

**PATIENT INTRODUCTION**

DATE: \_\_\_\_\_

PATIENT Mr. \_\_\_\_\_  
Mrs \_\_\_\_\_  
Ms. FIRST MIDDLE LAST (MAIDEN)

AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

CIRCLE ONE: SINGLE SEPERATED DIVORCED WIDOWED MARRIED

NAME OF PERSON LEGALLY RESPONSIBLE (IF PATIENT IS A MINOR)  
\_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

PATIENT'S HOME PHONE # \_\_\_\_\_ WORK PHONE# \_\_\_\_\_

PATIENT EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

EMERGENCY CONTACT: FULL NAME \_\_\_\_\_

ADDRESS PHONE NUMBER

DO YOU HAVE MEDICARE? YES \_\_\_\_\_ NO \_\_\_\_\_ # \_\_\_\_\_

INSURANCE COMPANY NAME \_\_\_\_\_

MEMBERSHIP # \_\_\_\_\_ GROUP # \_\_\_\_\_

ARE YOU BENEFICIARY? YES \_\_\_\_\_ NO \_\_\_\_\_ DEPENDENT ? YES \_\_\_\_\_ NO \_\_\_\_\_

Here by authorized Dr. Emdur or Dr. P. Tiruvilumala and Dr. Bao to furnish to the above insurance company(s) or to a designated attorney, all information which paid insurance company or attorney may request. I hereby assign to the above mentioned doctor all moneys to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above name insurance company, over and above my understanding, I am financially responsible to said doctor(s) for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

# HEALTH HISTORY

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MAIN PROBLEM

\_\_\_\_\_

\_\_\_\_\_

RECENT HOSPITALIZATION OR SURGERIES \_\_\_\_\_

\_\_\_\_\_

MEDICATIONS \_\_\_\_\_

DOSE \_\_\_\_\_ FREQUENCY \_\_\_\_\_

\_\_\_\_\_

ALLERGIES \_\_\_\_\_

LAST MENSTRUAL PERIOD \_\_\_\_\_ NORMAL? YES \_\_\_\_\_ NO \_\_\_\_\_

BIRTH CONTROL \_\_\_\_\_

LAST DATE OF THE FOLLOWING EXAMS OR TESTS: PLEASE CIRCLE

ELECTROCARDIOGRAM	_____	NORMAL?	YES	NO
TUBERCULOSIS TEST	_____	NORMAL?	YES	NO
PAP SMEAR	_____	NORMAL?	YES	NO
MAMMOGRAM	_____	NORMAL?	YES	NO
PROSTATE EXAM	_____	NORMAL?	YES	NO
BLOOD _____	URINE _____	STOOL _____		
TETANUS SHOT	_____			

HABITS: TOBACO, #/day \_\_\_\_\_

ALCOHOL, drinks/day \_\_\_\_\_

DRUGS, type \_\_\_\_\_

OTHER PROBLEMS	YOU	FAMILY	HAVE YOU HAD	YES	NO
DIABETES	_____	_____	WEIGHT LOSS	_____	_____
HIGH BLOOD PRESSURE	_____	_____	SKIN LESIONS	_____	_____
TUBERCULOSIS	_____	_____	VISUAL PROBLEMS	_____	_____
SEIZURES	_____	_____	HEARING PROBLEMS	_____	_____
ASTHMA BRONCHITIS A	_____	_____	FREQUENT COLDS	_____	_____
KIDNEY OR BLADDER	_____	_____	DENTAL PROBLEMS	_____	_____
CANCER	_____	_____	HOARSENESS	_____	_____
HEPATITIS	_____	_____	BREAST DRAINAGE	_____	_____
ANEMIA	_____	_____	BREAST LUMPS	_____	_____
ARTHRITIS	_____	_____	DIFF. BREATHING	_____	_____
INTESTINAL PROBLEMS	_____	_____	PALPITATIONS	_____	_____
EMOTIONAL PROBLEMS	_____	_____	CHRONIC COUGH	_____	_____
ULCER DISEASE	_____	_____	CHEST PAIN	_____	_____
GONORRHEA, SYPHILLIS	_____	_____	SWALLOWING PROBLEM	_____	_____
GLAUCOMA	_____	_____	DIARRHEA / CONSTIPATION	_____	_____
STROKE	_____	_____	BLOOD IN STOOL	_____	_____
RHEUMATIC FEVER	_____	_____	NAUSEA / VOMITING	_____	_____
GALLBLADDER STONES	_____	_____	PAINFUL URINATION	_____	_____
KIDNEY STONES	_____	_____	CHRONIC HEADACHES	_____	_____
PARASITES	_____	_____	DIZZINESS / WEAKNESS	_____	_____
OTHER PROBLEMS	_____	_____	SEXUAL PROBLEMS	_____	_____
			SLEEPING PROBLEMS	_____	_____

SIGNATURE \_\_\_\_\_ REVIEWED BY \_\_\_\_\_

## Authorization For Use or Disclosure of Protected Health Information

Larry I. Emdur, D.O., Ph.D., F.C.C.P., INC.  
Diplomate American Board Of Internal Medicine  
Specialty Board In Pulmonary Medicine

Maria F. Baumann ( Privacy Officer )  
619-286-8803

*As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.*

I hereby authorize this medical practice to use and disclose health information concerning

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(patient name and address) as follows:

**Health information to be used or disclosed (check only one box): \***

Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

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All psychotherapy notes may be released, except as specifically provided below:

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**Effect of Refusal to Sign Authorization [Note: Physician Practice must include one of the following, as appropriate:]**

[I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.] *or*

[I understand that if I do not sign this form:]

[I cannot participate in this research-related treatment.]

[A health plan may not enroll me or make me eligible for benefits.]

[My physician will not perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.]

This authorization is effective now and will remain in effect until

\_\_\_\_\_

(*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Print Name: \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient (to the extent minor could not have consented to the care)
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient \*\*
- spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

Name of patient: \_\_\_\_\_

\*Signed: \_\_\_\_\_ Dated: \_\_\_\_\_  
*Treating Physician*

*\* For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released. Under*

## PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

\_\_\_\_\_  
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

By: \_\_\_\_\_  
Physician's or Authorized Representative's Signature (Date)

By: \_\_\_\_\_  
Patient's or Patient Representative's Signature (Date)

By: \_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print or Stamp Name of Physician, Medical Group or Association Name

\_\_\_\_\_  
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.