PAUL E. HUGHES, MD

PATIENT INFORMATION

Name _____ Home Phone _____
Last First Middle

Address _____ Cell Phone _____
Street Apt #

_____ Work Phone _____
City State Zip

Birthdate: ____/____/____ Gender: F or M E-Mail_____

Social Security Number_____ **Preferred Language** _____

Your Race_____ **Your Ethnic Background**_____

Marital Status: Single Married Other_____

Reason For Visit_____

How did you find out about this practice? _____

Who is your Primary Care Physician? _____

What is your occupation? _____

Your Employer's Name and Address: _____

Person to contact IN CASE OF EMERGENCY _____

Relationship _____ Their Phone# _____

AUTHORIZATIONS AND CONSENTS

I HEREBY AUTHORIZE PAUL E HUGHES MD , to examine, evaluate and treat me.

I authorize release of any necessary medical information to Medicare or to my insurance needed to process claims for my services.

I request that Medicare and/or insurance benefits be paid directly to the physicians.

I UNDERSTAND THAT PAUL E HUGHES MD AND /OR KEVIN S FINNESEY MD WILL BILL MY INSURANCE, AND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY CO-PAYMENTS, DEDUCTIBLES OR ANY UNPAID SERVICES IF THEY ARE NOT COVERED OR PAID.

ADDITIONAL CONSENTS (Please fill out and circle your answer):

I AUTHORIZE PAUL E HUGHES MD TO LEAVE MESSAGES REGARDING MY MEDICAL CONDITION AT THIS PHONE NUMBER (___) ___-_____ **YES** **NO**

I AUTHORIZE PAUL E HUGHES MD TO REVIEW MY MEDICATIONS AT ALL MY PHARMACIES TO CHECK FOR INCOMPATIBILITY OR DRUG INTERACTIONS. **YES** **NO**

NOTICE TO CONSUMERS: MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA (800)633-2322 www.mbc.ca.gov

Patient Signature _____ Date _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_____

Subscriber's Name (if other than Patient) _____

Subscriber's Relationship to Patient: Self Spouse Parent Other_____

Subscriber's Date of Birth ___/___/____

Subscriber's ID _____

Subscriber's Group Number _____

SECONDARY INSURANCE NAME:_____

Subscriber's Name (if other than Patient) _____

Subscriber's Relationship to Patient: Self Spouse Parent Other_____

Subscriber's Date of Birth ___/___/____

Subscriber's ID _____

Subscriber's Group Number _____

Workers Compensation Carrier_____

Claims Address_____

Adjustor Name _____

Contact Phone Number ( ) _____ Ext. Fax Number ( ) _____

Claim Number _____ Date of Injury _____

Body Part Claim Covers _____

Employer at Time of Injury _____

PLEASE GIVE THE RECEPTIONIST A COPY OF YOUR INSURANCE CARDS

IF YOU DO NOT HAVE INSURANCE THAT COVERS YOUR VISITS OR TREATMENTS AT THIS FACILITY, YOU WILL BE EXPECTED TO PAY AT THE TIME OF YOU VISIT.

CONSENT FOR OTHERS TO OBTAIN INFORMATION ON MY BEHALF

NAME:_____

RELATIONSHIP TO PATIENT:_____

NAME:_____

RELATIONSHIP TO PATIENT:_____

NAME:_____

RELATIONSHIP TO PATIENT:_____

NAME:_____

RELATIONSHIP TO PATIENT:_____

PATIENT SIGNATURE:_____

DATE:_____

Health History

General/Constitutional

Chills	O Yes	O No
Fever	O Yes	O No
Fatigue	O Yes	O No
Headache	O Yes	O No
Weight gain	O Yes	O No
Weight loss	O Yes	O No
Night sweats	O Yes	O No
Change in appetite	O Yes	O No
Lightheadedness	O Yes	O No

Allergy/Immunology

Blistering of skin	O Yes	O No
Hives	O Yes	O No
Rash	O Yes	O No

ENT

Nosebleed	O Yes	O No
Sore throat	O Yes	O No
Ringing in the ears	O Yes	O No
Ear pain	O Yes	O No
Blocked ear(s)	O Yes	O No
Excessive thirst	O Yes	O No
Weakness	O Yes	O No
Excessive sweating	O Yes	O No

Gastrointestinal

Blood in stool	O Yes	O No
Nausea	O Yes	O No
Diarrhea	O Yes	O No
Vomiting	O Yes	O No
Rectal bleeding	O Yes	O No
Change in bowel habits	O Yes	O No
Constipation	O Yes	O No

Health History

Cardiovascular

Chest pain at rest	O Yes	O No
Chest pain with exertion	O Yes	O No
Dizziness	O Yes	O No
Weakness	O Yes	O No
Weight gain	O Yes	O No
Irregular heartbeat	O Yes	O No

Skin

Hives	O Yes	O No
Itching	O Yes	O No
Rash	O Yes	O No
Skin cancer	O Yes	O No
Mole(s)	O Yes	O No
Blistering of skin	O Yes	O No

Genitourinary

Blood in urine	O Yes	O No
Abdominal pain/swelling	O Yes	O No
Pain in lower back	O Yes	O No
Painful urination	O Yes	O No

Musculoskeletal

Painful joints	O Yes	O No
Swollen joints	O Yes	O No
Leg cramps	O Yes	O No
Joint stiffness	O Yes	O No
Muscle aches	O Yes	O No
Trauma to arm(s)	O Yes	O No
Trauma to hip(s)	O Yes	O No
Trauma to knee(s)	O Yes	O No
Trauma to ankle(s)	O Yes	O No

Health History

Past Medical History

gout	O Yes O No
asthma	O Yes O No
depression	O Yes O No
alcohol abuse	O Yes O No
drug abuse	O Yes O No
diabetes, type I	O Yes O No
diabetes, type II	O Yes O No
mumps	O Yes O No
typhoid fever	O Yes O No
AIDS/HIV	O Yes O No
herpes	O Yes O No

Social History

Tobacco Use: O Yes O No

Family History

Father	O Yes O No
Mother	O Yes O No
Siblings	O Yes O No
Spouse	O Yes O No