Moses J. Fallas, M.D., FACS

PATIENT REGISTRATION

PATIENT NAME:		**DATE OF BIRTH:**	**SEX:** ☐ Female ☐ Male	**APPOINTMENT DATE:**
ADDRESS:	**APT:**	**CITY:**		**STATE / ZIP CODE:**
PRIMARY PHONE: ☐ Cell ☐ Home ☐ Work		**SECONDARY PHONE:** ☐ Cell ☐ Home ☐ Work		**SOCIAL SECURITY NO.:**
EMPLOYER:		**EMPLOYER ADDRESS:**		**HOW DID YOU HEAR ABOUT OUR PRACTICE?**
PRIMARY CARE PHYSICIAN:		**ARE YOU HERE BECAUSE OF A JOB RELATED INJURY OR ACCIDENT?** ☐ YES ☐ NO		**EMAIL ADDRESS:**

OTHER CONTACTS

Emergency Contact	NAME:	RELATIONSHIP:	PHONE:
Responsible Party (Person paying the bill or parent. Complete if different from patient)	GUARANTOR NAME:	RELATIONSHIP:	PHONE:
	ADDRESS:	GUARANTOR DOB:	GUARANTOR SSN:

INSURANCE INFORMATION

Primary	COMPANY NAME:	INSURED'S SSN:	ID NO:
	INSURED'S NAME:	INSURED'S D.O.B.:	GROUP NO:
	EFFECTIVE DATE:	SEX: ☐ Female ☐ Male	INSURANCE TYPE:
Secondary	COMPANY NAME:	INSURED'S SSN:	ID NO:
	INSURED'S NAME:	INSURED'S D.O.B.:	GROUP NO:
	EFFECTIVE DATE:	SEX: ☐ Female ☐ Male	INSURANCE TYPE:

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Moses J. Fallas, M.D. I acknowledge that I am financially responsible for payment whether or not covered by insurance. **I acknowledge that the above information is true and correct.**

Signature **Date**

Moses J. Fallas, M.D., FACS

Brendan J. Carroll, M.D.,FACS

Patient History Form

Patient Name: _____ Date of Birth: _____

Present problem (why you are here)? _____

_____

Today's Date: _____

Medical History

Current Medications (or attach list):

_____

_____

_____

- ☐ COUMADIN
- ☐ PLAVIX
- ☐ ASPRIN
- ☐ Pradaxa
- ☐ Xeralto
- ☐ Eliquis

Drug or Anesthesia Allergies:

_____

_____

Do you have sleep apnea?_____

Previous Illnesses

_____

_____

_____

_____

_____

_____

Previous Surgeries

_____

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_____

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Check any substance(s) you use and describe how much you use:

- ☐ Alcohol_____
- ☐ Drugs/Herbals_____
- ☐ Tobacco_____

Review Of Symptoms

Currently have or have had in the past year:

General:
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss

Cardiovascular:
- ☐ Chest pain/Angina
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ Ankle/Leg Swelling
- ☐ Irregular heartbeat
- ☐ Angioplasty/Stents
- ☐ Heart Attack/MI
- ☐ Pacemaker/Defibrillator

Pulmonary:
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Asthma

Hepatobiliary
- ☐ Cirrhosis
- ☐ Gallstones
- ☐ Jaundice
- ☐ Hepatitis

Gastrointestinal
- ☐ Incontinence
- ☐ Reflux
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colitis
- ☐ Irritable Bowel
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Cancer
- ☐ Vomiting Blood
- ☐ IBD/Chron's Disease

Genitourinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Difficult Urination
- ☐ Prostate Disease

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ Numbness
- ☐ Weakness
- ☐ Seizures/Epilepsy
- ☐ Stroke

Endocrine
- ☐ Adrenal
- ☐ Thyroid
- ☐ Diabetes
- ☐ Use Steroid/Hormones

GYN
- ☐ Pregnant
- ☐ Breast Lumps
- ☐ Nipple Discharge
- ☐ Breast Cancer
- ☐ Abnormal Mamo
- ☐ Abnormal Period

Musculoskeletal
- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ DVT (blood clot in leg)
- ☐ Back Pain
- ☐ Joint pain/swelling
- ☐ Sore that won't heal

Skin
- ☐ Abnormal moles/lumps
- ☐ Change in moles/lump
- ☐ Bruise/bleed

Conditions you have ever had:
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Bleeding Disorders
- ☐ Transfusions
- ☐ Ulcers
- ☐ Tuberculosis

Additional Information you want the Doctor to know:

_____

_____

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_____

Moses J. Fallas, M.D., FACS
Brandon J. Carroll, M.D., FACS
9001 Wilshire Blvd. Suite 304
Beverly Hills, CA 90211
310-855-1023 (Fallas)
310-854-0151 (Carroll)
310-855-1024 (Facsimile)

Required Notifications

Dear Patient:

There are several notifications which we are required to give you to be in compliance with various law and regulations. Please take the time to read these notices as they contain important information.

If you like you may keep the attached notice, however to reduce our use of paper, you may return any unwanted copies to us.

Please indicate, by initial and signature, that you have read the following notices.

_____ Notice of financial and insurance policies for all non-Medicare patients

_____ Notice of Surgery Center affiliations

_____ Notice of privacy practices (to be in compliance with HIPPA laws)* you will receive this notice upon your arrival in the office. You may initial at that time.

Please don't hesitate to see me should you have any questions, problems or concerns.

Thank You,

Dyana Yates.

Office Manager