BRUCE F. FRIEDMAN, M.D. INC.

(714) 549-9330
11180 WARNER AVENUE, SUITE 255
FOUNTAIN VALLEY, CA 92708

(949) 753-9300
22 ODYSSEY, SUITE 240
IRVINE, CA 92618

REFERRED BY: _____

PRIMARY PHYSICIAN: _____ CITY: _____ PHONE: _____

PATIENT REGISTRATION SHEET

PLEASE PRINT CLEARLY **ALL BLANKS MUST BE COMPLETED**

PATIENT FULL LEGAL NAME_____SEX _____DOB_____ AGE _____

HOME ADDRESS _____CITY _____STATE _____ZIP _____
(Must be street address)

MAILING ADDRESS _____CITY _____STATE _____ ZIP _____

HOME PHONE (_____)_____ May we leave a detailed message? _____

CELL PHONE (_____)_____ May we leave a detailed message? _____

DRIVER'S LIC#/CA ID# _____ SOCIAL SECURITY # _____

MARITAL STATUS (PLEASE CHECK ONE): ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

RACE: (PLEASE CHECK ONE): ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ WHITE
☐NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ ASIAN ☐ OTHER RACE

ETHNICITY: (PLEASE CHECK ONE): ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

EMPLOYER _____ OCCUPATION _____

ADDRESS _____CITY _____ STATE _____ ZIP _____

WORK PHONE (_____)_____

RESPONSIBLE PARTY

NAME _____PATIENT'S RELATIONSHIP _____PHONE #(____)_____

ADDRESS _____ CITY _____ STATE _____ZIP _____

EMPLOYER _____ ADDRESS _____

WORK PHONE (_____)_____DRIVER'S LIC/CA ID#_____SS# _____DOB_____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ PHONE # (_____)_____

ADDRESS _____CITY _____ STATE _____ZIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ SECONDARY INS CO _____

INSURED NAME _____ DOB:_____ INSURED NAME _____ DOB:_____

ID# _____ ID # _____

DO YOU HAVE ANY OTHER INSURANCE? YES / NO INITIALS_____

OUR OFFICE DOES NOT TREAT WORK RELATED INJURIES/CONDITIONS. OUR PRACTICE IS UNFAMILIAR WITH THE PREPARATION AND REPORTS REQUIRED IN ACCORDANCE WITH TITLE 8 CALIFORNIA CODE OF REGULATIONS ANDTHOSE REQUIRED UNDER THE CALIFORNIA LABOR CODE. INITIALS _____

ASSIGNMENT AND RELEASE

I AUTHORIZE INSURANCE PAYMENT OF MEDICAL BENEFITS BE MADE DIRECTLY TO DR. BRUCE FRIEDMAN FOR SERVICES RENDERED. I UNDERSTAND AND ACCEPT PERSONAL FINANCIAL RESPONSIBILITY FOR PAYMENT OF ANY CHARGES FOR SERVICES NOT COVERED BY MY INSURANCE COMPANY. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIMS.

_____ _____

SIGNATURE DATE

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DATE: _____
NAME: _____
DATE OF BIRTH: _____
OCCUPATION: _____
PRIMARY CARE PHYSICIAN: _____
MAJOR SYMPTOMS: _____

_____
DATE OF ONSET: _____
BETTER/WORSE/SAME(circle one) IN THE PAST ____DAYS/WEEKS/MONTHS(circle one)
HOBBIES OR ACTIVITIES(put a star next to those causing symptoms):

_____
ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES/NO
IF SO, PLEASE LIST:_____
DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES/NO
IF SO, PLEASE LIST_____
DO YOU HAVE ANY FOOD ALLERGIES? YES/NO IF SO, PLEASE LIST:

_____
ALLERGY SYMPTOMS: (circle those that apply)
GENERAL: FATIGUE IRRITABILITY SLEEP LOSS LOSS OF SCHOOLWORK
EYES: RUN ITCH RED PUFFY CIRCLES
EARS: POP ITCH HEARING LOSS
NOSE: ITCH SNEEZE RUN OR STUFFY CONGESTION POST NASAL DRIP
SINUS: FULLNESS HEADACHES PRESSURE INFECTIONS
MOUTH: ITCH
CHEST: WHEEZE COUGH SHORTNESS OF BREATH CHEST TIGHTNESS
SKIN: ECZEMA RASH ITCH HIVES DRYNESS
THROAT: DRY SORE HOARSE
WHICH OF THE FOLLOWING TRIGGER YOUR SYMPTOMS: (circle those that apply)
DOG CAT OTHER ANIMALS DUST TOBACCO SMOKE GRASS/FIELDS
DAMPNESS MILDEW/MOLD HEATER AIR CONDITIONING SANTA ANA WINDS
ENVIRONMENT:
HOW OLD THE HOUSE/APARTMENT THAT YOU LIVE IN? _____
HOW LONG HAVE YOU LIVED THERE? _____
WHAT TYPE OF MATTRESS DO YOU HAVE? _____
ARE YOUR PILLOWS SYNTHETIC OR FEATHERS? _____
WHAT TYPE OF HEATING DO YOU HAVE? (GAS/ELECTRIC) _____
HOW OFTEN ARE FILTERS CHANGED? _____
DO YOU HAVE THE FOLLOWING IN THE HOUSE? (circle those that apply)
ANIMALS PLANTS SMOKERS
DO YOU HAVE THE FOLLOWING IN THE BEDROOM? (circle those that apply)
KNICK KNACKS BOOKS STUFFED ANIMALS
FAMILY HISTORY OF ALLERGY: (circle those that apply)
HAYFEVER ASTHMA ECZEMA OTHER (please explain) _____
PREVIOUS MEDICAL HOSPITALIZATIONS: _____

_____
PREVIOUS SURGERIES: _____

_____

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Acknowledgement of Receipt of Notice of Privacy Practices

BRUCE F. FRIEDMAN, M.D., INC.

11180 WARNER AVE, SUITE 255

FOUNTAIN VALLEY, CA 92708

PRIVACY OFFICER: BRUCE F. FRIEDMAN, M.D.

(714) 549-9330

I hereby acknowledge that I have read a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name and Address of Patient: _____

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PATIENT NAME (PRINT)

PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand about medical insurance, eligibility, coverage, our office policy and medical services.

It must be understood that:

- **We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.**
- **Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for the service.**
- **Not all insurance companies/third party payors pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.**
- **All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.**
- **Patients are personally responsible for Knowing and Understanding their own Insurance Policy, Eligibility and Coverage.**
- **Patients are responsible for payment of outstanding Deductibles and Co-insurance amounts at time of service. Co-payments will be collected at the time of service.**
- **Patients are financially responsible for payments of all non-authorized procedures and non-covered services.**
- **Any appointment, including allergy testing, missed or not cancelled more than 24 hours in advance will incur a *$35.00 charge***
- **Returned checks are subject to a *$35.00 fee*.**
- **Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.**

The Patient or Patient's Legal Representative hereby acknowledges that he/she is Eligible for Health Insurance Benefits and Coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services, and agrees to pay all charges to the Physician accordingly.

_____ _____
Signature of Patient or Guardian **Date**

_____ _____
Witness **Date**