Eli Chen, M.D.
2430 Samaritan Dr. San Jose, CA 95124
(408) 782-4060 (phone) / (408) 659-8388 (fax)

PATIENT INFORMATION

Last Name:_____ Legal First Name: _____ MI: ___ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: M F Height: __' ___" Weight: _____lbs Social Security #: _____

Responsible Party: _____ Relation to Patient: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Email address: _____ Preferred Means of Contact: Home / Cell / Work / Email

Employer, or if Student, School/Grade : _____

Preferred Pharmacy Name: _____ Pharmacy Address: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Medical Group/IPA: _____

ID#: _____ Group#: _____

Subscriber Name: _____ Relation to Patient: _____ D.O.B.: _____

Address (if different from patient): _____

Secondary Insurance Carrier: _____ Medical Group/IPA: _____

ID#: _____ Group#: _____

Subscriber Name: _____ Relation to Patient: _____ D.O.B.: _____

Address (if different from patient): _____

WORKER'S COMPENSATION INFORMATION

Worker's Compensation Carrier/Insurance: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Claim#: _____ Employer: _____ Phone#: _____

D.O.I.: _____ Accepted Body Part(s): _____

Adjuster's Name: _____ Phone#: _____

Eli Chen, M.D.
2430 Samaritan Dr. San Jose, CA 95124
(408) 782-4060 (phone) / (408) 659-8388 (fax)

Financial Policy

PPO/HMO's

We will submit claims directly on your behalf to your respective insurance carrier. The patient / guardian are responsible for any co-pays or patient responsibility on the day of the visit. Referrals are the responsibility of the patient / guardian to obtain from their primary care physician **PRIOR** to their appointment in this office. **IF REFERRALS ARE NOT OBTAINED, THE PATIENT / GUARDIAN IS FULLY RESPONSIBLE FOR CHARGES INCURRED OR THE OFFICE VISIT WILL BE CANCELED.** We are limited by HMO's to provide treatment only for what is authorized. If you choose to have treatment for additional problems not authorized by your plan, you will be financially responsible for the charges.

Co-pays

All co-pays are due at the time of service, **no exceptions**.

Deductibles

For patients with high deductibles, all or a portion of the deductible may be collected prior to any surgeries or office procedures.

Balances

Balances should be paid promptly. If you have outstanding balances, we may request those balances be paid prior to receiving any further treatments, including office visits.

Worker's Comp

Your Worker's Compensation Carrier / Adjuster must authorize all visits in advance. All services are to be paid by Worker's Comp. In the event the Worker's Comp Carrier should deny a claim, the patient will be responsible for the bill.

Cash Pay

A consultation fee of $200.00 will be collected on the day of the patient's initial office visit. A $100.00 office fee will be due and payable for any office visits thereafter, this charge would not include any additional services outside the office visit such as: casting, injections, medications, etc.

Cancelled /No Show Appointments

If the patient fails to notify office within 48 hours of the patient's visit, a cancellation charge of $35.00 will be applied to your account.

Returned Check

In the event of insufficient funds, a returned check fee of $25.00 will be added to your account balance along with the payment amount which was on the check.

IT IS THE RESPONSIBILITY OF THE PATIENT / GUARDIAN TO INFORM OUR OFFICE OF ANY CHANGES IN THEIR INSURANCE COVERAGE AND BILLING INFORMATION.

Signature of Responsible Party: _____
(Parent / Guardian of minor child)

Date: _____

Eli Chen, M.D.
2430 Samaritan Dr. San Jose, CA 95124
(408) 782-4060 (phone) / (408) 659-8388 (fax)

Important information regarding HIPAA

PATIENT RECORDS OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

( ) Home Telephone: _____
( ) OK to leave a detailed message
( ) Leave message with callback number only

( ) Written Communication
( ) OK to mail to home address
( ) OK to mail to work/office address
( ) OK to fax: _____

( ) Work Telephone: _____
( ) OK to leave detailed message
( ) Leave message with callback number only

( ) Other: _____

_____ _____
Patient Signature Date

_____ _____
Print Name Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual. Health care entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES MAY BE PERMITTED IN THE CASE OF AN EMERGENCY.

Please list any other persons you wish Morgan Hill Orthopaedics & Sports Medicine to release information to.

_____

_____

Eli Chen, M.D.
2430 Samaritan Dr. San Jose, CA 95124
(408) 782-4060 (phone) / (408) 659-8388 (fax)

Reason for Today's Visit: _____

When did you first become aware of this problem? _____

Who may we thank for referring you? _____

Primary Care Physician: _____

Other Physicians (e.g. cardiologist): _____

Medical History:

	YES	NO		YES	NO
Anemia	___	___	Hypothyroidism	___	___
Atrial Fibrillation	___	___	Irritable Bowel Syndrome	___	___
Arthritis (specify)	___	___	Liver Disease	___	___
Asthma	___	___	Myocardial Infarction	___	___
Bleeding Disorder (specify)	___	___	Neuropathy	___	___
Blood Clots	___	___	Peripheral Vascular Disease	___	___
Cancer (specify)	___	___	Peptic Ulcer Disease	___	___
Carotid Artery Disease	___	___	Psychiatric Illness (specify)	___	___
Congestive Heart Failure	___	___	Renal Disease	___	___
COPD	___	___	Seizure Disorder	___	___
Diabetes Mellitus	___	___	Skin Problems (specify)	___	___
Gout	___	___	Sleep Apnea	___	___
Heart Valve Disorder (specify)	___	___	Stroke	___	___
HIV/AIDS	___	___	Tuberculosis	___	___
Hypertension	___	___	Other (specify)	___	___

Do you have any allergies to medications? Yes ___ No ___ If so, please list each medication ***and reaction***.

_____ _____

_____ _____

_____ _____

Eli Chen, M.D.
2430 Samaritan Dr. San Jose, CA 95124
(408) 782-4060 (phone) / (408) 659-8388 (fax)

Please list all medications/supplements you currently take, *including dosage and frequency.*

Medication	Dose	Frequency	Medication	Dose	Frequency

Surgical History:

Please list all past surgeries and hospitalizations:

Surgery/Hospitalization	Date	Physician

Have you ever had problems with general anesthesia? Yes ___ No ___ If so, please specify:

_____

_____

Eli Chen, M.D.
2430 Samaritan Dr. San Jose, CA 95124
(408) 782-4060 (phone) / (408) 659-8388 (fax)

Family History:

Does anybody in your immediate family have any of the following medical conditions?

	Mother	Father	Sibling(s)	Son(s)/Daughter(s)	Other (specify)
Cancer (please specify)	___	___	___	_____	_____
Diabetes	___	___	___	_____	_____
Epilepsy/Seizures	___	___	___	_____	_____
Heart Disease	___	___	___	_____	_____
High Blood Pressure	___	___	___	_____	_____
Immune Disorder	___	___	___	_____	_____
Stroke	___	___	___	_____	_____

Social History:

Tobacco Use: Yes ___ No ___

Cigarettes: Packs per day_____ How many years?_____ If you quit, when? _____

Other (specify):_____ Amount per day_____ How many years?_____ If you quit, when? _____

Alcohol Use: Yes ___ No ___

If yes, please specify what type and how often: _____

Do you use any drugs other than prescribed or over the counter medication? Yes ___ No ___

If yes, please list: _____

Indicate any other important information that you feel the doctor should know: _____

_____

Marital Status/ Relationship:_____

Who currently resides in your home with you? _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Black or African American ☐ Other Race

Eli Chen, M.D.
2430 Samaritan Dr. San Jose, CA 95124
(408) 782-4060 (phone) / (408) 659-8388 (fax)

Review of Systems:

Constitutional:	Yes	No	Comments
good health	___	___	_____
recent weight changes	___	___	_____
recurrent fevers, chills, sweats	___	___	_____
fatigue	___	___	_____
difficulty sleeping	___	___	_____
Eyes:			
blurred or double vision	___	___	_____
change in vision	___	___	_____
glaucoma	___	___	_____
Ears/Nose/Mouth/Throat:			
changes in hearing	___	___	_____
ringing in the ears	___	___	_____
recent nose bleeds	___	___	_____
chronic sinus problems	___	___	_____
loose teeth	___	___	_____
Respiratory:			
asthma or wheezing	___	___	_____
breathing problems	___	___	_____
coughing up blood	___	___	_____
chronic cough	___	___	_____
pneumonia	___	___	_____
shortness of breath at rest	___	___	_____
Cardiovascular:			
exertional shortness of breath	___	___	_____
shortness of breath lying flat	___	___	_____
heart racing/palpitations	___	___	_____
swelling of feet/ankles	___	___	_____
blood clots (including in the past)	___	___	_____
blue discoloration of hands/feet	___	___	_____
Gastrointestinal:			
changes in appetite	___	___	_____
bleeding ulcers	___	___	_____
constipation	___	___	_____
black or bloody stools	___	___	_____
abdominal pain	___	___	_____

Eli Chen, M.D.
2430 Samaritan Dr. San Jose, CA 95124
(408) 782-4060 (phone) / (408) 659-8388 (fax)

Genitourinary:	Yes	No	Comments
blood in urine	___	___	_____
urinary incontinence	___	___	_____
difficulty with urinary stream	___	___	_____
urinary tract infections	___	___	_____
sexually transmitted disease	___	___	_____
Neurologic:			
headaches	___	___	_____
numbness or tingling sensations	___	___	_____
weakness or paralysis	___	___	_____
changes in memory/concentration	___	___	_____
loss of balance/coordination	___	___	_____
difficulty speaking	___	___	_____
Psychiatric:			
anxiety/agitation/nervousness	___	___	_____
depression	___	___	_____
excessive energy	___	___	_____
suicidal thoughts/ideation	___	___	_____
Musculoskeletal:			
difficulty walking	___	___	_____
back/neck pain	___	___	_____
joint stiffness (specify)	___	___	_____
muscle pain (specify)	___	___	_____
joint swelling (specify)	___	___	_____
Endocrine:			
heat or cold intolerance	___	___	_____
excess thirst or urination	___	___	_____
thyroid problems	___	___	_____
Allergy/Immunology			
low resistance to infection	___	___	_____
recent cold/flu	___	___	_____
environmental allergies	___	___	_____
Hematologic/Lymphatic			
easy bruising	___	___	_____
frequent bleeding	___	___	_____
enlarged lymph nodes	___	___	_____