

**East Bay Family Practice  
Patient Information**

Patient Name \_\_\_\_\_ Sex: F M Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Social Security # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Employer/School \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Full Time  Part Time  E-mail \_\_\_\_\_

Marital Status Single  Married  Divorced  Separated  Widow/er  Minor

Parent/Spouse/Partner \_\_\_\_\_ Sex: F M Date of Birth \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Responsible Party for Payment Self  Spouse/Partner  Parent  Other  Name \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_  
Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_ Group name \_\_\_\_\_  
Phone # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship to Patient: Self  Spouse/Partner  Parent  Other

Social Sec # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_  
Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_ Group name \_\_\_\_\_  
Phone # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship to Patient: Self  Spouse/Partner  Parent  Other

Social Sec # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

**For HMO Patients Only**

I have chosen \_\_\_\_\_ to be my primary care physician as of \_\_\_\_\_ date

through (circle one) HILL PHYSICIANS ALLIANCE

Please note that failure to provide us with correct insurance information or to notify us of any changes in your insurance could result in medical charges to you.

**PLEASE SIGN AGREEMENTS ON REVERSE**

**ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT**

I hereby give lifetime **authorization for payment of insurance benefits to be made directly to East Bay Family Practice Medical Group Inc.** and any assisting physicians for services rendered. I understand that **I am responsible for all charges** whether or not they are covered by insurance. In the event of default I agree to pay all costs of collection and reasonable attorney's fees. I hereby **authorize East Bay Family Practice to release all information necessary to secure the payment of benefits.** I further agree that a photocopy of this agreement shall be as valid as the original.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**CANCELLATION - RESCHEDULE POLICY**

Failure to cancel or reschedule an appointment at least 24 hours in advance will result in a charge (\$50 - \$100) directly to the patient, which is not billable to the patient's insurance company. After three such occurrences the patient may be asked to leave the practice.

I hereby am advised of the cancellation - reschedule policy of East Bay Family Practice.

Signed \_\_\_\_\_ Date \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

We would like to thank whoever referred you.

**East Bay Family Practice  
3100 Telegraph Avenue, Suite 2109  
Oakland, CA 94609**

**To our patients:**

We welcome you to our office and promise to provide you with the highest quality medical care. However, we must ask that in return you help us by accepting the following responsibilities. We ask that you sign below to acknowledge that you have read and understand these policies.

**We require at least 24-hour notice if you cancel or change your appointment.**

- You will be billed \$50 if you miss an appointment or fail to give 24-hour notice to cancel a regular appointment. You will be billed \$100 if you miss a physical exam appointment (cancel less than 24-hours in advance).
- Missing or late cancellations of three appointments may result in termination of our relationship with you as a patient.

**All co-payments, deductibles, share of cost payments, and other fees are due at the time of your visit.**

- We accept checks, cash, Visa or MasterCard. You will be responsible for \$15.00 plus bank charges if your check does not clear.
- We charge \$10.00 to bill for your co-pay

**If you have an outstanding balance, a payment must be made at the time of your visit.**

- We will ask you to make a payment on your outstanding balance at each visit and regularly by mail until the balance is cleared.
- We cannot schedule further care in the office if you do not make regular payments on your bill.

**We charge a fee to complete forms (including disability forms and letters).**

- Fees are determined by the length and complexity of the form (\$20- \$150).
- Fees may be waived if forms can be completed during allotted appointment time.
- We charge an additional \$10.00 to rewrite lost forms, prescriptions and vaccine records.
- Please allow 7 business days for completion of forms.

**Urgent /same- day appointments are available Monday-Friday.**

- Please call after 9am Monday- Friday, to make urgent/same-day appointments. If you are very ill, you will be scheduled for same-day appointment.
- We make every effort to stay on schedule but can never predict how many patients will require urgent appointments. Please be patient if you are told there may be a lengthy wait for same- day appointments.

I understand and agree to the conditions listed above:

\_\_\_\_\_  
PRINT PATIENT'S NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

Today's Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

### EAST BAY FAMILY PRACTICE MEDICAL HISTORY

**GENERAL INFORMATION:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Birthplace: \_\_\_\_\_ How many years in USA: \_\_\_\_\_

What is your ethnicity, race or cultural group(s)? \_\_\_\_\_

What is your occupation? Current: \_\_\_\_\_

If not currently employed, give last occupation and year: \_\_\_\_\_

Do you like your work? \_\_\_\_\_

Are you or have you ever been exposed to anything at your workplace that is bad for your health (especially toxic substances)? \_\_\_\_\_

Have you ever been in a long-term relationship? \_\_\_\_ Yes \_\_\_\_ No When? \_\_\_\_\_

Are you satisfied with your present living situation? \_\_\_\_ Yes \_\_\_\_ No

Who is in your household and what is your relationship to each?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any pets in your household? If so, what kind and how many?

\_\_\_\_\_

	Yes	No
Does anyone living with you have a chronic health problem?	_____	_____

What? \_\_\_\_\_

Do you use a seatbelt when you are in the car? \_\_\_\_\_

Do you have smoke alarms in your home? \_\_\_\_\_

If you have small children, do you have Ipecac syrup at home? \_\_\_\_\_

Do you have a gun in your home? \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Do you have any allergies to:

Medicines: \_\_\_\_\_

Other: \_\_\_\_\_

Current medicines (including birth control pills, eyedrops, skin preparations, vitamins, and over-the-counter preparations such as laxatives): \_\_\_\_\_

\_\_\_\_\_

Did you have regular medical care as a child? \_\_\_\_ Yes \_\_\_\_ No

Did you have the usual childhood immunizations? \_\_\_\_ Yes \_\_\_\_ No

What date did you receive your most recent immunization for:

Tetanus \_\_\_\_\_ Measles \_\_\_\_\_ Rubella \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Flu \_\_\_\_\_

Polio \_\_\_\_\_ Mumps \_\_\_\_\_ Pneumococcal Pneumonia \_\_\_\_\_

When was your last TB test? \_\_\_\_\_

Have you ever had a positive TB test? \_\_\_\_ Yes \_\_\_\_ No When? \_\_\_\_\_ Treated? \_\_\_\_\_

Please list any surgeries you have had:

Type	Date	Place
------	------	-------

- 1.
- 2.
- 3.

Please list hospitalizations other than surgery:

Type	Date	Place
------	------	-------

- 1.
- 2.
- 3.

Have you required medical attention for accidents or broken bones?

What	Date	Place
------	------	-------

- 1.
- 2.
- 3.

Are you generally in good health? \_\_\_\_ Yes \_\_\_\_ No

Have you ever had any of the following (please circle and explain below):

- |  |                                     |                            |
|--|-------------------------------------|----------------------------|
| Anemia   | Glaucoma/eye disease                | Serious pelvic infections  |
| Arthritis  | Gout                                | Polio                      |
| Asthma   | Hay fever                           | Prostate trouble           |
| Birth defect/congenital problem  | Head injury                         | Stomach/intestinal disease |
| Breast disease   | Heart problem                       | Strep throat               |
| Cancer   | Heart murmur                        | Stroke                     |
| Convulsions, seizures or fits  | Herpes                              | Thyroid disorder           |
| DES exposure (your mother took medicine during pregnancy to prevent miscarriage) | High blood pressure                 | Tuberculosis               |
| Diabetes   | Kidney disease or stones            | Vaginal infections         |
| Fainting spells  | Liver disease (hepatitis/cirrhosis) | German measles (Rubella)   |
| Gallbladder disease  | Lyme disease                        | Measles (hard or 5-day)    |
|  | Mononucleosis (mono)                | Mumps                      |
|  |                                     | Other: _____               |

Explain: \_\_\_\_\_

Do you have sex with (please check): men \_\_\_\_ women \_\_\_\_ both \_\_\_\_ neither \_\_\_\_

How many sexual partners have you had in the last 2 years? \_\_\_\_\_

Have you ever had (please check): Gonorrhea \_\_\_\_ Chlamydia \_\_\_\_ Syphilis \_\_\_\_

Venereal warts \_\_\_\_ Herpes \_\_\_\_ HIV (AIDS) \_\_\_\_

Are you and your partner using condoms? \_\_\_\_ Yes \_\_\_\_ No

Do you always use them? \_\_\_\_ Yes \_\_\_\_ No

**HABITS:**

Have you smoked cigarettes regularly? \_\_\_\_ Yes \_\_\_\_ No

For how many years? \_\_\_\_\_

How many per day average? \_\_\_\_\_ Now? \_\_\_\_\_

Have you quit? \_\_\_\_\_ When? \_\_\_\_\_

Do you use snuff, chewing tobacco, cigars, pipe (please circle which)? \_\_\_\_ Yes \_\_\_\_ No

Do you drink alcoholic drinks (please check): Beer \_\_\_\_ Wine \_\_\_\_ Liquor \_\_\_\_

How many glasses per week? \_\_\_\_\_

Do you feel you have a drinking problem? \_\_\_\_ Yes \_\_\_\_ No

Do you drink (circle) coffee, tea, soft drinks? \_\_\_\_ Yes \_\_\_\_ No

How many cups per day? \_\_\_\_\_

Do you use any street drugs? \_\_\_\_ Yes \_\_\_\_ No

What? \_\_\_\_\_ How frequently? \_\_\_\_\_

Do you exercise? \_\_\_\_ Yes \_\_\_\_ No How frequently? \_\_\_\_\_

What do you do? \_\_\_\_\_

Do you feel you have a good diet? \_\_\_\_ Yes \_\_\_\_ No

How many servings a week do you eat of: Fruit \_\_\_\_\_ Vegetables \_\_\_\_\_

How many times per week do you eat fried or fast foods? \_\_\_\_\_

Do you try to eat a diet low in fat? \_\_\_\_ Yes \_\_\_\_ No

How many hours per day do you: Work \_\_\_\_\_ Sleep \_\_\_\_\_ Watch TV \_\_\_\_\_

**FAMILY HISTORY:**

List age and any diseases if living; age and cause of death if dead.

	Age	Alive (Yes/No)	Diseases or Causes of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers or Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sons or Daughters	_____	_____	_____
	_____	_____	_____

Has any close blood relative, including grandparents, had (circle and give relationship):

High blood pressure	Colitis	Bleeding
Stroke	Bowel disease	Leukemia
Heart disease	Ulcer or other stomach disease	Cancer
Kidney disease	Liver disease	Migraine
Diabetes	Arthritis	Epilepsy
Goiter (thyroid)	Gout	Tuberculosis
Asthma	Anemia	Glaucoma
Hay fever	Emotional or psychiatric problems	Other:

**REVIEW OF SYSTEMS:**

	Yes	No
Has your weight changed?	_____	_____
Do you have recurrent fever, chills or sweats?	_____	_____
Are you cold or warm when others are not?	_____	_____

Yes No

Are you always tired? \_\_\_\_\_  
Have you noticed any new lumps or swollen glands? \_\_\_\_\_  
Do you have any physical disability? \_\_\_\_\_  
Please explain: \_\_\_\_\_

**Head and Neck:**

Do you have frequent or very severe headaches? Since when? \_\_\_\_\_  
Do you have neck pain? \_\_\_\_\_  
Have you had a recent episode of loss of consciousness? \_\_\_\_\_

**Eyes:**

Do you wear glasses or contact lenses? \_\_\_\_\_  
Have you had an eye exam in the past 2 years? \_\_\_\_\_  
Have you noticed any recent change in your vision? \_\_\_\_\_  
Do you have pain in your eyes? \_\_\_\_\_

**Ears:**

Do you have trouble hearing? \_\_\_\_\_

**Nose, Throat, Mouth:**

Has your voice become hoarse? \_\_\_\_\_  
Do you have hay fever? \_\_\_\_\_  
Do you have frequent nose bleeds? \_\_\_\_\_  
Do you have trouble swallowing? \_\_\_\_\_  
Do you have toothaches? \_\_\_\_\_  
Do you have nasal congestion/sneezing? \_\_\_\_\_

**Respiratory:**

Do you easily get short of breath? \_\_\_\_\_  
Do you cough up blood? \_\_\_\_\_  
Do you cough up phlegm or sputum? \_\_\_\_\_  
Have you had a cough for more than one month? \_\_\_\_\_

**Cardiovascular:**

Do you have an irregular heart beat? \_\_\_\_\_  
Do you have chest pain? \_\_\_\_\_  
Do you have cramps in your legs when walking? \_\_\_\_\_  
Do your ankles swell? \_\_\_\_\_  
Do you wake up short of breath? \_\_\_\_\_

**Gastrointestinal:**

Has your appetite changed? \_\_\_\_\_  
Do you have indigestion/heartburn? \_\_\_\_\_  
Have you had recent episodes of vomiting? \_\_\_\_\_  
Are you often nauseated? \_\_\_\_\_  
Has your abdomen become swollen? \_\_\_\_\_  
Do you vomit blood? \_\_\_\_\_  
Do you have frequent abdominal pain? \_\_\_\_\_  
Do you have bleeding from your rectum? \_\_\_\_\_  
Do you have hemorrhoids? \_\_\_\_\_  
Do you have frequent diarrhea? \_\_\_\_\_  
Do you have constipation? \_\_\_\_\_

**Musculoskeletal:**

- Do you have weakness in any part of your body? \_\_\_\_\_
- Do you have stiff, painful joints? \_\_\_\_\_
- Do you have any red, swollen joints? \_\_\_\_\_
- Do you have easily broken bones? \_\_\_\_\_
- Do you have back pain? \_\_\_\_\_

**Skin:**

- Does your skin itch or burn? \_\_\_\_\_
- Do you bruise easily? \_\_\_\_\_
- Do you have acne? \_\_\_\_\_
- Do you have a tendency to bleed? \_\_\_\_\_
- Do you have trouble healing skin wounds? \_\_\_\_\_
- Do you have any new rash? \_\_\_\_\_

**Neurological:**

- Are you often dizzy? \_\_\_\_\_
- Have you had recent fainting or blackout spells? \_\_\_\_\_
- Is any part of your body numb? \_\_\_\_\_
- Do you shake or tremble? \_\_\_\_\_
- Has your speech changed recently? \_\_\_\_\_
- Do you lose your balance? \_\_\_\_\_

**Personal:**

- Do you often feel lonely or depressed? \_\_\_\_\_
- Do you often cry? \_\_\_\_\_
- Do you have trouble relaxing? \_\_\_\_\_
- Do you worry a lot? \_\_\_\_\_
- Do you have trouble sleeping? \_\_\_\_\_
- Have you recently had or do you want psychiatric help? \_\_\_\_\_
- Have you ever used medicines for emotional or psychiatric problems? \_\_\_\_\_
- Have you ever been in the hospital for emotional or psychiatric problems? \_\_\_\_\_
- Are you often anxious? \_\_\_\_\_
- Are there problems within your family? \_\_\_\_\_
- Are these: in the past? \_\_\_\_\_
- recent or current? \_\_\_\_\_
- Have you ever been emotionally or physically abused by your partner or someone important to you? \_\_\_\_\_
- Within the last year have you been hit, slapped, kicked or otherwise physically hurt by someone? \_\_\_\_\_

If Yes, by whom (circle all that apply):

Partner or Spouse    Acquaintance    Stranger    Other    Multiple

Total number of times: \_\_\_\_\_

- Within the last year has anyone forced you to have sexual activities? \_\_\_\_\_

If Yes, who (circle all that apply):

Partner or Spouse    Acquaintance    Stranger    Other    Multiple

Total number of times: \_\_\_\_\_

- Are you afraid of your partner or anyone you listed above? \_\_\_\_\_

**For Women Only:**

Your periods first started when you were \_\_\_\_\_ years old.

From the beginning of one period to the beginning of the next is \_\_\_\_\_ days.

Your periods last for \_\_\_\_\_ days.

Periods are: \_\_\_\_\_heavy \_\_\_\_\_moderate \_\_\_\_\_light

Do you have cramps? \_\_\_\_\_Yes \_\_\_\_\_No

Your last period began \_\_\_\_\_.

Are you and your partner using a birth control method? \_\_\_\_\_Yes \_\_\_\_\_No

Type? \_\_\_\_\_

Your last Pap smear was \_\_\_\_\_

Abnormal Pap in the past? \_\_\_\_\_Yes \_\_\_\_\_No

Number of pregnancies?\_\_\_\_\_ Number of miscarriages:\_\_\_\_\_ Number of abortions:\_\_\_\_\_

Number of live births:\_\_\_\_\_ Number of stillborns:\_\_\_\_\_

Please describe any complications with above pregnancies or deliveries:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Yes No

Do you have burning or pain when urinating?

\_\_\_\_\_

Are you urinating more frequently now?

\_\_\_\_\_

Do you get up at night more than twice to urinate?

\_\_\_\_\_

Do you have trouble holding your urine?

\_\_\_\_\_

Is your urine black, brown or bloody?

\_\_\_\_\_

Was your last period regular?

\_\_\_\_\_

Do you have spotting or bleeding between periods?

\_\_\_\_\_

Do you have a vaginal discharge that bothers you?

\_\_\_\_\_

Do you have any sores or rash around your vagina?

\_\_\_\_\_

Have you noticed any changes in your breasts, i.e., lumps, sores, or nipple discharge?

\_\_\_\_\_

Have you noted any change in your sexual function?

\_\_\_\_\_

Do you have orgasms?

\_\_\_\_\_

Do you have any questions or concerns about sexuality or your sexual functioning?

\_\_\_\_\_

**For Men Only:**

Do you have trouble starting your stream of urine?

\_\_\_\_\_

Has the strength of your urine stream changed?

\_\_\_\_\_

Do you dribble urine?

\_\_\_\_\_

Do you have burning or pain when urinating?

\_\_\_\_\_

Are you urinating more frequently?

\_\_\_\_\_

Is your urine black, brown or bloody?

\_\_\_\_\_

Do you have burning or discharge from your penis?

\_\_\_\_\_

Do you have any swelling, lumps or pain in your testicles?

\_\_\_\_\_

Do you have any sores or rash in the genital area?

\_\_\_\_\_

Have you noted any change in your sexual function?

\_\_\_\_\_

Are you able to get and maintain erections?

\_\_\_\_\_

Are you able to ejaculate?

\_\_\_\_\_

Are you and your partner using a contraceptive method?

\_\_\_\_\_

What? \_\_\_\_\_

Do you have any questions or concerns about sexuality or your sexual functioning?

\_\_\_\_\_

# East Bay Family Practice

Medical Group, Inc.

Janet Arnesty, MD  
Steve Bryzman, PA  
Audrey D'Andrea, MD  
Rebecca Riseman, NP

Edie Silber, NP  
Deanna Ward, MD  
Sarah White, NP  
Polly Young, MD  
Sharon Healy, Practice Mgr

There are services that your practitioner may recommend that may not be covered by your insurance. We cannot know everyone's insurance plan's benefits. We will try to inform you of services that are sometimes denied. You may choose not to have these services. If we do provide you with a noncovered service, you will be responsible for payment.

## **You are responsible for knowing what your plan covers.**

Medical billing continually becomes more complex with each passing year. Several private and government organizations work together to modify the, regulations and codes that govern how providers can bill insurance companies for their services. Our first priority is to provide you with the best medical care. We must document and code this care according to the required guidelines.

Medicare and many insurance companies do not cover "routine" or "preventive" care. This includes, but is not limited to, annual exams, immunizations, TB tests, screening blood tests, and travel counseling.

Your signature below indicates that you have read this notice and that you agree to pay for noncovered services. It also allows us to bill your insurance and provide them with the information they need to process your claim. **Please have your insurance card with you for every visit.**

**With Medicare, HMO, PPO, EPO, POS, and indemnity plans, contracted providers agree to accept the allowed amount on covered services as payment in full. The patient is responsible for the deductible, coinsurance, copay, and noncovered services. Please verify this information and your benefits directly with your insurance company before your appointment.**

.....  
I request that payment of insurance benefits be made on my behalf to East Bay Family Practice Medical Group, Inc. I authorize any holder of medical information about me to release to the insurance carrier and its agents information needed to determine these benefits. This remains in effect until revoked by me in writing. I authorize East Bay Family Practice Medical Group, Inc., to use my Protected Health Information for treatment, payment, and operations purposes.

\_\_\_\_\_  
(printed name)

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

# **East Bay Family Practice**

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Sharon Healy, Practice Mgr

## **Knowing your own health insurance**

To help you to better understand how your own health coverage works, we have designed the following questionnaire. It is for your use. We recommend filling it out, making one copy to carry with you, and leaving another at home. (on your refrigerator?)

Insurance company name\_\_\_\_\_

Name and birthdate of plan subscriber  
(family member whose employment provides the plan)\_\_\_\_\_

Administering group (HMO or PPO)\_\_\_\_\_

Insurance ID #\_\_\_\_\_

Group name and number\_\_\_\_\_

Primary Care Provider (if HMO or  
EPO)\_\_\_\_\_

Office visit copay\_\_\_\_\_

Annual deductible (met?)

Emergency room copay\_\_\_\_\_

Mental health copay\_\_\_\_\_

Contracted hospital\_\_\_\_\_

Contracted lab\_\_\_\_\_

Contracted radiology (xray) facility\_\_\_\_\_

Preferred pharmacy  
(and phone number)\_\_\_\_\_

Benefit limitations and exclusions\_\_\_\_\_

Preventive/well care?\_\_\_\_\_

Travel?\_\_\_\_\_

Other?\_\_\_\_\_