Babak N. Rad, M.D., Inc.

PERSONAL INFORMATION

Date_____

Last Name_____First Name_____M.I._____

Date of Birth_____Age_____Marital Status ☐ S ☐M ☐ D ☐ W

Social Security Number_____

Home Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____

Work Phone_____Preferred Method Of Contact ☐ Home ☐ Cell ☐ Work

Can We Leave Messages On Your Preferred Method Of Contact with Test Results?_____

Name of pharmacy_____Pharmacy phone_____

Pharmacy address_____

Occupation_____Employer_____

Spouses Name_____Date Of Birth_____

Home Address_____

Home Phone_____Work Phone_____

Occupation_____Employer_____

Emergency Contact_____Relationship_____

Telephone_____

INSURANCE INFORMATION

Primary Insurance Company_____

Subscriber_____Date of Birth_____

Policy Number_____Group Number_____

Secondary Insurance Company_____

Subscriber_____Date of Birth_____

Policy Number_____Group Number_____

PersonalPhysician_____Referred By_____

Babak N. Rad, M.D.
510 Superior Avenue, Suite 200-G
Newport Beach, CA 92663
(949) 791-6767

Dear Patient:

It is my office policy to request that the patient call the office for their X-ray, laboratory, or pathology results. Do not assume they are normal if you have not heard from our office. I feel that you should know, and if desired, have copies of all tests performed, but that you should take responsibility to make sure they have been reviewed. If abnormal tests are found, I plan to inform you, however, at times, the results are sent to the wrong physician or to your primary care physician and not this office. By your participating in your care and assuring that you know that the tests taken have been received by this office, and reviewed by the physician personally, we can act together as a team to achieve the highest quality health care.

Please sign below so my office is advised that you have been informed of the above policy and understand it fully.

Patient's Signature _____ Date _____

Witness Signature _____ Date _____

Babak N. Rad, M.D.

Today's date_____

Name_____Date of Birth_____

What is the reason for your visit today?_____

Medical History Questionnaire

- ☐ High Blood Pressure
- ☐ Heart Disease- narrowed heart arteries
- ☐ Angioplasty/Stent
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Valve Problems- type_____
- ☐ Irregular Heart Rhythm- type_____
- ☐ Other Heart Problems_____

- ☐ Asthma
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Lung Cancer
- ☐ Other Lung Problems

- ☐ Diabetes Mellitus - Insulin dependent
- ☐ Diabetes Mellitus - Non-insulin dependent
- ☐ Hypothyroidism
- ☐ Pituitary Gland Problems_____
- ☐ Other Glandular Problems_____

- ☐ Peptic Ulcer Disease
- ☐ Hiatal Hernia
- ☐ Esophageal Reflux
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Jaundice
- ☐ Hepatitis-type_____
- ☐ Cirrhosis
- ☐ Diverticulosis
- ☐ Irritable Bowel Syndrome
- ☐ Colon Cancer
- ☐ Rectal Cancer
- ☐ Other Gastrointestinal Problems_____

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Broken Bones
- ☐ Spinal Problems
- ☐ Varicose Veins

- ☐ HIV
- ☐ Immune problems
- ☐ Venereal Disease-type_____

- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Traumatic Head Injury
- ☐ Migraine Headaches

- ☐ Abnormal Bleeding after Dentistry/Surgery
- ☐ Blood disorder-type_____

Male Patients
- ☐ Enlarged Prostate Gland
- ☐ Prostate Cancer
- ☐ Erectile Dysfunction
- ☐ Impotence

Female Patients
- ☐ Abnormal Pap Smear
- ☐ Breast Cancer

Number of Pregnancies_____
Number of Births_____
Age of Menopause_____

Do you need antibiotics before dental work or surgery?_____

Other Medical Problems:
_____

Previous Surgery

- ☐ Appendectomy
- ☐ Gallbladder Removal
- ☐ Small Intestine Surgery
  Type_____
- ☐ Colon Surgery
  Type_____
- ☐ Repair of Groin Hernia-side_____
- ☐ Repair of Abdominal Wall Hernia
- ☐ Hysterectomy- through ☐ Vagina or ☐ Abdomen
- ☐ Removal of Ovaries and Fallopian Tubes

- ☐ Heart Bypass Surgery
- ☐ Repair of Heart Valve
  Type_____
- ☐ Insertion of Pacemaker
- ☐ Insertion of Defibrillator
- ☐ Replacement of Knee
- ☐ Replacement of Hip
- ☐ Breast Biopsy
- ☐ Breast Cancer Surgery
  Type_____

- ☐ Hemorrhoidectomy
- ☐ Anal Fistula Surgery
- ☐ Repair of Rectocele
- ☐ Repair of Enterocele
- ☐ Bladder Suspension
- ☐ Abdominoplasty
  (tummy tuck)
- ☐ Other surgery:
  _____
  _____

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Health History

Name_____Today's Date_____

Age_____Date of Birth_____Date of Last Physical Exam_____

SYMPTOMS Check symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Sweats

EYE, EAR, NOSE, THROAT
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Difficulty swallowing
- ☐ Throat problems

PULMONARY
- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing blood

CARDIOVASCULAR
- ☐ Angina(chest pain)
- ☐ Mitral Valve Prolapse
- ☐ Irregular heart beat-type_____
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Low blood pressure
- ☐ Ankle or foot swelling
- ☐ Varicose veins
- ☐ Pain in leg muscles when walking
- ☐ Phlebitis

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion/heartburn
- ☐ Rectal bleeding
- ☐ Abdominal pain
- ☐ Bloating/gas

GENITOURINARY
- ☐ Difficulty with urination
- ☐ Incontinence of urine
- ☐ Frequent urination
- ☐ Blood in the urine
- ☐ Venereal disease

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Broken bones
- ☐ Back or spinal problems
- ☐ Artificial (prosthetic) joints

NEUROLOGIC
- ☐ Migraine headaches
- ☐ Fainting spells
- ☐ Severe head injury
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Paralysis
- ☐ Other neurologic disorders:

_____

HEMATOLOGIC
- ☐ Anemia (low blood count)
- ☐ Bone marrow problems
- ☐ Abnormal bleeding
- ☐ History of DVT (blood clots)

Location:_____

Other symptoms:

_____

_____

_____

MEDICATIONS

Name	Dosage	Name	Dosage
1)_____		4)_____	
2)_____		5)_____	
3)_____		6)_____	

DRUG ALLERGIES

Name of drug and type of reaction

_____

SOCIAL HISTORY

Tobacco use- Packs of cigarettes per day_____ How many years have you been smoking?_____

Alcohol use- Number of drinks per day_____ Type of alcohol (i.e. beer, wine, etc.)_____

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Financial Agreement

We welcome you to our office and would like you to know that we are committed to providing you with the best possible medical and surgical care. In order to achieve these goals, we need your understanding of our financial policy.

It is the responsibility of the patient to know and understand the policies and benefits of their insurance plan. This includes co-payments, deductibles, contracted providers (physicians, hospitals, laboratories, radiology, etc.) and the current claims address. Your insurance is a contract between you and your insurance company. We can not be held responsible for information received when verifying insurance benefits since it is not a guarantee of payment or eligibility. We **strongly encourage** you to contact your insurance company to confirm benefits and coverage. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor.

As a courtesy, our office will bill your insurance company for the services provided. Please present your insurance card(s) for each of your insurance carriers at the time of your visit. If there are changes to your insurance plan(s), please inform us immediately. You will be asked for a new copy of your card annually. The following is a summary of our financial policy:

- **PPO Plans:** We have agreed to take a discount from your insurance company. Your deductible, co-insurance, and co-pays are your responsibility and are due at the time of treatment.

- **Medicare:** We accept assignment from Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy. However, you are responsible for the balance regardless of payment from a secondary insurance.

- **HMO Plans (Greater Newport Physicians):** All co-pays must be paid at the time of your visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. You are responsible for obtaining approval for treatment with your Medical Group or PCP prior to treatment.

- **Cash Patients:** Payment is due in full at the time services are rendered.

- We accept cash, checks, VISA, MASTERCARD, and American Express.

- Partial payments for services rendered are not accepted. **Any partial payments on an outstanding balance will be subjected to a monthly fee of $ 25.00 until the balance is paid in full**.

- A $ 25.00 charge will be applied for any returned check.

- **If you should need to cancel an appointment, we require 24 hour notice. Failure to give our office a 24 hours notice will result in you (not your insurance company) being charged a fee of $ 25.00.**

- **Surgery/colonoscopy deposits and cancellation fees:** If you are scheduled to have an elective procedure, you may be required to pay a $ 250.00 deposit toward any out-of-pocket expenses i.e. deductibles or co-insurance. You may also be required to leave a credit card image to cover a $ 100.00 penalty to be charged if you cancel your surgery/colonoscopy without giving 2 weeks notice.

If you have any questions about the above information, please do not hesitate to ask us.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Signed:_____Date:_____

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Dear Patient,

As part of your office examination, you may need to have the following procedures to assist Dr. Rad with your diagnosis:

1. Abdominal examination (feeling the tummy)

2. Digital rectal examination (finger examination of the anorectal region)

3. Anoscopy (instrument examination of the anal canal)
   (this may show up as "SURGERY" on your explanation of benefits)

4. Proctoscopy (instrument examination of the rectum)
   (this may show up as "SURGERY" on your explanation of benefits)

If for any reason, you do not want Dr. Rad to perform any of these examinations, please inform our office staff.

By signing below, you acknowledge that you have been informed of our procedure policy.

_____

(Signature)