



**SPORTS & OCCUPATION
MEDICAL ASSOCIATES**

"Health Care for the Activities of Daily Living"

Norman J. Kahan, M.D.

Physical Medicine & Rehabilitation
555 Knowles Dr. Suite 207 515 South Dr. Suite 16
Los Gatos, California 95032 Mountain View, CA 94040
Phone (408) 374-1112 Fax (408) 374-1133

Julia S. Kahan, M.D.

Orthopedic Surgery
555 Knowles Dr. Suite 207
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Phone (408) 374-1110 Fax (408) 374-1133

| | | | | | | |
|--|--|------------------------|-------|---|---------------------------------|--|
| LAST NAME | | FIRST NAME | | MIDDLE | DATE OF BIRTH | AGE |
| STREET ADDRESS | | | | CITY | STATE | ZIP |
| HOME PHONE () | | WORK PHONE () | | | MARITAL STATUS M S D W | |
| EMPLOYER NAME | | | | OCCUPATION | | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| EMPLOYER ADDRESS | | CITY | STATE | ZIP | | |
| SPOUSE OR PARENT'S NAME | | SOCIAL SECURITY NUMBER | | DRUG ALLERGIES : PLEASE LIST | | |
| EMERGENCY CONTACT INFORMATION | | | | | | |
| NAME | | RELATIONSHIP | | HOME PHONE () | WORK PHONE () | |
| INSURANCE INFORMATION PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST | | | | | | |
| INSURANCE COMPANY | | | | SUBSCRIBER | | RELATIONSHIP AND D.O.B. |
| CLAIM ADDRESS | | CITY | STATE | ZIP | PHONE NUMBER | |
| IDENTIFICATION NUMBER | | | | GROUP NUMBER | | |
| HISTORY OF PROBLEM | | | | | | |
| PART OF BODY <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT | | | | DATE OF INJURY/ONSET OF SYMPTOMS | | |
| WERE YOU INJURED ON THE JOB? YES NO | | | | WERE YOU INJURED DUE TO AN ACCIDENT? YES NO | | |
| *IF YES, PLEASE FILL OUT NEXT SECTION | | | | | | |
| WORK RELATED INJURIES | | | | | | |
| NAME OF COMPENSATION INSURANCE CARRIER | | | | CLAIM ADJUSTER | | PHONE NUMBER |
| INSURANCE CARRIERS ADDRESS | | CITY | STATE | ZIP | INDUSTRIAL CLAIM NUMBER | DATE OF INJURY |
| AUTHORIZATION GIVEN BY : | | | | PHONE NUMBER | | EMPLOYER (AT TIME OF INJURY) |
| AUTHORIZATION FOR : <input type="checkbox"/> EVALUATION <input type="checkbox"/> TREATMENT <input type="checkbox"/> 2ND OPINION <input type="checkbox"/> QMC <input type="checkbox"/> A/M <input type="checkbox"/> OTHER _____ | | | | | | |
| REFERRED BY : | | | | TITLE/RELATIONSHIP | | |
| ADDRESS | | CITY | STATE | ZIP | PHONE NUMBER | |

I hereby authorize Sports & Occupation Medical Associates to release information regarding my treatment to my insurance company or its representatives. I also authorize payment to be made directly to Sports & Occupation Medical Associates for all charges rendered by myself or my dependents. I understand that I am responsible for any amounts not covered by my insurance company. Should my account be referred to an attorney for collection, I shall pay actual attorney's fees and collection expense.

SIGNATURE _____ DATE _____



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PATIENT QUESTIONNAIRE

Name _____

Who referred you to this office? _____

What are you being seen for today? LEFT RIGHT

| | | | |
|----------|---------|----------|-------|
| NECK | FOREARM | LOW BACK | CALF |
| SHOULDER | WRIST | HIP | ANKLE |
| ELBOW | HAND | THIGH | FOOT |
| | FINGER | KNEE | TOE |

Date you injured yourself: _____

How did you injure yourself? _____

Do you suffer from any of the following conditions?

| | | | |
|-------------------|---------------|-------------|-----------|
| THYROID DISEASE | HYPERTENSION | DIABETES | ULCER |
| BLEEDING DISORDER | HEART DISEASE | EMPHYSEMA | HEPATITIS |
| KIDNEY DISEASE | HEART ATTACK | ASTHMA | MIGRAINES |
| HEART MURMUR | HEARTBURN | BLOOD CLOTS | GOUT |
| HIGH CHOLESTEROL | SEIZURES | DEPRESSION | CANCER |
| OTHER _____ | | | |

Which medications are you currently taking?

Do you have allergies to any medications? _____

What surgeries have you had in the past?

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____ How much? _____ How often? _____

Are you Right or Left Handed? _____ Height _____ Weight _____

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To Our Patients,

We participate in and are providers for numerous insurance programs as a convenience to our patients. Our goal as always, is to provide our patients with the best care possible. In this day and age of managed health care each program has their own rules and regulations that must be followed and unfortunately that information is not always readily accessible to the physician/provider.

We can at the time of your first contact with the office or at your initial appointment tell you if we participate with your insurance company. We will then gladly have our billing service bill your primary insurance for you. However, the ultimate responsibility for knowing what your insurance requires lies with you. For example, your insurance may require that you be referred only to a particular lab for blood work or that you have your prescriptions only through a particular pharmacy. This is information that should be provided to you as the consumer, which you then will need to pass on to us as the need arises. We ask that you familiarize yourself with your insurance policy and any special requirements. We will certainly do our best to meet your insurance guidelines and regulations.

Your copay is due at the time of your visit or a \$10.00 administration fee will be applied to your balance.

I understand that I am responsible for providing all necessary information regarding my insurance and any special needs that I might require.

Signed _____

Date _____

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Acknowledgment of Receipt of Notice of Privacy Practices

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 will be posted in the receptionist area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor parent
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased parent

Name of Patient: _____

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