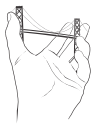

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date: __ /__ /____

NEW PATIENT INFORMATION

GENERAL INFORMATION

First Name | Last Name | M.I.

Address | City | State | Zip

Email

Cell Phone | Home Phone | DOB / / | Age

Which hand is your dominant hand? ☐ Left ☐ Right | Gender ☐ Male ☐ Female | Height (inches) | Weight (pounds)

SSN - - | Occupation | Employer

Employer Address | City | State | Employer Phone

EMERGENCY CONTACT INFORMATION: First Name | Last Name

Relationship | Primary Phone

How would you prefer we contact you? ☐ Cell Phone ☐ Text ☐ Email

PRIMARY INSURANCE CARRIER OR WORKERS COMPENSATION

For Workers Compensation please enter your claim number (if known) as "Subscriber ID" in the section below.

Carrier Name | Subscriber ID

Group Number | Relationship to Patient

First Name | Last Name

Claims Address | City | State | Zip

SECONDARY INSURANCE CARRIER

Carrier Name | Subscriber ID

Group Number | Relationship to Patient

First Name | Last Name

Claims Address | City | State | Zip

Claims Examiner | **Phone** | **Fax**

PRIMARY PHYSICIAN INFORMATION

PCP Name | Address

City | State | Zip | Office Phone

Referring Physician | Address

City | State | Zip | Office Phone

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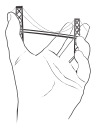

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INJURY INFORMATION

Reason for Visit	Date of Injury
Previous Treatment? ☐ Yes ☐ No If Yes, when	Injury Type? ☐ Auto ☐ Work Comp ☐ Third Party Liability ☐ Other
Has a Workers Compensation claim been filed? ☐ Yes ☐ No	Are you still working? ☐ Yes ☐ No

HEALTH HISTORY

Please indicate with a check mark if you have been diagnosed or treated for any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer/Chemotherapy (within 6 months)
- ☐ Chronic Liver Disease
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Chronic Pain
- ☐ Current Pregnancy
- ☐ Diabetes
- ☐ Dialysis
- ☐ Emphysema
- ☐ Fractures
- ☐ Heart Disease
- ☐ Hepatitis B or C
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Indwelling Hardware
- ☐ Migraine
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker or ICD device
- ☐ Peripheral Vascular Disease
- ☐ Psoriasis
- ☐ Recent Head or Brain Injury
- ☐ Rheumatoid Arthritis
- ☐ Spine Disease
- ☐ Stent Placement
- ☐ Thyroid Disease
- ☐ I have no significant medical history (select if applicable)

Symptoms or conditions not listed above:

SURGICAL HISTORY

Have you had any problems related to surgery either before, during or after surgery? ☐ Yes ☐ No

If Yes, please describe

Have you had any problems with anesthesia? ☐ Yes ☐ No If Yes, please describe

Do you have a family history of anesthesia complications?

Please list ALL surgeries that you have had (including dates):

Surgery	Date
Surgery	Date
Surgery	Date

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SOCIAL HISTORY

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Domestic Partner

Marijuana Use ☐ Current daily smoker ☐ Current occasional smoker ☐ Former smoker ☐ Not a smoker

If marijuana smoker or former smoker, how many years have you been smoking and how often per day?	Years	Daily Usage

Tobacco Use ☐ Current daily smoker ☐ Current occasional smoker ☐ Former smoker ☐ Not a smoker

If smoker or former smoker, how many years have you been smoking and how often per day?	Years	Daily Usage

Alcohol Use ☐ No alcohol use ☐ Social drinker ☐ Moderate (1-2 drinks/day) ☐ Heavy Drinker

Please describe non-prescription drug use:

MEDICATIONS & ALLERGIES

Current Medications (please list here)

Please indicate below any allergies, the name of the substance and the type of reaction you have experienced.

☐ No Known Allergies

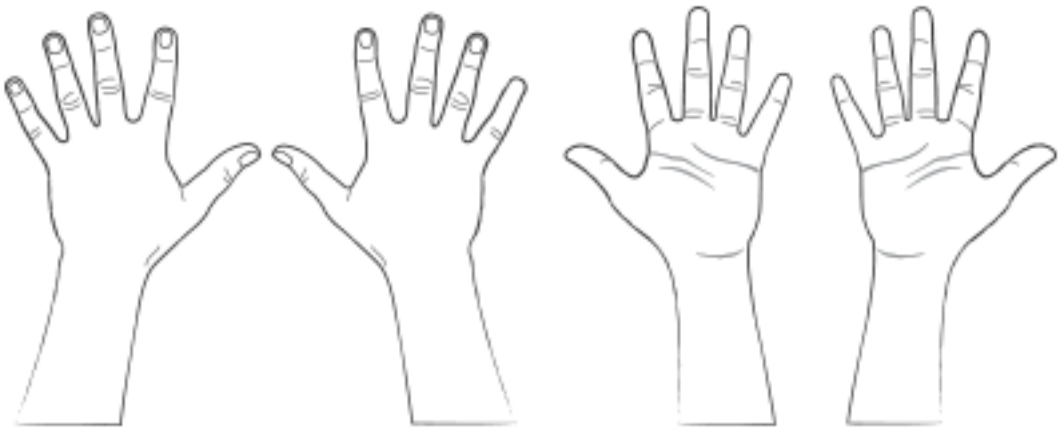
☐ Medication Allergies, please explain:

☐ Latex, please explain:

☐ Tapes/Adhesives, please explain:

PAIN MAP

INSTRUCTIONS: Please draw markers on the body that correspond to the markers to the right describing your symptoms.



- SHOOTING PAIN
- RADIATING PAIN
- DULL PAIN
- NUMBNESS
- TINGLING
- LACERATIONS

Please rate your pain today on a scale from 0 to 10 where 0 is no pain and 10 is pain as bad as it can be: _____

This form was completed by ☐ Patient ☐ Parent/Guardian

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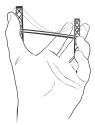

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RESPONSIBLE PARTY (if not the patient)

First Name	Last Name	M.I.

Address	City	State	Zip

D.O.B. / /	Relationship to patient

THE HAND CENTER OF SAN FRANCISCO FINANCIAL AGREEMENT, PRIVACY AGREEMENT & DISCLOSURES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I hereby acknowledge that I have reviewed Hand Center of San Francisco's Notice of Privacy Practices at http://www.sfhand.com/Images/PrivacyNotice.pdf. I understand that a copy of the current Notice will be available in the office, and that a copy of any amended Notice of Privacy Practices will be available at each future appointment and on the website at: http://www.sfhand.com/Images/PrivacyNotice.pdf

PATIENT DISCLOSURE

California Law imposes disclosure requirements for Physicians that have a financial interest in a facility to which they refer patients. In compliance with the law, please be advised that Dr. Bickel and Dr. Lang have a financial interest in Pacific Heights Surgery Center of San Francisco where your surgery may be performed. If you prefer that your surgery not be performed at Pacific Heights Surgery Center, please let us know so that the office can make other arrangements for any procedures.

FINANCIAL AGREEMENT

I hereby assign money to be paid to The Hand Center of San Francisco, Inc. for services rendered to me by physicians employed by the corporation. In the event that money is paid to me directly by any insurance company for said services, I agree to hold such funds in trust and to promptly remit these funds to The Hand Center of San Francisco, Inc. to cover any portion of the bill not paid to The Hand Center Of San Francisco, Inc. or its representatives, upon presentation of a notice thereof. This agreement is entered into San Francisco, CA and shall not be revoked unless so stipulated in writing.

By signing below you acknowledge that you have read and understand the above and you have reviewed the privacy policy from our website. You agree that you have completed this form accurately to the best of your knowledge. You agree to abide by the office financial policy.

PATIENT NAME (PRINTED) **PATIENT (OR RESPONSIBLE PARTY) SIGNATURE** **DATE**

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