Thomas Goodheart, M.D.

Huntington Beach, Calif. 92648

DATA SET:_____

ACCOUNT NUMBER

DATE: / /

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	HOME PHONE

ADDRESS	SEX MARITAL STATUS AGE M-F M S W D

CITY, STATE	ZIP	DATE OF BIRTH / /

PATIENT'S EMPLOYMENT NAME/ADDRESS	WORK PHONE NUMBER	SOCIAL SECURITY

DRIVERS LICENSE	OCCUPATION	SPOUSE'S SOCIAL SECURITY

SPOUSE	OCCUPATION
SPOUSE'S BUS. ADDR/NAME	PHONE NUMBER
REFERRED BY (DOCTOR)	PHONE NUMBER

PERSONAL INSURANCE INFORMATION (MUST BE COMPLETED FOR BILLING)

PRIMARY INSURANCE COMPANY	SUBSCRIBER
ADDRESS	CERTIFICATE #
CITY, ST., ZIP	GROUP # OR NAME
PHONE NUMBER ( )	RELATIONSHIP
SECONDARY INSURANCE COMPANY	SUBSCRIBER
ADDRESS	CERTIFICATE #
CITY, ST., ZIP	GROUP # OR NAME
PHONE NUMBER ( )	RELATIONSHIP

NAME OF NEAREST RELATIVE OR FRIEND - NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)

NAME	PHONE NUMBER
ADDRESS	RELATIONSHIP

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the above named doctor to furnish information to insurance carriers on my behalf concerning my illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits.

Patient's signature _____

1 COMPREHENSIVE HEALTH HISTORY - MALE

NAME:_____ **DATE:**_____

HOME PHONE # _____ **WORK PHONE #**_____

CURRENT CONDITIONS:

Please briefly list the problems for which you came to see the doctor:

PROBLEMS: **DATE BEGAN:**

PAST MEDICAL PROBLEMS:

Please mark whether you've had each problem with an (X), and note the year diagnosed if possible:

No	Yes	Year		No	Yes	Year		No	Yes	Year	
			Heart Murmur				Stomach Ulcer				Anemia
			Heart Attack				Hepatitis				Bleeding Tendency
			Arteriosclerosis				Pancreatitis				Blood Transfusion
			(Hardening of the Arteries)				Colitis				Acne
			Stroke				Diverticulosis				Eczema
			Cancer or Tumor				Hernia				Psoriasis
			High Blood Pressure				Hemorrhoids				Glaucoma
			High Cholesterol				Kidney/Bladder Problem				Cataracts
			Diabetes				Prostate Problem				Eye or Eyelid Infections
			Thyroid Problem				Arthritis				Loss of Vision
			Allergies				Gout				Ear Infections
			Strep Throat				Back Problems				Hearing Loss
			Mononucleosis				Headaches				Measles
			Sinusitis				Head Injury				Mumps
			Bronchitis				Seizures or Convulsions				Rubella
			Pneumonia				Mental Problems				Chicken Pox
			Asthma				Nervous Breakdown				Polio
			Emphysema				Neuropathy				Herpes
			Tuberculosis				Aids				Malaria

Other/Comments:

PAST SURGERIES, HOSPITALIZATIONS, OR INJURIES:

Please list **all** of the times you have been operated on, hospitalized, or seriously injured. Include problems treated as an inpatient and as an outpatient, and include both childhood and adult events:

Operation, Illness, or Injury: **Year:** **Hospital and City:**

1._____

2._____

3._____

4._____

5._____

CURRENT MEDICATIONS:

Please list all medications you are now taking. Include those you obtain without a prescription such as aspirin, herbs, and vitamins. Include dosage and number of times per day.

1.	4.	7.
2.	5.	8.
3.	6.	9.

CURRENT ALLERGIES:

Please list all allergies to medications, foods, dust, pollen, bee stings, etc.:

Allergic to:	**Effect:**	**Allergic to:**	**Effect:**
1.		4.	
2.		5.	
3.		6.	

RECENT DIAGNOSTIC TESTS:

When was your last Chest X-ray? Date: Result:

When were your last blood tests? Date: Result:

Any other recent tests such as urinalysis, EKG, treadmill test, or sigmoidoscopy?

Type of test:	Date:	Result:
1.		
2.		
3.		
4.		

IMMUNIZATIONS AND TRAVEL:

If you have received any of the following shots, please write in the date:

Last Tetanus Shot
Pneumococcal Pneumonia
Measles, Mumps, Rubella
Hepatitis A
Hepatitis B
Other

Have you traveled outside of the country in the last two years? No Yes Where?

Have you had a tuberculin (TB) skin test? No Yes Result?

Have you had an Aids test? No Yes Result?

NAME:_____

HEALTH HABITS:

Please circle or fill in the appropriate responses:

Do you smoke cigarettes or use any tobacco products?

Currently:	In the Past:	Number of years:	Number of packs per day:
Yes No	Yes No	_____	_____

Do you drink any alcoholic beverages?

Rarely/Never: Occasionally: Frequently: Daily: Amount:

Do you exercise:

Rarely/Never: Occasionally: Regularly: Type of Exercise:

FAMILY HEALTH HISTORY:

Please fill in the following information if known:

Relationship:	**Age if Living:**	**Age at Death:**	**State of Health or Cause of Death:**
Father			
Mother			
Siblings			
Children			
Spouse			

Have any **Blood Relatives** had any of the following illnesses?

Illness:	**Family Members:**	**Illness:**	**Family Members:**
Heart Disease		Rheumatoid Arthritis	
High Blood Pressure		Gout	
High Cholesterol		Migraine Headaches	
Diabetes		Epilepsy	
Thyroid Problem		Multiple Sclerosis	
Stroke		Mental Problems	
Cancer		Depression	
Asthma/Emphysema/Bronchitis		Suicide	
Tuberculosis		Alcoholism	
Peptic Ulcer		Aids	
Gallbladder Problem		Venereal Disease	
Colitis/Irritable Bowel		Blood Disease	
Kidney Problem		Cystic Fibrosis	
Breast/Gynecologic Problem		Birth Defects	
Glaucoma		Hereditary or Genetic Disease	

Other/Comments:

REVIEW OF BODY SYSTEMS - MALE

Please circle the appropriate response to the following questions:

Do you have:

Fevers, chills, or night sweats?	Rarely/Never	Occasionally	Frequently
Unexplained weight loss of ten pounds or more?	Rarely/Never	Occasionally	Frequently
Chest pain or pressure with exertion?	Rarely/Never	Occasionally	Frequently
Heart beat that is too slow, too fast, or irregular?	Rarely/Never	Occasionally	Frequently
Fainting episodes?	Rarely/Never	Occasionally	Frequently
Leg Cramps with walking?	Rarely/Never	Occasionally	Frequently
Swollen feet or ankles?	Rarely/Never	Occasionally	Frequently
Difficulty breathing when lying flat?	Rarely/Never	Occasionally	Frequently
Difficulty breathing with exertion?	Rarely/Never	Occasionally	Frequently
Wheezing?	Rarely/Never	Occasionally	Frequently
Chest pain with deep breaths?	Rarely/Never	Occasionally	Frequently
Chronic cough?	Rarely/Never	Occasionally	Frequently
Cough up blood?	Rarely/Never	Occasionally	Frequently
Runny nose or sneezing spells?	Rarely/Never	Occasionally	Frequently
Nasal or sinus congestion, or post-nasal drip?	Rarely/Never	Occasionally	Frequently
Nosebleeds?	Rarely/Never	Occasionally	Frequently
Difficulty swallowing your food?	Rarely/Never	Occasionally	Frequently
Heartburn, nausea, or upset stomach?	Rarely/Never	Occasionally	Frequently
Vomiting?	Rarely/Never	Occasionally	Frequently
Diarrhea (watery stools)?	Rarely/Never	Occasionally	Frequently
Constipation?	Rarely/Never	Occasionally	Frequently
Bloody stools or black tarry stools?	Rarely/Never	Occasionally	Frequently
Pain when you urinate?	Rarely/Never	Occasionally	Frequently
Blood in urine?	Rarely/Never	Occasionally	Frequently
Wake up at night to urinate?	Rarely/Never	Occasionally	Frequently
Loss of urine when laughing or coughing?	Rarely/Never	Occasionally	Frequently
Other types of accidental loss of urine?	Rarely/Never	Occasionally	Frequently
Difficulty starting urinary stream or emptying bladder?	Rarely/Never	Occasionally	Frequently
Dribbling after urination?	Rarely/Never	Occasionally	Frequently
Penile discharge?	Rarely/Never	Occasionally	Frequently
Pain or lump in testicle or scrotum?	Rarely/Never	Occasionally	Frequently
Impotence?	Rarely/Never	Occasionally	Frequently
Headaches?	Rarely/Never	Occasionally	Frequently
Severe pain in neck, back, muscles, or joints?	Rarely/Never	Occasionally	Frequently
Moles that have changed size or color?	Rarely/Never	Occasionally	Frequently
Skin rash or sores that won't heal?	Rarely/Never	Occasionally	Frequently
Numbness, tingling, or tremor?	Rarely/Never	Occasionally	Frequently
Weakness or paralysis?	Rarely/Never	Occasionally	Frequently
Trouble keeping your balance?	Rarely/Never	Occasionally	Frequently
Blurred or double vision?	Rarely/Never	Occasionally	Frequently
Difficulty hearing?	Rarely/Never	Occasionally	Frequently
Ringing in ears?	Rarely/Never	Occasionally	Frequently
Pain or discharge from ears?	Rarely/Never	Occasionally	Frequently
Problems with teeth, jaws, or gums?	Rarely/Never	Occasionally	Frequently

Patient Signature:_____

CONSENT TO TREAT

I hereby give my consent to examination and treatment and authorize Thomas A. Goodheart, M.D. to render any treatment necessary, as well as to release any information required in the course of my examination or treatment.

_____ _____

SIGNATURE DATE

WAIVER FORM

I understand that any eligibility for coverage by _____ _____ cannot be confirmed at this time. I wish to receive medical services from Dr. Thomas Goodheart. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

_____ _____

Patient / Responsible Party Date

AGREEMENT REGARDING ALL INSURANCE TYPES

I understand that Dr. Goodheart accepts all insurances out-of network only. I agree to receive medical services from Dr. Goodheart on an OUT-OF-NETWORK BASIS ONLY and on a self referral basis. If I do have OUT-OF-NETWORK BENEFITS, then I understand that my insurance will pay a percentage of Dr. Goodheart's fees and I will be financially responsible for the remainder of the balance with no discounts. If I do not have OUT-OF-NETWORK BENEFITS, then I understand that my insurance will pay nothing and I will be fully responsible for all charges incurred.

_____ _____

Signature Date

PATIENT FINANCIAL AGREEMENT AND MEDICAL INSURANCE AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our PAYMENT POLICY.

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance in writing by our office manager. We accept cash, personal checks, Master Card/Visa. There will be an additional $25.00 fee for any checks which are returned by the bank due to insufficient funds. We will be glad to bill your insurance company as a courtesy; however, in order to do so we must have completed insurance forms and a copy of your insurance card and driver's licence. Any missed appointments without at least 24 hours notice will be charged to you on a cash basis of $50.00 for follow up appointments and $85.00 for extended appointments such as physicals/consultations. Any insurance prior authorizations you request of us will be charged to you on a cash basis in the amount of $55.00.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however, that:

1. YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER in some cases, AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.

2. YOU ARE RESPONSIBLE FOR MAKING SURE THAT THE DOCTOR YOU SELECT TO CARE FOR YOU AND ANY LABORATORIES USED ARE PHYSICIANS/LABS ALLOWED BY YOUR INSURANCE COMPANY FOR EACH AND EVERY APPOINTMENT.

We must emphasize that as medical care providers our relationship is with you. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are YOUR RESPONSIBILITY from the date that the services are rendered. We encourage you to contact us for assistance in the management of your account should you have temporary difficulty with timely payments.

If you have any questions about the above information or uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I HAVE READ ALL THE INFORMATION ABOVE. I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ALL SERVICES RENDERED. I AGREE TO PAY FOR ALL SERVICES NOT PAID FOR BY MY INSURANCE.

_____ _____

Signature Date