



**BASS**  
MEDICAL GROUP

A division of BASS Medical Group

[www.BlueHillsMedicalGroup.com](http://www.BlueHillsMedicalGroup.com)

## ***IMPORTANT!!***

It is critical that we know all medications  
that you are taking.

Please bring a complete list of your current medications  
(including strength and how many you take a day) to  
your appointment.

If you are unable to bring a list, then bring all of your  
medications in a bag and our staff will make a list for  
the doctor.

## ***DO WE HAVE YOUR CURRENT BILLING INFORMATION?***

Please make sure you have your current insurance cards  
with you at the time of check in.



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## NEW PATIENT REGISTRATION

Date: \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address \_\_\_\_\_ Pharmacy \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last Name First MI

Date of Birth: \_\_\_\_\_  Male  Female Marital Status: S M W D Age \_\_\_\_\_

Race: \_\_\_\_\_ Are you Hispanic?  Yes  No

Language: \_\_\_\_\_ Religion: \_\_\_\_\_ /or  Declines to specify

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State/zip code: \_\_\_\_\_ Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

Is this work-related?  Yes  No If yes, date of injury: \_\_\_\_\_ Claim #: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ SS# \_\_\_\_\_

## PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: \_\_\_\_\_

Insurance is through:  Patient  Spouse  Parent  Other DOB of Insured: \_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_

Insurance is through:  Patient  Spouse  Parent  Other DOB of Insured: \_\_\_\_\_

If patient is a Minor, are parents  Married,  Divorced? Custodial Parent \_\_\_\_\_

Custodial Parent's Home Phone: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

Custodial Parent's SS #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## PHYSICIAN INFORMATION

Referring Physician's Name: \_\_\_\_\_ City: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ City: \_\_\_\_\_



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**EMERGENCY CONTACT INFORMATION**

Name of Emergency Contact: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize BASS Medical Group to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to BASS Medical Group. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at BASS Medical Group are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: [www.mbc.ca.gov](http://www.mbc.ca.gov).

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



# BASS

MEDICAL GROUP

**BASS BLUE HILLS MEDICAL**  
*Dr. B Sofia Jalilie M.D. & Dr. Aradhana Kar M.D.*

A division of BASS Medical Group

## PATIENT HISTORY FORM

DATE \_\_\_/\_\_\_/\_\_\_

REFERRING DOCTOR \_\_\_\_\_

NAME \_\_\_\_\_ PRIMARY CARE DOCTOR \_\_\_\_\_

DOB \_\_\_\_\_ REASON FOR VISIT \_\_\_\_\_

MEDICATIONS		
Please list all current medications, including vitamins:		
Name of medication	Dose	Frequency

ALLERGIES	
Please list all drug allergies:	
Drug	Reaction

PAST MEDICAL HISTORY			
Please check whether you have or have had any of the following conditions:			
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure/Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	COPD/emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary artery disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congestive heart failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic renal failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dementia (e.g., Alzheimer's)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Atrial fibrillation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type _____		Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type _____		HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Others: _____			

PAST SURGICAL HISTORY			
Please list all prior surgeries:			
Surgery	Year	Surgery	Year

NAME \_\_\_\_\_ DOB \_\_\_\_\_

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family h/o	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Additional Space for Family History:			

SOCIAL HISTORY	
Drinks Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes how often? Daily - Weekly - Monthly - Socially - Rarely
	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor Amount? When was your last drink?
Tobacco Use	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many packs per day?
	How many years did you smoke? What year did you quit?
Drug Use	Do you currently use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever used intravenous drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine Use	If yes, what kind? Please circle: Coffee - Soda - Chocolate - Tea - Other? How many cups? How many sodas?
Employment	Occupation (past or present):
Social History	Marital Status, please circle one: Single , Married , Widowed , Divorced Who Lives in your home with you? _____ Do you have children? _____ If so how many _____
Miscellaneous	Have you ever received a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No

NAME \_\_\_\_\_ DOB \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

**Constitutional**

- Fever  Yes  No
- Headache  Yes  No
- Unexplained weight loss  Yes  No
- Other: \_\_\_\_\_

**HEENT**

- Runny nose  Yes  No
- Difficulty hearing  Yes  No
- Other: \_\_\_\_\_

**Neurologic/Psychiatric**

- Numbness  Yes  No
- Tingling  Yes  No
- Weakness  Yes  No
- Dizziness  Yes  No
- Memory loss  Yes  No
- Seizures  Yes  No
- Anxiety  Yes  No
- Spinal cord injury  Yes  No
- Headache  Yes  No
- Difficulty Sleeping  Yes  No
- Other: \_\_\_\_\_

**Metabolic/Endocrine**

- Excessive thirst  Yes  No
- Too hot  Yes  No
- Too cold  Yes  No
- Other: \_\_\_\_\_

**Immunologic**

- Hay fever  Yes  No
- Food allergies  Yes  No
- Other: \_\_\_\_\_

**Respiratory**

- Shortness of breath  Yes  No
- Wheezing  Yes  No
- Cough  Yes  No
- Other: \_\_\_\_\_

**Musculoskeletal**

- Joint pain  Yes  No
- Back pain  Yes  No
- Artificial joints  Yes  No
- Other: \_\_\_\_\_

**Cardiovascular**

- Chest pain  Yes  No
- Irregular pulse  Yes  No
- Heart attack  Yes  No
- Heart valve problem  Yes  No
- Other: \_\_\_\_\_

**Hematologic**

- Easy bruising or bleeding  Yes  No
- Blood clots in arms or legs  Yes  No
- Anemia  Yes  No
- Other: \_\_\_\_\_

**Gastrointestinal**

- Abdominal pain  Yes  No
- Nausea/vomiting  Yes  No
- Indigestion/heartburn  Yes  No
- Diarrhea  Yes  No
- Constipation  Yes  No
- Other: \_\_\_\_\_

**Genitourinary**

- Back Pain  Yes  No
- Cloudy Urine  Yes  No
- Nausea  Yes  No
- Other: \_\_\_\_\_

**Vascular**

- Cool Extremity  Yes  No
- Pain in limb  Yes  No
- Varicose Veins  Yes  No
- Other: \_\_\_\_\_

**Dermatologic**

- Rash  Yes  No
- Boils/infections  Yes  No
- Other: \_\_\_\_\_



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## ***BILLING AND FINANCIAL POLICY – pg 1***

The following sets forth the policies of BASS Medical Group. Please review this information and sign where indicated below.

- ❖ I understand that it is my responsibility to furnish BASS Medical Group with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.
- ❖ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$25.00 No Show Fee. These amounts must be cleared with our financial office prior to your next appointment.
- ❖ I understand that a cancellation fee of \$50.00 may be billed directly to myself if a 48 hour cancellation notice is not provided to our office. All cancellation fees must be cleared with our financial office prior to your next appointment.
- ❖ I understand that a surgery cancellation fee of \$250.00 may be billed directly to myself if a surgery is cancelled. This fee will also be assessed if cancellation has not been made 7 days prior to scheduled surgery date. This fee must be cleared with our financial office before surgery can be rescheduled.
- ❖ It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. BASS and/or its representatives will make every effort to assist you but BASS will not be held accountable for understanding every insurance plan.
- ❖ I understand that there is a \$15.00 fee (per form) to complete disability paperwork associated with my care.
- ❖ I understand that there is a \$45.00 fee for Urgent or non urgent Rx requests without appointments
- ❖ I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with at least 2 statements for any balance due after insurance payment. Payment in full is due within 30 days of your first statement unless other arrangements have been made. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be a final notice and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.
- ❖ We are not Medi-Cal providers. You will be responsible for all charges if you elect to see one of our physicians



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- ❖ I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of BASS Medical Group.

\_\_\_\_\_  
Legal Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Relationship to Patient





### HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 1 of 3

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPAA (the Health Insurance Portability and Accountability Act of 1996) this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

**PERMITTED USES & DISCLOSURES:** The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent *via* fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

**PATIENT RIGHTS:** The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.\* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM

❖ MAIN OFFICE ❖

20555 Prospect Road Cupertino, CA 95014 ❖ PHONE NUMBER ❖ 408-996-9339

FAX NUMBER ❖ 408-996-3550



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**HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 2 of 3**

- You have the right to request an alternate means or location to receive communications regarding your health information.\* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., *via* telephone text or email).
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

\* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent *via* Text, *via* email, or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.
- **MINORS:** We take patient privacy laws very seriously. The State of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for minors in this age range, as they may designate.

**IF PATIENT IS A MINOR, PLEASE STATE AGE: \_\_\_\_\_ AND DATE OF BIRTH: \_\_\_\_\_**

- **WHOM I DESIGNATE:** Please designate who our offices CAN disclose your health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:

This authorization to Release Health Information is voluntary.

**OK to Spouse:** Please list name, alternative address, phone number, & email address of Spouse, as applicable: \_\_\_\_\_

**OK to Family Members:** Please list name(s), alternative address, phone numbers, & email addresses of Family Member(s), as applicable: \_\_\_\_\_

**OK to Other (E.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative).** Please list name(s), alternative address, phone numbers, and email addresses of authorized person(s) or entities: \_\_\_\_\_

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**HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 3 of 3**

- OK to leave health information on answering machine, voicemail, telephone text, or email.
- DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

IF PATIENT IS A MINOR, PLEASE STATE AGE: \_\_\_\_ AND DATE OF BIRTH: \_\_\_\_\_

DO NOT RELEASE TO: \_\_\_\_\_

[Please list names, as applicable].

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

**ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT**

This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/they are signing (E.g., parent, guardian, conservator):

Name: \_\_\_\_\_

Capacity and/or Relationship to patient: \_\_\_\_\_

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.

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