Upland Grove Medical Group

1330 San Bernardino Road, Suite B, Upland, CA 91786 • (909) 981-0608 Fax: (909) 982-5327

General Information

Patient Name_____ Date of Birth_____/_____/_____ Age_____
(last) (first)

Address_____ City, State_____ Zip _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Phone ( )_____ Mobile Phone ( )_____

SS#_____-_____-_____ DL#_____

Primary language_____ Do You Need an interpreter? ☐ Yes ☐ No

How Were You Referred To Our Office? ☐ Physician ☐ Friend ☐ Insurance ☐ Ad ☐ Other

Is your visit today related to an illness or injury from your work? ☐ Yes ☐ No

Adjuster _____ Claim #_____

Employment Information

Employer_____ Phone ( ) _____

Address _____City, State_____ Zip_____

Insurance/Billing Information

Responsible Party_____Relationship_____ DOB_____

Employer of Responsible Party (if different from patient) _____

Insurance_____ Phone ( ) _____

Address_____ City, State_____ __ Zip_____

Policy Holder_____ Relation to Patient_____

Insured SS#_____ Policy/Group# _____

Emergency Contact: _____ Phone ( ) _____

Patient Responsibility

Due to stringent rules adopted by the Federal Government (HIPAA-Health Insurance Portability and Accountability Act) with regard to patient confidentiality, the responsibility of delivery of medical testing results and medical records will be the responsibility of the patient. Many facilities will no longer provide a copy of your medical testing or records via fax or mail without an authorization signed by you on the date it is being requested. This is for your protection but our office is unable to obtain your testing results with a phone call. It is your responsibility to assure that the results of any testing from other facilities are faxed to our office in time for your next appointment.

I authorize Upland Grove Medical Group (Gregory Suelzle, M.D.) to obtain medical records, testing, x-rays or any pertinent information to assist in evaluation and treatment of my medical condition. This authorization shall remain in effect for 1 (one) year unless revoked by me in writing.

_____ _____

Responsible Party **Date**

Insurance Benefit Assignment/Consent to Disclose Medical Information

Medicare - Authorization & Benefit Assignment

I request that payment of authorized **Medicare** benefits be made to Upland Grove Medical Group for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any Personal Health Information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of Personal Health Information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Name of Beneficiary HIC (Medicare Number)

Insurance - Authorization & Benefit Assignment

I hereby authorize Upland Grove Medical Group to furnish Personal Health Information concerning my illness and treatment to insurance carriers or other entity necessary to pay the claim, and I hereby assign to Upland Grove Medical Group all payment for medical services rendered to my dependents or myself. I understand I am responsible for patient deductibles and any amount not covered by the insurance. Laboratory, radiology and other ancillary services provided in connection with physician's office will be billed separately. Co-pays must be made at the time of service and a fee of $25.00 will be added to any returned check balances. I understand and agree to give at least 24 hours notice if I am unable to keep an appointment. Failure to do so will result in a "No-Show" charge of $25.00 added to my account balance.

_____ _____

Responsible Party Signature Date

Consent to Treatment

The undersigned consents to the treatment including emergency treatment or services which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures rendered to the patient under the general and specific instructions of the patient's physician.

_____ _____

Responsible Party's Signature Date

Consent To Treatment of a Minor

I hereby consent to and authorize for my **minor child:**

_____ _____

Name of Minor Child Minor's Birth Date

Diagnostic and/or therapeutic treatment including emergency treatment or services which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures rendered under the general and specific instructions of the physician. I am a legal guardian or parent with the legal authority to give consent to treatment.

_____ _____

Parent/Guardian Signature Date

Does the minor child live with you? ☐ YES ☐ NO Your phone number if different from child: _____

If divorced, name of person with legal custody of minor child _____

Patient's Rights

You may refuse to give consent and may object to any part of this form. If so, please ask to speak with us about that. If you chose to give consent in this document, you may revoke your consent in the future, in writing. This right, and other rights that you have in regard to your Personal Health Information use and disclosure are detailed in our Privacy Notice. If you did not receive a copy of this Privacy Notice, please ask for one and read it carefully. We value you as a patient and strive to achieve the highest standards in our service to you.

Identification Verified by: _____

To Our Patients;

Your privacy is of utmost concern to us. Please take a moment to complete this information so that we only contact you and/or leave messages where you want.

	OK to contact you at this number To confirm, cancel or reschedule an appointment information?	Is it OK to leave a message?
1. _(_____)_____ Home Phone	☐ Yes ☐ No	☐ Yes ☐ No
2. _(_____)_____ Work Phone	☐ Yes ☐ No	☐ Yes ☐ No
3. _(_____)_____ Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No
4. _____ E-Mail Address	☐ Yes ☐ No	☐ Yes ☐ No
5. _(_____)_____ Emergency Contact	Relationship: _____	

UPLAND GROVE MEDICAL GROUP
Gregory Suelzle, M.D., Board Certified Pain Management · CApainMD.com

ACKNOWLEDGEMENT OF NOTICE REGARDING PRIVACY OF INFORMATION

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to provide you, the patient, a Notice of our Privacy Practices. The notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

En conformidad con el acto de la Portabilidad y de la Responsabilidad del seguro médico de 1996 (HIPPA), nos otros es requerido que laproporcione al paciente el Aviso de la Practicas de la Privacidad. Este aviso describe cómo la información de la salud sobre usted puede ser utilizada y ser divulgada, y cómo usted puede tener el acceso a esta información. Por favor lea esta informacion cuidadosmente.

.....

I hereby acknowledge that I was given a copy of Upland Grove Medical Group's Notice of Privacy Practices to read. I was also given the opportunity to have a copy to take with me if I desired. In addition, a Notice of Privacy Practices is posted in the patient waiting area.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrctions.

I would like to receive a copy of Upland Grove's Notice of Privacy Practices via e-mail

at: _____

_____ _____
Signature Date

_____
Print Name

If not signed by patient, please indicate relationship:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this receipt of Notice of Privacy Practices form but was unable to do so as documented below:

Date: Initials: Reason:

UPLAND GROVE MEDICAL GROUP
Gregory Suelzle, M.D., Board Certified Pain Management · CApainMD.com

Dear Patient,

If you are a new patient, welcome to our office! If you are an existing patient, thank you for your continued trust in our services.

In order to comply with new regulations concerning your privacy and the confidentiality of your medical information, you are given the following information and forms:

1. **HIPAA Notice of Privacy Practices for Personal Health Information**
   This notice describes our practice policies in regard to your Personal Health Information - how it is used and disclosed. The law now requires us to provide you with this information. Please read it carefully and feel free to ask any questions you may have.

2. **General Information Form**
   If you have been here before, please fill this out as an update to your existing information. It contains a "**Patient Responsibility**" notice and authorization that we are required to give you.

3. **Insurance Benefit Assignment/Consent to Disclose Medical Information**
   As part of **HIPAA** (Health Insurance Portability and Accountability Act) we must have your consent to disclose some medical information for obtaining insurance benefits as well as for providing treatment.

4. **Patient Contact Information Sheet**
   In order to protect your privacy, you can tell us where we may contact you regarding appointments, etc.

5. **Information sheet about important rights you have about medical treatment**
   Read this carefully. We are required to provide you with this important information about your medical treatment decisions.

Please do not hesitate to ask us if you have any questions about this information or anything else about our medical practice. It is our goal to provide you the highest quality service at all times.

Sincerely,

Gregory Suelzle, M.D.

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Patient's Pain Questionnaire, Gregory Suelzle, M.D.

Last Name _____ First Name _____ Age ____ Male/Female

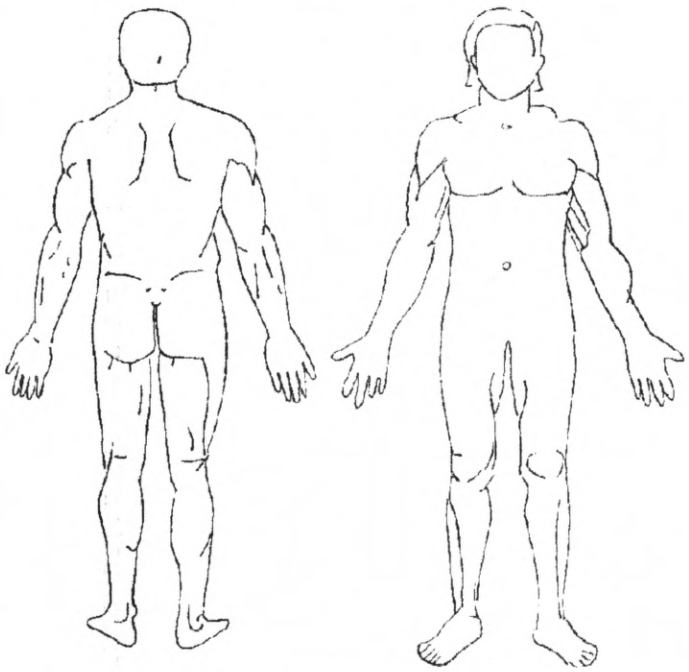
List Doctors you have seen/City

_____

_____

_____

Shade in Where You Have Pain



Circle Words that Describe Your Pain

Dull Ache Sharp Burning Stiff Cold Hot
Tightness Off and On Shooting Muscle Spasm
Electrical Entire Body Worse in the Morning
Worse in the Afternoon Worse in the Evening
Worse at Night Constant All Day

When did you start having this pain?

What month? _____ of what year? _____

What do you think caused the pain?

_____

_____

What makes the pain increase?

Sitting Standing Walking Twisting Bending
Lifting Moving neck

What makes the pain decrease?

Sitting Standing Walking Laying down
Injections Medications

Pain Level Place an (**X**) along this line to indicate how severe your pain is today

No Pain _____ Worst Pain Possible

Please circle what activities you can do: Walk 5 8 10 15 20 30 60 minutes
grocery shop housework cook meals do dishes yard work drive

How many days have you missed work last month due to pain? _____

☐ I do not work outside the home

Please circle any of the following treatments you have had:

Physical Therapy - how many weeks? _____ Pool Therapy Biofeedback Tens Unit
Chiropractic Manipulation Acupuncture Psychological Counseling for Pain Back Surgery
Trigger Point Injections Nerve Blocks Epidural Steroids Other _____

Please list all the surgeries you have had? _____

_____

What type of work do you do? _____

What was your last date of work? _____

Was there ever a lawsuit regarding your pain? **Y** **N**
Is this a work-related injury? **Y** **N**
Have you ever been on Disability? **Y** **N**

Patient's Pain Questionnaire, Gregory Suelzle, M.D. Patient's Name _____

Who do you live with at home? _____

Are you: single married separated divorced widowed

Please list any medical problems that you have had

_____

_____

Please circle any medical problems that you have had and the approximate year when you first had it.
Place an (**F**) next to it if one of your family members has had the problem.

Stomach Problems
Bleeding Problems
Asthma / Bronchitis
Emotional Changes
Depression
Decreased Concentration
Decreased Appetite
Unexplained Crying
Treatment by a Psychiatrist
Constipation
Cancer
Liver Problems / Yellow Skin
Fainting Spells

High Blood Pressure / Irregular heartbeats
Heart Disease / Heart Attack
Shortness of Breath / Loud Snoring
Difficulty Sleeping
Pneumonia
Headaches
Kidney Problems
Night Sweats / Fever
Weight Loss / Weight Gain
Diabetes
Numbness / Weakness
Epilepsy, Stroke
Changes in Bowel, Bladder or Sexual Function

Have you ever smoked? **Y** **N** What year did you stop? _____

Were you ever a heavy drinker of alcohol? **Y** **N** When did you stop? _____

Have you ever used street drugs? **Y** **N**

Please circle: Marijuana Speed Amphetamines Cocaine IV Drugs

Please circle if you have had any of the following tests:	Approximate Date	At Which Hospital?
X-Ray	_____	_____
MRI	_____	_____
CT-Scan	_____	_____
Nerve Test	_____	_____

Are you allergic to any medications? Please List:

_____ _____

_____ _____

Do you take any Tylenol Medications **Y** **N** How many do you take on an average per day? _____

DO YOU TAKE ANY BLOOD THINNER MEDICATION? **Y** **N** **WHAT DO YOU TAKE?** _____

Please list all medications (including over the counter medications) or give the nurse your list for our records.

_____

_____

_____

Medications used in the past / Any problems you had: _____

_____