TODAY'S DATE:_____

***PATIENT INFORMATION:*** ___ Single ___ Married ___ Other

NAME:_____ BIRTHDATE: ___/___/___ SEX: M F
First Middle Last

ADDRESS: _____
Number Street

_____ EMAIL ADDRESS: _____
City State Zip Code

HOME PHONE: (___)_____ CELL PHONE: (___)_____ WORK PHONE: (___)_____

ARE YOU: ___ EMPLOYED ___ NOT EMPLOYED ___ STUDENT ___CHILD

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Number Street City State Zip Code

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

***RESPONSIBLE PARTY INFORMATION:*** RELATIONSHIP TO PATIENT: __ SELF __ SPOUSE __ PARENT __ OTHER

NAME:_____ BIRTHDATE: ___/___/___ SEX: M F
First Middle Last

ADDRESS: _____
Number Street City State Zip Code

HOME PHONE: (___)_____ CELL PHONE: (___)_____ WORK PHONE: (___)_____

ARE YOU: ___ EMPLOYED ___ NOT EMPLOYED ___ STUDENT ___CHILD

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Number Street City State Zip Code

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

***INSURANCE INFORMATION:***

*PRIMARY INSURANCE:* _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S NUMBER:_____ GROUP/POLICY NUMBER: _____

*SECONDARY INSURANCE:* _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S NUMBER:_____ GROUP/POLICY NUMBER: _____

DO YOU HAVE ANOTHER HEALTH BENEFIT PLAN? ___ YES ___ NO
IS YOUR CONDITION RELATED TO: ____ EMPLOYMENT ____ AUTO ACCIDENT ___ OTHER ACCIDENT

WHO REFFERED YOU TO OUR OFFICE? _____

NAME OF YOUR PERSONAL PHYSICIAN:_____
Name Phone number or city where practice is located

IN CASE OF EMERGENCY, NOTIFY: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

I authorize Dr. Bresnick and staff to give me reasonable and proper medical care by today's standards.
I, the patient or responsible parties, authorize release of medical information for the purpose of processing medical claims.
I also authorize my insurance company to pay benefits directly to Stephen D. Bresnick, M.D., Inc.
I authorize Dr. Bresnick to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
I understand that Encino Surgicenter is co-owned by Stephen D. Bresnick, MD and George H. Sanders, MD.
I hereby give permission to Stephen Bresnick, MD and his staff to take photographs of myself with the understanding that such photographs are for confidential clinical records, and that all photographs remain the property of the doctor.

**SIGNATURE:** _____ **DATE:** _____

**NAME:**_____ **AGE:**_____ **WT:**_____

**HT:____'/____"**

| ***HAVE YOU HAD, OR DO YOU STILL HAVE:*** | ***YES*** | ***NO*** |
|---|---|---|
| COLD OR COUGH WITHIN THE LAST TWO WEEKS | | |
| BREATHING PROBLEMS (ASTHMA, ETC.) | | |
| CHEST PAINS OR ANGINA | | |
| HEART PROBLEMS | | |
| PALPITATIONS, IRREGULAR OR FAST HEARTBEAT | | |
| SHORTNESS OF BREATH AT ANY TIME | | |
| HIGH BLOOD PRESSURE | | |
| ANY CIRCULATORY PROBLEMS | | |
| BLOOD DISORDER | | |
| BLEEDING PROBLEMS | | |
| ANY IMMUNE PROBLEMS OR DISEASE | | |
| LIVER DISEASE (HEPATITIS, JAUNDICE, ETC.) | | |
| STOMACH PROBLEMS (ULCERS, ETC.) | | |
| INTESTINAL PROBLEMS | | |
| NECK OR BACK PAIN OR INJURIES | | |
| SEIZURES | | |
| HEADACHES | | |
| STROKE OR TEMPORARY PARALYSIS | | |
| PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT | | |
| ANY VISUAL OR EYE PROBLEMS (DRYNESS, ETC.) | | |
| GLASSES OR CONTACT LENSES | | |
| DIABETES | | |
| THYROID PROBLEMS | | |
| KIDNEY OR BLADDER PROBLEMS | | |
| COLD SORES OR OTHER HERPES INFECTIONS | | |
| PROBLEMS WITH ALCOHOL OR DRUG ABUSE | | |
| WEIGHT CHANGES IN THE PAST YEAR | | |
| CONNECTIVE TISSUE DISEASE (LUPUS, RHEUMATOID ARTHRITIS, SCLERODERMA, ETC.) | | |
| CANCER OF ANY TYPE | | |

| ***HAVE YOU HAD, OR DO YOU STILL HAVE:*** | ***YES*** | ***NO*** |
|---|---|---|
| ALLERGIES OR UNFAVORABLE REACTIONS TO ANY MEDICATIONS OR SUBSTANCES<br>_____<br>_____<br>_____ | | |
| SURGERY (PLEASE LIST TYPE AND DATES) INCLUDE ALL COSMETIC SURGERY<br>_____<br>_____<br>_____ | | |
| ANY PRESCRIPTION MEDICATIONS OR VITAMINS WITHIN LAST 3 YEARS<br>_____<br>_____<br>_____ | | |
| DO YOU TAKE ASPIRIN, ADVIL OR OTHER ANTI-INFLAMMATORY MEDICATIONS | | |
| HAVE YOU EVER SMOKED<br>HOW MUCH PER DAY_____ YEARS _____<br>IF YOU'VE QUIT, WHEN_____ | | |
| DO YOU DRINK ALCOHOL<br>HOW MUCH PER WEEK_____ | | |
| WHEN WAS YOUR LAST PHYSICAL EXAM<br>_____ | | |
| HAVE YOU HAD CHILDREN?<br>AGES: _____ | | |
| HAVE YOU BEEN TOLD YOU HAVE ANY OTHER DISEASES NOT MENTIONED ABOVE?<br>IF YES, PLEASE LIST THEM:<br>_____ | | |

**REASON FOR VISIT:** _____