WEST COAST ASSOCIATES for Minimally Invasive Thoracic Surgery

Clark B. Fuller, M.D.
Ali Mahtabifard, M.D.

T 310 854 0909
F 310 652 4053

150 N. Robertson Blvd
Suite 150
Beverly Hills, CA 90211

Patient Name ____

Address ____

Telephone ____

Primary Insurance ______________________________ [ ] Self [ ] Spouse

SSN / ID# ______________________________

Name ______________________________ DOB __________

Secondary Insurance ______________________________ [ ] Self [ ] Spouse

Name ______________________________ DOB __________

AUTHORIZATION TO PAY SURGEON

I hereby authorize payment direct to the above named physicians for professional or surgical benefits otherwise payable to me. I understand that I am financially responsible to these physicians for charges not covered by my insurance. A Photostat (copy) of this authorization is as valid as the original.

Signature of Insured ______________________________ Date __________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the above named physicians to release information regarding the medical history, treatment, disability or benefits payable for claims billed to my insurance by this office. I hereby authorize these surgeons to file an appeal for any unpaid or denied claims on my behalf. I hereby authorize these surgeons the release of my medical records for treatment purposes of my medical care. A Photostat (copy) of this authorization is as valid as the original.

Signature of Insured ______________________________ Date __________

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Name ____ DOB ____________

Address____

City/State/Zip __________________________________

Home Phone_____________________ Cell Phone_____________________

Work Phone _____________________ Occupation ___________________

Weight_________________________ Height ________________________

Marital Status [ ] Married [ ] Single [ ] Divorced [ ] Widow/Widower

Reason for consultation ____

Referring Physician____

Phone ________________________ Fax__________________________

Address____

City/State/Zip ____

May we share information with and contact this physician in regards to your medical condition and treatment? [ ] Yes [ ] No

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account with this office for any professional services rendered. I have read all the information and completed the above form. I certify that the above information is the best of my knowledge true and correct.

Name ____ Date ____________

Signature ____________________________________

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Have you ever had surgery before? [ ] Yes [ ] No

If yes, please list the surgical procedures below.

PROCEDURE	YEAR

Please list any blood relatives who have had cancer below.

RELATION	TYPE OF CANCER

Do you now or have you ever smoked? [ ] Yes [ ] No

When was your last cigarette? ________________________

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HEALTH HISTORY

List all medication you are allergic to below.

MEDICINE	REACTION

List all medications you are taking below.

MEDICINE	DOSAGE	FREQUENCY

HAVE YOU EVER SUFFERED FROM?

[ ] High Blood Pressure

[ ] Diabetes

[ ] Heart Attack

[ ] Stroke

[ ] Other Illnesses: ________________________________

____

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GENERAL MEDICAL HISTORY

YES	NO	GENERAL
	☐	Recent Weight Change
☐	☐	Fever
☐	☐	Chills
☐	☐	Fatigue
☐	☐	Poor appetite
☐	☐	Night sweats
		EYES
☐	☐	Blurred vision
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Loss of vision
☐	☐	Discharge
		EAR, NOSE, THROAT
☐	☐	Ringing in ears
☐	☐	Loss of hearing
☐	☐	Nasal discharge
☐	☐	Bleeding gums
☐	☐	Swollen glands
☐	☐	Non-healing mouth sore
☐	☐	Difficulty swallowing
☐	☐	Hoarseness
		CARDIORESPIRATORY
☐	☐	Cough
☐	☐	Sputum production
☐	☐	Cough blood
☐	☐	Shortness of breath
☐	☐	Chest pain
☐	☐	History of pneumonia
☐	☐	History of heart attack
☐	☐	Heart murmur
☐	☐	Ankle swelling
		GASTRO-INTESTINAL
☐	☐	Nausea or vomiting
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Changes in bowel habits
☐	☐	Abdominal pain
☐	☐	Heartburn
☐	☐	Black stool
☐	☐	Blood from rectum
☐	☐	Jaundice or hepatitis
☐	☐	Ulcer disease
☐	☐	Gallstones
		HEMATOLOGY
☐	☐	Anemia
☐	☐	Easy bruising
☐	☐	Easy bleeding
☐	☐	History of transfusion

YES	NO	MALE
☐	☐	Lumps in testicles
☐	☐	Difficulty starting urine
☐	☐	Prostate problems
		GYNECOLOGY
☐	☐	Last mammogram ___________
☐	☐	Post-menopausal
☐	☐	Lumps in breast
☐	☐	Pelvic pain
☐	☐	Hormone therapy
		MUSCULOSKELETON
☐	☐	Back pain
☐	☐	Joint swelling
☐	☐	Varicose veins
☐	☐	Leg ulcers
☐	☐	Leg cramps
		SKIN
☐	☐	Rashes
☐	☐	Non-healing sore
☐	☐	Changes in mole
☐	☐	History of skin cancer
☐	☐	History of melanoma
		NEURO-PSYCHIATRIC
☐	☐	Headache
☐	☐	Convulsions
☐	☐	Paralysis
☐	☐	Numbness
☐	☐	Dizziness
☐	☐	Insomnia
☐	☐	Depression
☐	☐	Personality change
☐	☐	Previous psychiatric treatment
		ENDOCRINE
☐	☐	Diabetes
☐	☐	Low blood sugar
☐	☐	Thyroid problem
☐	☐	Radiation to neck or tonsil
		GENITO-URINARY
☐	☐	Kidney or flank pain
☐	☐	Burning on urination
☐	☐	Frequency of urination
☐	☐	Get up at night to urinate
☐	☐	Blood in urine
☐	☐	History of kidney stones
☐	☐	History of urinary infections