East Street Physicians Center
1555 East Street, Suite 220
Redding, CA 96001
Phone: (530) 247-8200
Fax: (530) 247-8202

KENT BRUSETT, M.D.

Patient Registration Information

Appointment Date: _____ Referring Physician: _____

Reason for today's visit: _____

Please have Insurance cards & photo ID available for the front desk to copy

PATIENT'S PERSONAL INFORMATION

Name: _____

Mailing Address: _____

City/State: _____Zip Code: _____

Home Pone: _____ Cell: _____ Work: _____

Email Address: _____

Preferred method of contact for appointment reminders: ☐ Voice ☐ Text ☐ Email

SS # _____Date of Birth: _____Age: _____

Sex: Male/Female **Ethnicity:** Hispanic or Non-Hispanic **Race:** _____ **Preferred Language:** _____

Employer Name & Address: _____

Spouse's Name: _____

If patient is a minor, name of Parent/Guardian: _____

Pharmacy you prefer: _____

Pharmacy Location (street name)_____

INSURANCE INFORMATION

Policy Holder's Name & relationship to patient: _____

Policy Holder's SS#_____

Primary Insurance: _____ ID# _____ Group # _____

Secondary Insurance: _____ ID# _____Group # _____

Is your condition a result of a work injury: Yes / No Date of injury: _____ Claim # _____

EMERGENCY CONTACT

Emergency Contact (That does not live with you or different/additional number)

Name & Relationship to patient: _____

Home Phone: _____ Cell: _____

Kent Brusett, M.D.

Date: _____

Patient Name: _____DOB: _____

Hospital you Prefer: _____Family Physician:_____ Cardiologist: _____

Height: _____ Weight: _____

~PATIENT HISTORY~

Major events, illnesses, surgeries, and hospitalizations (continue on separate page if needed)

1._____ 2._____

3._____ 4._____

Please check if any apply: ☐ High Blood Pressure ☐ Diabetes

☐ Implantable devices: Yes / No (if yes, please provide front desk with your device card.)

~MEDICATIONS~

Please list current **Medication(s)** and **Frequency** (continue on back of this page if needed)

☐ **IF NONE PLEASE CHECK**

1._____Dosage_____Frequency_____

2._____Dosage_____Frequency_____

3._____Dosage_____Frequency_____

4._____Dosage_____Frequency_____

Are you currently taking **blood thinners**?_____

~ALLERGIES~

Please list allergies and your reaction to them:

☐ **IF NONE PLEASE CHECK**

1._____Reaction_____

2._____Reaction_____

3._____Reaction_____

~FAMILY MEDICAL HISTORY~

Mother: Alive _____or Age of death: _____Cause of death: _____

Father: Alive _____or Age of death: _____Cause of death: _____

Please check the following illness (es) that run in your family:

☐ Diabetes: Type: _____ ☐ Cancer: Type: _____

☐ Heart Disease ☐ Stroke ☐ Arthritis ☐ Anemia ☐ High Blood Pressure ☐ Kidney Disease

~SOCIAL HISTORY~

Current tobacco use? Yes / No ☐ Cigarettes ☐ E-cigarettes ☐ Chewing Tobacco ☐ Other _____

☐ Light (1-9 cig/day) ☐ Moderate (10-19 cigs/day) ☐ Heavy (20-39 cigs/day) ☐ Very Heavy (40+ cigs/day)

Did you previously smoke? _____When and how much?_____

Drink Alcohol? _____How much & How often?_____

Use street drugs? Yes/ No If yes type:_____ Use Marijuana? ☐ Yes ☐ No

What is your occupation?_____

Any religious beliefs that affects your medical care?_____

Any other information you would like your Doctor to know?_____

ILLNESSES/AILMENTS

Please check the following illness and; or ailments you now have or have ever had.

○ Albumin in urine ○ Allergy ○ Alzheimer's disease ○ Anemia or bleeding tendencies ○ Arthritis ○ Asthma ○ Blood in urine, kidney stones or renal failure ○ Bronchitis ○ Cancer ○ Chicken pox ○ Diabetes ○ Diphtheria ○ Emphysema	○ Gallbladder problems ○ Growths ○ Hay fever ○ Heart attack or stroke ○ Heart murmur ○ Hepatitis, yellow jaundice or cirrhosis ○ High blood pressure ○ High thyroid ○ Jaundice ○ Low blood pressure ○ Low thyroid ○ Malignancy ○ Measles ○ Mononucleosis	○ Mumps ○ Nephritis ○ Nervous breakdown ○ Neuritis ○ Paralysis ○ Pneumonia ○ Psychiatric treatment ○ Rheumatic fever ○ Sugar in urine ○ Swollen glands ○ Tuberculosis ○ Tumor ○ Venereal disease such as herpes, syphilis, gonorrhea or AIDS

Have you experienced any other illness not listed above?_____

_____

_____

SYMPTOMS AND PROBLEMS

Following is a list of symptoms and problems. Please check any of the following you presently have, or have experienced in the last 5 years.

GENERAL:
- ○ Weight loss/gain
- ○ Fatigue
- ○ Fever

SKIN:
- ○ Itching or Rash
- ○ Skin Lumps
- ○ Bleeding Moles

HEAD AND NECK:
- ○ Frequent or unusual headaches
- ○ Changes in vision
- ○ Eye pain, redness, tearing
- ○ Double vision
- ○ Cataracts
- ○ Glaucoma
- ○ Difficulty hearing
- ○ Ringing in ears
- ○ Ear drainage
- ○ Earaches
- ○ Frequent ear infection
- ○ Frequent or unusual nosebleeds
- ○ Hay fever
- ○ Sinus trouble
- ○ Toothaches
- ○ Frequent or unusual sore throat
- ○ Tongue pain or lumps
- ○ Oral bleeding
- ○ Hoarseness
- ○ Lumps in neck (swollen glands)
- ○ Goiter (thyroid enlargement)
- ○ Neck pain

RESPIRATORY:
- ○ Persistent or unusual cough
- ○ Wheezing
- ○ Asthma
- ○ Bronchitis
- ○ Tuberculosis
- ○ Pain with breathing
- ○ Emphysema
- ○ Pneumonia
- ○ Other respiratory disorder

CARDIAC:
- ○ Heart pains (angina)
- ○ Other types of chest pain
- ○ High blood pressure
- ○ Rheumatic fever
- ○ Leg swelling
- ○ Shortness of breath

GASTROINRESTINAL:
- ○ Trouble swallowing
- ○ Heartburn
- ○ Nausea
- ○ Vomiting of blood
- ○ Indigestion
- ○ Recent change of bowel habits
- ○ Black or tarry stools
- ○ Rectal bleeding
- ○ Constipation
- ○ Diarrhea
- ○ Abdominal pain
- ○ Poor appetite
- ○ Yellow coloring skin or eyes
- ○ Hepatitis or liver disease
- ○ Other gastrointestinal disorder

URINARY:
- ○ Frequent urination
- ○ Frequent urination at night
- ○ Pain or burning with urination
- ○ Inability to control urination
- ○ Urinary tract or kidney infections
- ○ Urinary or kidney stones

GYNECOLOGIC:
- ○ Irregular or absent menstrual periods
- ○ Vaginal discharge or itching
- ○ Hernia or groin bulging

MALE GENITAL:
- ○ Hernia or groin bulging
- ○ Testicular or scrotal pain
- ○ Testicular lumps

EXTREMITIES:
- ○ Joint pains
- ○ Arthritis
- ○ Gout
- ○ Muscular pains
- ○ Leg pain with walking
- ○ Varicose veins
- ○ Blood clots

ENDOCRINE:
- ○ Diabetes
- ○ Thyroid problems
- ○ Heat or cold intolerance
- ○ Excessive thirst or urination

HEMATOLOGIC:
- ○ Anemia
- ○ Easy bruising or bleeding
- ○ Transfusion reactions

NEUROLOGIC:
- ○ Fainting or blackouts
- ○ Seizures
- ○ Paralysis
- ○ Numbness or tingling
- ○ Tremors

Have you experienced any other symptoms or problems not listed above?_____

_____

POST-OPERATIVE PAIN MEDICATION CONTRACT

This is an agreement between _____ (the patient) and the surgeon concerning the use of narcotic pain-killers for the treatment of **POST-OPERATIVE PAIN.**

*****PLEASE INITIAL BELOW THAT YOU UNDERSTAND*****

_____These medications are to be used to decrease my pain but they will not take away my pain completely. I understand that narcotic pain-killers are strong medications and have been informed of the risks and side effects involved with taking them.

_____I agree to take this medication as prescribed and not to change the amount or frequency of the medication.

*****Refill Requests** can take up to **48** hours to process, **DO NOT** wait until you run out!!

_____I understand that there is a "**30** day policy" in which pain medication will be prescribed. Pain Exceeding the 30 day past operative period will be referred out to Pain Management.

_____It is my responsibility to tell my provider if I am currently taking any pain medication from another doctor. If so, **Please list prescribing Doctor/Facility that you are currently receiving pain medication from:**

_____

_____I will fill my prescriptions at one pharmacy of my choice; pharmacy name and location:

_____

_____I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know the doctor may discontinue prescribing (narcotic pain-killers) prescriptions for me.

X_____

Patient signature Date

X_____

Printed name of patient

In the event that you need surgery we will be asking you to identify which hospital is contracted with your insurance company. If your surgery is scheduled at a non-contracting facility, it could result in a reduction of payment or possibility non-payment. If you aren't sure, contact your insurance company directly for that information.

We will contact your insurance company prior to surgery to pre-certify the procedure. This is not a guarantee of payment. It is your responsibility as the patient to know and/or check your benefits with your insurance carrier.

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO KENT BRUSETT, MD and any assisting physicians for services rendered. I understand that I am financially responsible for all charges weather or not they are covered by insurance. In the event of default, I agree to pay all cost of collection, and if necessary reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits; I further agree that a photocopy of this agreement shall be valid as the original.

Signature:_____Date:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

Please sign indicating that you have read and understand our notice of privacy practices

Signature: _____ Date: _____

Relationship (if not signed by patient):_____

Internal use only

If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time):_____

By (name and title):_____

AUTHORIZATION FORM TO RECEIVE HEALTH INFORMATION

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State, Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

_____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

_____
Name

_____
Address

_____
City, State, Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

_____
_____
_____

UNLESS YOU SIGN HERE,
NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

☐ **YES** - Disclose this information _____
☐ **NO** - Do not disclose this information _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this, authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions.

6. My purpose/use of the information if for _____

7. This authorization expires on _____20____, OR upon occurrence of the following event that relates to me or to the purpose or the intended use or disclosure of information about me: _____

FEES FOR COPIES: Federal and state law permit a fee to be charged for the copying of patient records. You may be required to rep-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFOR SIGNING-note that signature is required in two places.*

Signature of Individual* **(The person about whom the information relates)**	**Date of Individual's Signature**	**Date of Birth or Social Security Number**
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative Signature**	**Description of Authority to Act for the Individual**

A copy of this completed and dated from must be given to the individual or other signature

Official Use Only

Received	**Processed By**	**Log #**

Patient Authorization for Practice to RELEASE HELATH INFORMATION

Practice: Kent Brusett, MD

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability ACT (HIPPA).

In an effort to protect your healthcare information, please list any/all names and relation of those whom we have your permission to discuss appointments, billing, medical information, etc. (Example: spouse, significant other, parents, physicians, caretaker, etc.)

Name: _____Relation: _____

Name: _____Relation: _____

Name: _____Relation: _____

Name: _____Relation: _____

Name: _____Relation: _____

Name: _____Relation: _____

I have reviewed this consent from and am giving my permission to **Kent Brusett, MD** to use and disclose my health information in accordance. This authorization shall expire on _____ or in 5 years from the date signed if left blank.

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be by protected by the privacy rules.

To the extent that this form authorizes the sale of you Protected Health Information, such a disclosure will result in remuneration to the Practice.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit you revocation to the Privacy Officer of the Practice.

_____

Signature of patient or Guardian

_____

Relationship if other than Parent

_____

Printed name of patient

_____

Date Signed