

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 _____ Phycian _____

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

**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):

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	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Daytime Sleepy	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>

EYES:

	Yes	No
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Eye Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitive	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Vision	<input type="checkbox"/>	<input type="checkbox"/>

EARS/NOSE/ THROAT:

	Yes	No
Trouble Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congested	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR:

	Yes	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Can't lie Flat	<input type="checkbox"/>	<input type="checkbox"/>
Swelling Ankles	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY:

	Yes	No
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Sputum	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL:

	Yes	No
Heartburn/Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Change in BMs	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Black/Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY:

	Yes	No
Burning/Frequency	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime Frequency	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Libido	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL:

	Yes	No
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Edema	<input type="checkbox"/>	<input type="checkbox"/>

SKIN:

	Yes	No
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>
Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL:

	Yes	No
Loss of Strength	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Syncope	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHOLOGICAL:

	Yes	No
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE:

	Yes	No
Polyuria	<input type="checkbox"/>	<input type="checkbox"/>
Heat/Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Increased Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIC:

	Yes	No
Hives/Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal	<input type="checkbox"/>	<input type="checkbox"/>

HEMATOLOGY:

	Yes	No
Excessive Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Glands	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulant Use	<input type="checkbox"/>	<input type="checkbox"/>