PATIENT INFORMATION SHEET

Patient Name:_____Date of Birth_____

***E-Mail Address**_____

Sex: M☐ F☐ Marital Status : Married ☐ Single ☐ Divorced ☐ Widowed☐

Home Phone: ( )_____Cell # ( )_____Work # ( )_____

Home Address: _____

City/State/Zip_____

Employer:_____Occupation:_____

Spouse/Partner Name:_____Contact #( )_____DOB:_____

Emergency Contact:_____Contact # ( )_____

Primary Physician:_____Referring Physician:_____

Insurance Information

While we willingly work with our patients in regards to insurance billing, it is the patient's responsibility to know policy limits, deductibles, exclusions, and copayment, and authorization information.

Primary Insurance:_____Subscriber Name_____DOB:_____

Member ID #_____ Group #_____

Secondary Insurance:_____Subscriber Name_____DOB:_____

Member ID#_____Group #_____

Assignment of Benefits

I hereby authorize payment directly to Brian M. Chesnie for medical and/or surgical benefits, if any, otherwise payable to me for his services as described on the attached claim. I also realize that this may not represent the full payment for services rendered and I will be responsible for the balance due including copayments, coinsurance, and deductibles.

_____ _____

Patient Signature Date

Authorization for Release of Records

I hereby authorize Dr. Chesnie to release my medical records to my insurance company and/or my other treating physicians for the purpose of healthcare operations and/or for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

_____ _____

Patient Signature Date

Brian M. Chesnie, M.D., Inc.
1501 Superior Ave. # 212
Newport Beach, CA 92663

PATIENT NAME _____

PATIENT MEDICATION LIST & ALLERGIES

MEDICATION NAME	DOSAGE(mg)	# OF PILLS	FREQUENCY (How Often)?
EXAMPLE: Lisinopril	10 mg	1	twice daily breakfast and dinner
1			
2			
3			
4			
5			
6			

ALLERGIES & REACTIONS: _____

OTHER: ie Vitamins, Supplements, etc.

1 _____

2 _____

3 _____

4 _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge receipt of the Notice of Privacy Practices of Brian M. Chesnie, M.D., Inc. as required by HIPAA.

I hereby authorize my protected health information to be used and/or disclosed to immediate family members (spouse/children), my treating physicians, and/or my health insurance company as necessary to carry out normal treatment/healthcare operations. In addition, I consent to reconciliation of my medications via Surescripts prescription drug portal.

I understand that my protected health information will be released at the discretion of my physician and I also understand that I have a right to limit its use.
I understand that I have a right to revoke this authorization in writing, at any time, by sending such notification to Brian M. Chesnie M.D. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have a right to inspect or copy the protected health information to be used or disclosed as permitted under federal law. I also have a right to refuse to sign this authorization.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Description of Personal Representative's Authority

I **do not** authorize my medical information to be released to:

_____

_____