OAKS SURGICAL SPECIALISTS

PATIENT INFORMATION

Who referred you to our practice? _____

Patient _____
Last Name First Name Middle Name

SSN # _____ Home # _____ Cell # _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M ☐ F ☐ Age: _____ Birth Date:_____

Primary Insurance:_____ ID # _____

Name of Insured: _____ DOB:_____

Secondary Insurance:_____ ID # _____

Name of Insured: _____ DOB:_____

Responsible Party:_____ SSN:_____ DOB:_____

Purpose of visit: _____

Date of first symptom:_____ Imaging done:_____

Is today's visit due to an accident? If yes, ☐ Work ☐ Auto ☐ Other:_____

If work related: Date of Injury _____ Claim # _____

Case Manager:_____ Tel:_____

Is there a pending litigation due to illness / Injury? No Yes If yes, Tel:_____

Legal Information:_____

_____ _____
Patient or Guardian Signature / Relationship if not self Date

PATIENT'S CHECK LIST FOR MEDICAL HISTORY

NAME: **DATE:**

PAST SURGERIES: ☐ None – Or, list here any past surgeries with approximate age at which performed (include surgeries such as tonsillectomy, tumors, etc.)

ACCIDENTS: ☐ None – Or, list ant serious type injuries, with approximate age

PAST ILLNESSES: ☐ None – Or, list with age
Last childhood diseases:

FAMILY HISTORY: If any of the following have run in your family, check appropriate squares:
☐ Allergies ☐ Cancer ☐ Tuberculosis ☐ Diabetes ☐ Heart Disease ☐ Stroke

Place a checkmark in the appropriate squares in the following list of symptoms.
If you have had a symptom in the apst and do not have it now, check square like this: ☒

1. HEAD AND NECK

	Yes	No		Yes	No		Yes	No
Severe headache?	☐	☐	Severe hearing loss?	☐	☐	Chronic nose obstruction?	☐	☐
Dizzy spells?	☐	☐	Ringing in ears?	☐	☐	Chronic sore tongue?	☐	☐
Failing vision?	☐	☐	Pain in ears?	☐	☐	Persistent sore gums?	☐	☐
Eye pain?	☐	☐	Discharge from ears?	☐	☐	Prolonged hoarseness?	☐	☐
Double vision?	☐	☐	Repeated nosebleeds?	☐	☐	Persistent neck rigidity?	☐	☐
See "floating lights"?	☐	☐	Toothache at present?	☐	☐	Swelling in neck?	☐	☐

2. HEART AND LUNGS

	Yes	No		Yes	No		Yes	No
Chest pain on effort?	☐	☐	Sit up to breathe easy?	☐	☐	Have night sweats?	☐	☐
Skipping heart beats?	☐	☐	Have chronic cough?	☐	☐	Ankles swelling?	☐	☐
Difficult breathing?	☐	☐	Spit up blood?	☐	☐	Any heart defects?	☐	☐

3. STOMACH AND INTESTINES

	Yes	No		Yes	No		Yes	No
Chronic abdominal pain?	☐	☐	Vomit blood?	☐	☐	Any blood from rectum?	☐	☐
Persistent nausea?	☐	☐	Skin turn yellow?	☐	☐	Clay colored stools?	☐	☐
Heart burn?	☐	☐	Any chronic diarrhea?	☐	☐	Habitual constipation?	☐	☐
Appetite loss?	☐	☐	Any black tarry stool?	☐	☐	Have hemorrhoids?	☐	☐

4. URINARY TRACT, ETC

	Yes	No		Yes	No	**(for females only)**	Yes	No
Any excess urination?	☐	☐	Pain on urination?	☐	☐	Painful menstruation?	☐	☐
Any urinary shutdown?	☐	☐	Any leakage of urine?	☐	☐	Excess menstruation?	☐	☐
Scanty urination?	☐	☐	Passed any stones?	☐	☐	Bleed between periods?	☐	☐
Any blood in urine?	☐	☐	Any bedwetting?	☐	☐	Any missed periods?	☐	☐
Excess night urination?	☐	☐	Any retention of urine?	☐	☐	Number of pregnancy?	☐	☐

5. MUSCLES & JOINTS

	Yes	No		Yes	No		Yes	No
Any tingling sensations?	☐	☐	Any limited motions?	☐	☐	Speech disturbances?	☐	☐
Any numbness?	☐	☐	Any Joint trouble?	☐	☐	Any seizure's?	☐	☐
Disturbances in walking?	☐	☐	Nervous breakdown?	☐	☐	Any alcohol problems?	☐	☐
Any muscle jerking?	☐	☐	Any strokes?	☐	☐	Any drug problems?	☐	☐
Any paralysis?	☐	☐	Any memory loss?	☐	☐	Any mental problems?	☐	☐
Any shaking?	☐	☐	Personality changes?	☐	☐	Any varicose veins?	☐	☐

6. ALLERGIES

	Yes	No		Yes	No		Yes	No
Any food allergies?	☐	☐	Inhalation allergy?	☐	☐	Adhesive tape allergy?	☐	☐
Any medication allergy	☐	☐	Any contact allergy?	☐	☐	Subject to skin rash?	☐	☐

If there is any food or medication allergy, please list them below:

If there are any additional health factors in your in your history or of any of the above points need clarifying use the space below for additional comments.

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LIST OF MEDICATIONS

Patient Name:_____ Date:_____

Name of medication	Strength	Frequency	Start Date	Stop Date

Privacy Act Statement - The information on this form contains confidential patient information that is legally protected by the Privacy Act of 1974, SU.S.C.522, and the Health Insurance Portability and Accounting Act of 1996, P.L. 104-109 and other applicable federal state laws

OAKS SURGICAL SPECIALISTS

PATIENT LIST OF PHYSICIANS

Patient Name: _____ Date: _____

Physician Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Specialty: _____

Physician Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Specialty: _____

Physician Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Specialty: _____

OAKS SURGICAL SPECIALISTS

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RAHIM AIMAQ, MD., F.A.C.S.
ANDREA M PAKULA, MD., F.A.C.S.
R. BRYAN FREEMAN, MD., F.A.C.S.

General Surgery • Hepatobiliary Surgery • Surgical Oncology • Robotic Surgery • Trauma and Critical Care Surgery • Bariatric Surgery

FINANCIAL PAYMENT PLAN AGREEMENT

I, _____, agree to pay Oaks Surgical Specialists the amount

of the **balance / Co-Pay / Co-Insurance** within six (6) monthly payments starting

_____(date of appointment).

These payments are to clear my balance by _____.
(six months from date signed)

_____ _____
PATIENT AND/OR RESPONSIBLE PARTY DATE

77 Rolling Oaks Drive, Suite 203 • Thousand Oaks, CA 91361 • Tel: 805.379.9696
18250 Roscoe Blvd, Suite 220 • Northridge, CA 91325 • Tel: 818.280.3901
Fax (805) 379-9695

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____

Fax: _____ **Phone:** _____

☐ **Please mail records.**
☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

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HIPAA Privacy Rule Individual Authorization Agreement Authorization for Disclosure of Protected Health Information for treatment, Payment, or Healthcare Operations (§164.SOS(a))

I, _____ understand that as part of my health care. Oaks Surgical Specialist originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my healthcare;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with and understand that physicians under Oaks Surgical Specialists Notice of Information Practices provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Oaks Surgical Specialists' Notice of Information Practices prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PHI Authorized:

Purpose Authorized:

Parties to whom my PHI is authorized to be released:

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I understand that:

- I have the right to request restrictions. as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations by other covered entities;

- I may revoke this content in writing at any time, except to the extent that Oaks Surgical Specialists has already taken action in reliance thereon.

☐ Accepted ☐ Denied

Signature of Individual or legal Representative Witness: _____

Printed Name of Individual or legal Representative Witness: _____

Date: _____

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