normal ❒Abnorm

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MEDICAL RELEASE FORM

Today's Date: _____

Patient Name: _____ Date of Birth _____-_____-_____
Please print

1. Permission to release information to Insurance Carriers:

I give permission to this office to release medical information to my health or automobile insurance company.

Patient/Guardian Signature: _____ _____
Date

_____
(Print Name of Patient/Guardian)

❏ Please contact me when you receive requests for information from my insurance carrier.

2. Permission to Share Information with Health providers:

I give permission to this office to share my medical information with my other health providers so that they may coordinate my care.

Patient/Guardian Signature: _____ _____
Date

_____
(Print Name of Patient/Guardian)

❏ Please contact me before sharing any information with my other health providers.

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HIPPA NOTICE OF PRIVACY PRACTICE - ACKNOWLEGEMENT OF RECEIPT

I hereby acknowledge that a current copy of the medical practice's Notice of Privacy Practices is available online at www.hhs.gov/hipaa as well as in the reception area. I further acknowledge that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Patient: _____

Patient/Guardian Signature: _____ _____
Date

_____
(Print Name of Patient/Guardian)

Address: _____

If not signed by the patient, please indicate relationship:

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient

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MEDICARE BENEFICIARY AGREEMENT

I, _____ Medicare beneficiary, clearly understand that by signing this contract, I will:

1. Agree not to submit a claim (for such items or services, even if such items or services are otherwise covered by Medicare).

2. Agree to be responsible, whether through insurance or otherwise, for payment of such items or services, and understand that no reimbursement will be provided for such items or services by Medicare.

3. Acknowledge that no limits apply to amounts that may be charged for such items or services.

4. Acknowledge that Medigap plans do not, and other supplemental plans may elect not to make payments for such items or services, because payment is not made with Medicare.

5. Acknowledge that, as a Medicare beneficiary, I have the right to such items and services provided by other physicians or practitioners, for whom payment would be made under Medicare.

Patient/Guardian Signature: _____ _____
Date

_____
(Print Name of Patient/Guardian)