Nina Lee-Tall, M.D. **3465 Torrance Blvd., Suite S, Torrance, CA 90503**

PATIENT'S INFORMATION:

LAST NAME:_____ FIRST NAME:_____ MI:_____ SEX: M / F

BIRTH DATE: / / MARITAL STATUS: ____ DL#:_____ SOC. SECURITY#:_____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE (H): _____ PHONE (C): _____ PHONE (W): _____ PHONE (OTHER):_____

BEST NUMBER TO CALL YOU DURING OFFICE HOURS: _____ EMAIL: _____

OCCUPATION: _____ EMPLOYER/PARENT IF <18 YEARS:_____

PHARMACY NAME (CITY, STREET, PHONE # IF KNOWN): _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN (IF DIFFERENT): _____ PHONE: _____

DO WE HAVE PERMISSION TO:

Leave a message on your home answering machine?	Yes / No (circle please)
Leave a message on your cell phone?	Yes / No
Leave a message for you at work?	Yes / No
Discuss your medical condition with anyone?	Yes / No

If Yes, please give name(s): _____

BILLING INFORMATION:

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S BIRTH DATE: / /

RELATION TO SUBSCRIBER (circle please): Self / Spouse / Child / Other

ASSIGNMENT OF INSURANCE BENEFITS: I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for the services provided. I also authorize Nina Lee-Tall, M.D., or my insurance company to release any information required to process my claim.

MEDICARE: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. If I only have Medicare, I will be responsible for whatever Medicare does not cover.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Past Medical History: (please note all that apply)

___ Seizure ___ Asthma ___ Major trauma (type): _____

___ Heart attack ___ Pacemaker ___ Cancer (type): _____

___ High blood pressure ___ Stroke ___ Lung disease (type): _____

___ Diabetes ___ Glaucoma ___ Heart disease (type): _____

___ Autoimmune disease ___ Liver disease ___ Thyroid disease (type): _____

___ Bleeding disorder ___ Kidney disease ___ Severe allergies (type): _____

Other Medical Problems (not listed above):

_____

_____

_____

Past Surgical History:

_____

_____

_____

Current Medications:

_____

_____

_____

Allergies to Medications:

_____

_____

_____

Family History of Medical Problems:

_____

_____

Smoking History: (please mark one)

___ Current EVERY day smoker ___ Current SOME day smoker ___ Former smoker

___ Never smoker ___ Smoking status unknown

Patient/Guardian Signature: _____

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To improve efficiency in the office and to better serve patients, the following policies are instituted:

_____ It is your responsibility to inform the staff of any insurance changes. The staff will make every effort to verify insurance eligibility and coverage at the time of your visit, but if we are unable to do so, you will be required to pay for your visit at the time of service. You will be responsible for billing your insurance for that date of service, should you wish to be reimbursed by your insurance.

_____ It is imperative that the staff has your current address and phone number(s). Please notify us of any changes.

_____ Insurance Co-Payments are due at the time of service. There is a $5 service charge for non-payment of the insurance Co-Payment at the time of service.

_____ There is a $20 charge for all returned checks. Repeat occurrences will result in a "cash only" policy for the patient.

_____ Statements are sent monthly. If your account is delinquent, you will be seen on a "cash only" basis. You will also be required to pay our balance prior to future medical services.

_____ As a courtesy, the staff will call to remind you of your office visit one day in advance. If you fail to show up for your appointment (NO SHOW), you will be charged $50. This charge is not billable to your insurance company. Patients with multiple late cancellations (cancelled on the day of appointment) will also be charged $50 at the third late cancellation and every occurrence thereafter.

_____ Patients arriving 20 minutes or more past their scheduled appointment time, will need to be rescheduled for a different time.

_____ In accordance with the laws of the State of California, Dr. Lee-Tall does NOT treat or prescribe medication for patients over the phone. A visit must be scheduled.

_____ Three "NO SHOW" appointments will result in our office asking you to transfer your medical care to another physician.

Patient's Name: _____

I have read, understand, and agree to the above stated policies.

Patient/Parent Signature: _____

Date: _____