The Center for Minimally Invasive Neurosurgery

450 N Roxbury Dr.
Beverly Hills, CA 90212
(310) 385-1918

Please provide the following information for our records.

Please bring your INSURANCE CARD and DRIVER'S LICENSE to your appointment. Thank you.

Patient Name: _____
Last First Middle

Date of Birth: _____ Social Security Number: _____ Sex: ☐ M ☐ F

Address: _____

City, State, Zip Code: _____

Telephone -- Home: _____ Work: _____ Cell: _____

As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Employer: _____ Occupation:_____

Address: _____

City, State, Zip Code: _____

Emergency Contact: _____

Relationship to Patient: _____Telephone: _____

Referred By: _____ Primary Physician: _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

Reason for visit with King, M.D, P.C.?

Please Explain: _____

The Center for Minimally Invasive Neurosurgery

INSURANCE INFORMATION

BLUE CROSS BLUE SHIELD OR BLUE CARE NETWORK:

_____ _____

Contract Number Group Number

Subscriber: _____ Date of Birth: _____

Relationship to Patient: _____

MEDICARE:

Medicare Number: _____ Are you or your spouse employed? ☐Yes ☐No

What is the basis for the patient's entitlement to Medicare?

☐ Age ☐ Disability ☐ Renal Disease ☐ Other (Explain)_____

OTHER INSURANCE: (Insurance Company) _____

Address: _____

City, State, Zip Code: _____

Policy/Claim Numbers: _____

Subscriber: _____ Date of Birth: _____

Relationship to Patient: _____

Employer of Subscriber (if different from above): _____

Address of Employer (if different from above): _____

Claim Adjuster Name (if applicable): _____ Telephone: _____

I authorize the release of any medical information necessary to process my insurance claim.
I authorize payment of medical benefits to Wesley King, M.D. for services rendered when they request that payment be made directly to them.

_____ _____

Signature (Patient, Responsible Party) Date

I understand that I am ultimately responsible for payment of services that are rendered to me.
I understand that the office of Wesley King, M.D will bill my insurance company, but that
I am responsible for any balance that my insurance does not pay as well as any copayments and/or deductibles.

_____ _____

Signature (Patient, Responsible Party) Date

Wesley A. King, M.D., PC
450 N. Roxbury Dr. Third Floor
Beverly Hills, CA 90210

Receipt of Notice of Privacy Practices

Patient Name: _____

DOB _____ ACCT # _____ Provider # _____

In the course of providing service to you, our office receives and stores health information that indentifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You, the patient, have the right to review such Notice prior to signing this consent form. Wesley King, M.D, PC reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health information at any time. If the Wesley King, M.D., PC does change the terms of its Notice of Privacy Practices, the Patient may obtain a copy of the revised Notice. Patient retains the right to request that Wesley King, M.D, PC further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Wesley King, M.D, PC is not required to agree to such requested restrictions; however, if Wesley King, M.D, PC does agree to Patient's requested restriction(s), such restrictions are then binding on Wesley King, M.D , PC

I have received/read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Wesley A King M.D, PC.

_____ _____
Signature of Patient or Authorized Representative Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Print Name Relationship to the Patient

_____
Source of Authority

The Center for Minimally Invasive Neurosurgery

SUMMARY NOTICE OF PRIVACY PRACTICES

Wesley King, M.D, PC is required by federal law to provide a Notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. The Notice describes each use and disclosure that we are permitted to make, and provides a description of your rights and our obligations under federal and state privacy laws. This is a summary of that Notice. The full Notice will be provided to you no later than the first time we provide services to you unless we provide services to you in an emergency.

USES AND DISCLOSURES

We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

• to provide information about your health condition to others who may treat you:

• to provide information about the treatment that we provided in order to obtain payment from your health plan,

• to report a communicable disease, domestic violence or criminal activity: or • to comply with a court order requiring the disclosure of your medical record.

These are just a few examples. For a full description of the uses and disclosures that we are to take, consult the Notice of Privacy Practices.

YOUR RIGHTS

While the records that we maintain about you belong to us, under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and copy the health information that we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect Also, you may request that we provide you with a list of each disclosure that we have made of your health information All of these rights are subject to some exceptions that are described fully in the Notice.

OUR OBLIGATIONS

We are required to provide you with our Notice of Privacy Practices and to abide by its terms.

We may amend the Notice from time to time. All amendments apply retroactively.

Our full Notice of Privacy Practices is attached or enclosed. Please read it carefully If you have any questions or require additional information, please contact:

Wesley A. King, M.D.,PC
450 N. Roxbury Dr. Third Floor
Beverly Hills, CA 90210

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ACKNOWLEDGEMENT OF PATIENT PRIVACY

By signing this form, you acknowledge receipt or review of the Notice of Privacy Practices of Wesley A. King, M.D., PC Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read the entire document which is available in printed form and on our website.

Our Notice of Privacy is subject to change and we have reserved the right to change it. If we change our notice, you may obtain a copy of the revised document by contacting our office or review the update on our website.

If you have any questions about our Notice of Privacy Practices, please contact us directly at:

Wesley A. King, M.D., PC
450 N. Roxbury Dr. Third Floor
Beverly Hills, CA 90210

I acknowledge receipt or review of the Notice of Privacy Practices of Wesley King, M.D., PC

Date of Signature:_____

Printed Name (patient)_____

Signature:_____

The Center for Minimally Invasive Neurosurgery

PATIENT HISTORY FORM

Dear Patient:

Thank you for choosing the Wesley King, M.D., PC for your neurosurgical healthcare needs. Your time and health concerns are very important to us. We certainly appreciate your trust and confidence in us, and we will do our best to meet all of your expectations.

Listed below are a few questions that will help us provide you with best medical care possible. Please answer as many of the questions as you can, as completely possible. If you do not understand one or more of the questions, or are uncomfortable answering one or more of the questions, please leave those questions blank. This information will be kept only as a confidential part of your medical record and is used solely for the purpose of providing you with the best medical care possible. We appreciate your help and cooperation in this regard.

Date: _____ / _____ / _____ onset

Last Name:_____ First Name: _____ Middle Initial:_____

Date of Birth:_____

Family Medical History: (what illness runs in your family?)

_____
_____
_____

Imaging: _____MRI _____CT _____X-Ray _____Myelogram _____Bone Scan

List all past surgeries: (include dates if known)

_____
_____
_____
_____
_____

Allergies to medications and reactions (include tape and latex allergies):

_____
_____
_____
_____
_____

Please list all current medications, supplements, vitamins, and herbs you take:

Drug	**Dose**	**How many times taken daily**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

Are you married? YES NO
Females—are you pregnant? YES NO UNSURE
Do you smoke? YES NO (# packs_____ for _____ years)
Do you use other forms of tobacco? YES NO (What? _____)
Do you drink alcohol? YES NO (# drinks weekly)

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Review of Symptoms: For the following symptoms, please place a check mark "√" next to those you currently experience and circle any that have been a problem in the past.

General
___ Fevers
___ Chills
___ Excessive Daytime Sleepiness
___ Recent Weight Gain (_____ lbs.)
___ Recent Weight Loss (_____ lbs.)
___ Other _____

Eyes
___ Blurred Vision
___ Double Vision
___ Other _____

ENT
___ Loss of Hearing
___ Nosebleeds
___ Snoring
___ Other _____

Heart
___Chest Pain
___ Other _____

Lung
___ Shortness of Breath
___ Wheezing
___ Chronic Cough
___ Other _____

GI
___ Abdominal Pain
___ Nausea
___ Vomiting
___ Constipation
___ Diarrhea
___ Dark/Bloody Stool (Melena)
___ Difficulty Swallowing
___ Other _____

GU
___ Painful Urination
___ Urinary Frequency
___ Urinary Urgency
___ Males – Testicular Pain
___ Females – May Be Pregnant
___ Other _____

Musculoskeletal
___ Joint Pains
___ Muscle Pains
___ Other _____

Skin
___ Skin Rash
___ Other_____

Neuro
___ Headache
___ Dizziness
___ Walking/Balance Problems
___ Falls
___ Other _____

Behavioral
___ Suicidal
___ Anxiety
___ Sleep Disturbances
___ Depression
___ Tendency to Cry
___ Other _____

Endocrine
___ Excessive Thirst
___ Other _____

Heme/Lymph
___ Easy Bleeding
___ Easy Bruising
___ Other _____

Form Completed by: _____Date:____/_____/____
Reviewed with patient by: _____Date:____/_____/_____