Dr. Ben Littlejohn M.D.

5855 Doyle Street STE 110 ¤ Emeryville, CA 94608 ¤ Phone: 510-529-3800 ¤ Fax: 510-529-3803

Thank you for choosing our office. In order to serve you properly, we will need the following information. **Please Print.** All information is strictly confidential.

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: ___/___/_____ SEX: M / F
(LAST) (FIRST) (MI)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

MAILING ADDRESS: _____YOUR S.S.# _____- ____-_____

PHONE: ( ) _____ PHONE: ( ) _____ Email: _____
Home/Work/Mobile Home/Work/Mobile

MARITAL STATUS: Single Married Divorced Widowed Race:_____Occupation: _____

EMPLOYER: _____ HOW DID YOU HEAR ABOUT OUR OFFICE:_____

RESPONSIBLE PARTY INFORMATION *COMPLETE ONLY IF PATIENT IS NOT RESPONSIBLE PARTY*

RESPONSIBLE PARTY: _____
(LAST) (FIRST) (MI)

ADDRESS:_____
(STREET) (APT#) (CITY) (STATE) (ZIP CODE)

EMPLOYER: _____ PHONE: ( ) _____ EXT:_____

INSURANCE INFORMATION *PLEASE COMPLETE AND GIVE OFFICE COPIES OF YOUR CARD(S)*

PRIMARY: _____ ID#_____ GROUP # _____
(INSURANCE COMPANY / PLAN NAME)

GROUP NAME: _____

ADDRESS: _____

POLICY HOLDER: _____DATE OF BIRTH: ___/___/____ RELATIONSHIP: _____

SECONDARY: _____ ID# _____ GROUP# _____
(INSURANCE COMPANY / PLAN NAME)

GROUP NAME: _____

ADDRESS: _____

POLICY HOLDER: _____DATE OF BIRTH: ___/___/____ RELATIONSHIP: _____

EMERGENCY CONTACT

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ HOME PHONE # _____ WORK PHONE# _____

PHARMACY

NAME OF PHARMACY: _____ PHONE #: ( ) _____

ADDRESS:_____

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PAYMENT FOR SERVICES I understand that it is my responsibility to verify with my insurance carrier if my physician is a participating provider, I realize that I am financially responsible for all medical and laboratory services rendered to me and / or my dependants regardless of the decision involving reimbursement by my insurance carrier.

INSURANCE, SERVICES & TREATMENT AUTHORIZATION

I hereby authorize payment of any medical benefits directly to Dr. Ben Littlejohn M.D. otherwise payable to me for rendered services as described on the attached claim. I authorize Dr. Ben Littlejohn M.D. to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company.

I also hereby authorize Dr. Ben Littlejohn M.D. and its medical staff to provide medical treatment and/or medical services to me.

_____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____

PATIENT NAME (PLEASE PRINT)

FOR OUR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Ben Littlejohn M.D., or any services furnished to me by one of their physicians. I authorize any holder of medical information about me to release that information to the Dr. Ben Littlejohn Inc. Administration and its agents including any information needed to determine these benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on the claim form, my signature authorizes release of the information to the insurer or agency shown. I understand that by accepting Medicare assignments, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE **DATE** **PATIENT NAME** (PLEASE PRINT)

_____

MEDICARE #

"DECLARATION"

I declare under penalty of perjury that all information contained in this document is true and factual to the best of my knowledge.

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE **DATE** **PATIENT NAME** (PLEASE PRINT)

Ben Littlejohn, M.D. ¤ Medical Director

Dr. Ben Littlejohn M.D.

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Your Name : _____ **Date:**

_____

What medications are you taking now (Name and Dosages):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DO YOU HAVE ANY ALLERGIES TO MEDICATION? ☐ YES ☐ NO

If yes, please name the medications _____

PAST OR CURRENT MEDICAL CONDITIONS

Check those that you have had an insert **APPROXIMATE DATE**

GENERAL

☐ Recent weight change _____
☐ Fatigue _____
☐ Poor Appetite _____
☐ Night Sweats _____

LUNGS

☐ Pneumonia _____
☐ Shortness of breath _____
☐ Asthma _____
☐ Chronic Cough _____
☐ Tuberculosis _____
☐ Other _____

HEART AND VASCULAR SYSTEM

☐ Hypertension _____
☐ High Cholesterol _____
☐ Heart Failure _____
☐ Heart Attack _____
☐ Palpitations _____
☐ Varicose Veins _____
☐ Swelling of ankles or legs _____
☐ Chest Pain _____
☐ Leg cramps - During rest or activity _____

HEMATOLOGY

☐ Easy Bruising _____
☐ Anemia _____
☐ History of transfusion _____
☐ Bleeding _____

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DIGESTIVE SYSTEM

- ☐ Abdominal pain/ Heart burn _____
- ☐ Hepatitis _____
- ☐ Blood in stool _____
- ☐ Irritable Bowel Disease _____
- ☐ Chronic Diarrhea_____
- ☐ Jaundice _____
- ☐ Ulcer disease _____
- ☐ Gallstones _____
- ☐ Pancreatitis _____
- ☐ Constipation _____
- ☐ Crohn's Disease _____
- ☐ Constipation _____
- ☐ Blood from rectum _____
- ☐ Other _____

ENDOCRINAL SYSTEM

- ☐ Thyroid Problems _____
- ☐ Low Sugar _____
- ☐ Diabetes _____
- ☐ Problems with potassium _____

GENITAL URINARY SYSTEM

- ☐ Kidney Stones _____
- ☐ Urinary Tract Infections _____
- ☐ Loss of urine with coughing or sneezing _____
- ☐ Prostate Enlargement _____
- ☐ Uremia Retention _____

EYES, EARS, NOSE, THROAT

- ☐ Blurred Vision _____
- ☐ Eye Pain _____
- ☐ Cataract _____
- ☐ Bleeding gums _____
- ☐ Difficulty Swallowing _____
- ☐ Loss of Vision _____
- ☐ Glaucoma _____
- ☐ Cavities _____
- ☐ Hearing Loss _____

SKIN

- ☐ Change in pigment or mole _____
- ☐ History of skin cancer or melanoma _____
- ☐ Non-Healing sores _____
- ☐ Rashes _____

NERVOUS SYSTEM

- ☐ Blackouts _____
- ☐ Seizures _____
- ☐ Pinched Nerves_____
- ☐ Weakness _____
- ☐ Multiple Sclerosis _____
- ☐ Stroke _____
- ☐ Headaches _____

MUSCULOSKELETAL SYSTEM

- ☐ Arthritis _____
- ☐ Joint Pain _____
- ☐ Leg Ulcers _____
- ☐ Back Pain _____
- ☐ Joint Swelling _____

Any Additional Medical Problems Not Listed Above Mark Here:

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1) _____ 2) _____ 3) _____ 4) _____

BROKEN BONES

WHICH _____ WHEN _____
WHICH _____ WHEN _____
WHICH _____ WHEN _____

SEXUALLY TRANSMITTED INFECTIONS

☐ Gonorrhea _____ ☐ Syphilis _____
☐ Herpes _____ ☐ Chlamydia _____
☐ Genital Warts _____ ☐ Other(s) _____
If you checked any, where you treated? ☐ YES ☐ NO WHEN? _____
Are you interested in obtaining HIV testing? ☐ YES ☐ NO

WHAT SURGERIES HAVE YOU HAD ?

Type: _____ When: _____
Type: _____ When: _____
Type: _____ When: _____

FAMILY HISTORY

Has anyone in your family ever had or do they currently have

☐ Heart Disease _____ ☐ Cancer _____
☐ Other hereditary Illnesses _____ ☐ Diabetes _____

SOCIAL HISTORY

Do you smoke (cigarettes, pipes, and cigars) now? ☐ YES ☐ NO
If yes, what do you smoke and for how long have you been smoking? _____
If no, have you ever smoked? ☐ YES ☐ NO WHEN: _____
If you do smoke, how much do you smoke? (i.e., number of cigarettes/packs per day) _____

Do you drink alcoholic beverages? ☐ YES ☐ NO HOW MUCH? _____
Have you recently used or ever used? ☐ cocaine, ☐ marijuana, ☐ narcotics, ☐ I.V. drugs

HEALTH MAINTENANCE

Please Fill In **APPROXIMATE DATE** for the following

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WHEN WAS YOUR LAST:

Lab Work _____ EKG _____ Last T.B. Test _____ Chest X-Ray _____

Colonoscopy _____

WOMEN: Last PAP Smear _____ Mammogram _____ DEXA (Bone) Scan _____

Last Menstrual Period _____ Do You Have A Birth Control Method? _____ Which? _____

MEN: Prostate Exam _____

VACCINATIONS

Insert "Date" if vaccinated, and date is known.

Write (+) if vaccinated, but date unknown.

Write date if known	**DATE**
Influenza	_____
Pneumococcus	_____
Tetanus, Diptheria Toxoids (TD)	_____
Measles (Rubeola)	_____
Mumps	_____
Rubella	_____
Polio-OPV	_____
Polio-IPV	_____
Hepatitis A	_____
Hepatitis B	_____
HiB (Haemophilus)	_____
Varicella #1	_____
Varicella #2	_____