MARTIN J. BACKMAN, M.D. – A MEDICAL CORPORATION
Diplomate, American Board of Psychiatry & Neurology

PATIENT's INFORMATION

Patient's Name: ______________________________ DOB: __________

Address: ____

City: ____________________________________ ZIP: __________

Phone (Home): ________________ Phone (Cell): ____________________

S.S.N.: ____________ Sex: _____ Marital Status: ________________

Referring Physician: ______________________ Phone: ____________

Reason for Referral: ______________________________________

Pharmacy's Name: ______________________ Phone: ______________

Address: ____________________________ City: ______________

State: ______________________________ ZIP: ______________

IS THIS VISIT RELATED TO INJURIES SUSTAINED AS A RESULT OF A WORK RELATED ACCIDENT OR ANY OTHER TYPE OF ACCIDENT? YES NO

IS THERE AN ATTORNEY INVOLVED? YES NO

I HEREBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN; AND, I AM FINANCIALLY RESPONSIBLE FOR THE REMAINING NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Do you authorize using telemedicine technology services in your visits if needed?

YES_____ NO_____ (Please initial response)

SIGNED: ______________________________ DATE: ________________

FRONT OFFICE CHECK LIST

ID CARD:	YES NO
INS. CARD:	YES NO
MED. REC:	YES NO
RXs:	YES NO

PAST MEDICAL HISTORY

_________ ADD/AHDH
_________ AIDS/HIV
_________ Blood Clots
_________ Dementia
_________ Coronary Artery Disease / Chest Pain
_________ Atrial Fibrillation
_________ Benign Prostate Hypertrophy
_________ Cancer (type)
_________ Cirrhosis of the Liver
_________ COPD
_________ Congestive Heart Failure
_________ Deppresion/Anxiety/Bipolar Disorder
_________ Diabetes
_________ Epilepsy
_________ Fibromyalgia
_________ Gastric reflux/Gastritis
_________ Hepatitis (type)
_________ High Cholesterol/ Triglicerides
_________ Hypertension
_________ Kidney Disease
_________ Multiple Sclerosis
_________ Muscle Disease
_________ Narcolepsy
_________ Neuropathy
_________ Parkinson's Disease
_________ Schizophrenia/Psychosis
_________ Sleep Apnea
_________ Stroke / TIA
_________ Systemic Lupus / Scleroderma
_________ Tremor
_________ Thyroid Disease (type)

OTHER CONDITIONS NOT LISTED

____
____
____
____
____
____
____

PAST SURGICAL HISTORY

_________ Heart (type?) _________________________
_________ Appendix
_________ Bladder
_________ Brain (type?) _________________________
_________ Breast (type?) _________________________
_________ Cataract (side?) _________________________
_________ Cesarean (how many?) _________________________
_________ Colon (type?) _________________________
_________ Gallbladder
_________ Hernia (side?) _________________________
_________ Hysterectomy
_________ Ovarian (side?) _________________________
_________ Pacemaker
_________ Thyroid
_________ Tonsillectomy
_________ Tubal ligation

PAST ORTHOPEDIC HISTORY

Cervical Spine _________________________
Thoracic Spine _________________________
Lumbar Spine _________________________
Upper extremities _________________________
Lower extremities _________________________
Head Injury (Loss of consiousness?) _______
____
____

OTHER SURGERIES NOT LISTED ABOVE:

____
____
____
____
____

ANY ADDITIONAL INFORMATION:

____
____
____
____
____
____
____
____

MEDICATIONS' LIST (Including over the counter medications)

Medication's Name	Reason for use of medication	Dosage	Form(caps-tabs-susp)

ALLERGIES: ______________________________

____

____

____

FAMILY HISTORY

_________ Alzheimer's Disease/Dementia
_________ Asthma
_________ BAD (Bipolar Affective Disorder)
_________ Blood Clots
_________ Cancer
_________ Congestive Heart Failure
_________ Coronary Artery Disease
_________ Diabetes
_________ Headaches
_________ High Cholesterol/Triglycerides
_________ Multiple Sclerosis
_________ Myopathy (Muscle Disease)
_________ Neuropathy
_________ Seizure Disorder (Epilepsy)
_________ Schizophrenia
_________ Sleep Apnea
_________ Stroke/ TIA
_________ Tremor
_________ Thyroid Disease
_________ Hypertension (High Blood Pressure)

)THER CONDITIONS NOT LISTED ABOVE ______________________________

____

____

____

OCIAL HISTORY

Tobaco:	YES	NO
Alcohol:	YES	NO
Drugs	YES	NO

REVIEW OF SYSTEMS   Please mark (X) if any symptoms are present

GENERAL

_________ Weight loss
_________ Fatigue
_________ Fever

SKIN

_________ Rash
_________ Lesions
_________ Itching

EYES

_________ Blurred vision
_________ Loss of vision
_________ Eye pain

EARS/NOSE/THROAT

_________ Hearing loss
_________ Ringing in the ears
_________ Nasal stuffiness
_________ Sore throat

CARDIOVASCULAR

_________ Chest pain
_________ Palpitations
_________ Shortness of breath
_________ Fainting spells
_________ Irregular Heart Beats

RESPIRATORY

_________ Cough
_________ Wheezing

NDOCRINE

_________ Heat/Cold Intolerance
_________ Loss of hair

GASTROINTESTINAL

_________ Nausea
_________ Vomiting
_________ Diarrhea
_________ Constipation
_________ Abdominal Pain

GENITOURINARY

_________ Burning urination
_________ Blood in urine
_________ Urinary leakage

MUSCULOSKELETAL

_________ Joint pain/swelling
_________ Stiffness
_________ Muscle pain

PSYCHIATRIC

_________ Anxiety
_________ Depression
_________ Mood swings
_________ Difficulty sleeping

HEMATOLOGIC

_________ Easy bruising
_________ Gums bleed easily
_________ Enlarged glands

NEUROLOGIC

_________ Headaches
_________ Tremors
_________ Numbness
_________ Memory loss
_________ Weakness
_________ Seizures
_________ Dizziness/Vertigo

INFORMATION REGARDING PARTIES PRIVY TO CONFIDENTIAL DATA

In order to protect your medical and personal information, please list the names and relationship of persons authorized by you to call on your behalf to obtain results of studies or to discuss tour clinical case if needed. Please be aware the ONLY the persons authorized by you will be able to contact us to discuss your care. If no person is listed, NO information will be provided to any person calling except for yourself. Please be aware that HIPPA mandates that said authorization MUST be given in writing.

NAME	RELATIONSHIP
______________________________	________________
______________________________	________________
______________________________	________________
______________________________	________________

______________________________________ ________________

PATIENT's NAME DATE

PATIENT RESPONSABILITIES:

I understand that it is my responsibility to follow through with any and all studies and referrals requested by Dr. Backman. I understand that I cannot assume that results are normal or that referrals have been approved or denied unless I have been notified. I also understand that if I have not received these results/referrals, it is my responsibility to obtain the information. Furthermore, I also understand that is my responsibility to follow-up as per the recommendations given by Dr. Backman in regard to office visits, testing and procedures.

I acknowledge that I have read and understand the above statement

______________________________________ ________________

PATIENT's NAME DATE

____

PATIENT's SIGNATURE

MARTIN J. BACKMAN, M.D. , A.M.E., Q.M.E.
A MEDICAL CORPORATION

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice:

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How we May Use or Share Your Information for:
    - Treatment
    - Payment
    - Health Care Operations
    - Notifications
    - Marketing
    - Research
    - Special Circumstances and the Law
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number shown at the top of this page to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements.

If, after reviewing the notice, you decide that you do not want to retain your copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices.

Signature ______________________ Printed Name ______________________ Date ____________

APPOINTMENTS AND PRESCRIPTION POLICIES

The office policy for appointment cancellations is 24 hours. If I 24-hour notice is not received for cancellation, the patient will be charged $35. No exceptions will be made.

Payments and co-payments must be made at the time of the visit.

Prescriptions will be refilled only during business hours

The charges mentioned above will be billed directed to the patient and not to the insurance company.

Failure to show up in 2 occasions without notice within a 12 month period will result in dismissal from the practice.

CALOPTIMA/MEDICAL PATIENTS: Please be aware that all DMV forms must be completed by the primary physician as per Medicaid policy.

______________________________ PATIENT's NAME

______________________________ DATE OF BIRTH

______________________________ PATIENT's SIGNATURE

______________________________ TODAY's DATE

MARTIN J. BACKMAN, M.D. , A.M.E., Q.M.E.
A MEDICAL CORPORATION

AUTHORIZATION TO RELEASE RECORDS

DATE OR REQUEST: ______________________________

TO: ______________________________

I HEREBY REQUEST THAT YOU RELEASE TO:

MARTIN J. BACKMAN, M.D. A MEDICAL CORPORATION
DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY
11180 WARNER AVE. SUITE #259
FOUNTAIN VALLEY, CA 92708

More than 30 pages email to:
recordsmb110@gmail.com
or send via USPS mail

Less than 30 pages fax to:
714-460-6705

MEDICAL RECORDS WHILE UNDER YOUR CARE, AS WELL AS ANY RESULTS OF TESTING AVAILABLE.

FROM: ____________________ TO: ____________________

____________________ ____________________
PATIENT'S NAME PATIENT'S SIGNATURE

____________________ ____________________
SOCIAL SECURITY # DATE OF BIRTH

For medical office release only

MARTIN J. BACKMAN, M.D. , A.M.E., Q.M.E.
A MEDICAL CORPORATION

AUTHORIZATION TO RELEASE RECORDS

DATE OR REQUEST: ______________________________________

TO:____

____

I HEREBY REQUEST THAT YOU RELEASE TO:

MARTIN J. BACKMAN, M.D.
DIPLOMATE, AMERICAN BOARD
OF PSYCHIATRY & NEUROLOGY
11180 WARNER AVE. SUITE #259
FOUNTAIN VALLEY, CA 92708

MEDICAL RECORDS WHILE UNDER YOUR CARE, AS WELL AS ANY RESULTS OF TESTING AVAILABLE.

FROM:____________________ TO: ____________________

____
PATIENT'S NAME

____
PATIENT'S SIGNATURE

____
SOCIAL SECURITY #

____
DATE OF BIRTH

____
ADDRESS- CITY-STATE-ZIP CODE

(FOR HOSPITAL USE ONLY)