PATIENT INFORMATION SHEET

Patient Name:_____ Date of Birth:_____

***E-Mail Address:**_____

Sex: M☐F ☐ Other☐Specify:_____Marital Status: Married☐ Single☐Divorced☐ Widow☐

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

Home Address: _____City/State/Zip_____

Employer:_____Occupation:_____

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

Emergency Contact Name and Contact # _____( )_____

Primary Physician Name and Phone # _____( )_____

How did you find us? Search Engine ☐ YELP ☐ Friend ☐_____Physcian☐_____

INSURANCE INFORMATION

******While we are willing to work with our patients in regards to insurance billing, it is the patient's responsibility to know provider status, policy limits, deductibles, exclusions, 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 no 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 and his staff 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 medical claims. This authorization shall remain in effect as long as charges are being submitted on my behalf for insurance claim processing or as dictated by the payor.

_____ _____

Patient Signature Date

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

PATIENT NAME:_____ DATE:_____

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING:

MEDICATION NAME	DOSAGE (MG)	# OF PILLS	FREQUENCY (HOW OFTEN

DRUG ALLERGIES & KNOWN REACTION

Please list known drug allergies and associated reaction:

ALLERGIC TO:	REACTION

Please list any other vitamins and/or supplements:_____

_____

_____

_____

Do you drink alcohol? Yes ☐ No ☐ If yes, what- how much/how often?_____

Do you smoke cigars, cigarettes, and/or marijuana? Yes ☐ No ☐ Former smoker ☐

When quit?_____ If yes, how often:_____

Height:_____ Weight:_____

Brian Chesnie, M.D., Inc.

REVIEW OF SYSTEMS

Patient Name:_____ Date:_____

PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOU HEALTH

GENERAL:	Yes	No
Weight Loss	☐	☐
Fever	☐	☐
Weight Gain	☐	☐
Sweats	☐	☐
Chills	☐	☐
Weakness	☐	☐
Loss of Appetite	☐	☐
Daytime Sleepy	☐	☐
Snoring	☐	☐
Fatigue	☐	☐

EYES:	Yes	No
Eye Pain	☐	☐
Blurred Vision	☐	☐
Eye Discharge	☐	☐
Light Sensitive	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Decreased Vision	☐	☐

EARS/NOSE/ THROAT:	Yes	No
Trouble Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Congested	☐	☐
Sore Throats	☐	☐
Nose bleeds	☐	☐
Hearing Aids	☐	☐

CARDIOVASCULAR:	Yes	No
Chest Pain	☐	☐
Palpitations	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Short of Breath	☐	☐
Can't lie Flat	☐	☐
Swelling Ankles	☐	☐

RESPIRATORY:	Yes	No
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Sputum	☐	☐

GASTROINTESTINAL:	Yes	No
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Change in BMs	☐	☐
Diarrhea	☐	☐
Jaundice	☐	☐
Abdominal Pain	☐	☐
Black/Bloody Stool	☐	☐
Bloating	☐	☐

GENITOURINARY:	Yes	No
Burning/Frequency	☐	☐
Nighttime Frequency	☐	☐
Blood in Urine	☐	☐
Erectile Dysfunction	☐	☐
Abnormal Discharge	☐	☐
Incontinence	☐	☐
Hesitancy	☐	☐
Decreased Libido	☐	☐

MUSCULOSKELETAL:	Yes	No
Joint Pain	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
Arthritis	☐	☐
Muscle Cramps	☐	☐
Edema	☐	☐

SKIN:	Yes	No
Rash	☐	☐
Dry Skin	☐	☐
Lesions	☐	☐
Itching/Burning	☐	☐

NEUROLOGICAL:	Yes	No
Loss of Strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐
Stroke/TIA	☐	☐
Syncope	☐	☐
Dizziness	☐	☐

PSYCHOLOGICAL:	Yes	No
Anxiety	☐	☐
Depression	☐	☐
Mood Swings	☐	☐
Insomnia	☐	☐

ENDOCRINE:	Yes	No
Polyuria	☐	☐
Heat/Cold Intolerance	☐	☐
Excessive Thirst	☐	☐
Increased Appetite	☐	☐
Weight Loss	☐	☐
Weight Gain	☐	☐

ALLERGIC:	Yes	No
Hives/Eczema	☐	☐
Hay Fever	☐	☐
Seasonal	☐	☐

HEMATOLOGY:	Yes	No
Excessive Bruising	☐	☐
Anemia	☐	☐
Enlarged Glands	☐	☐
Anticoagulant Use	☐	☐

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

I acknowledge receive 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.

By requesting my test results or my medical records via email instead of using the secure online portal available to me, I understand that my records will not be encrypted and therefore not be securely sent.

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 Date

_____

Print Name

***I DO NOT AUTHORIZE MY RECORDS TO BE RELEASED TO:(please list individuals you do not wish us to discuss or release your medical information to):

_____ _____

_____ _____

_____ _____