David Resneck-Sannes, M.D.
5403 Scotts Valley Dr., Suite A
Scotts Valley, CA 95066
PH (831) 438 - 5222 | FAX (831) 438 - 5229

PATIENT INFORMATION FORM

Date _____

Name: _____ Birthdate: _____ Sex: M / F

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

If a minor. Parent or Legal Guardian: _____

Is patient a student? ____ Yes ____ No School Attending: _____

IN CASE OF EMERGENCY CONTACT:

Person responsible for this account: ___ Self ___ Other

Name: _____ Relationship: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

ASSIGNMENT AND RELEASE

I hereby authorize Dr. David Resneck-Sannes, M.D. to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr. Resneck-Sannes for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Signature of Responsible Party *Relationship* *Date*

NEW PATIENT HEALTH HISTORY PART 1

Patient Name: _____ Birth date: ____/____/____ Date: ____/____/____

Referring Physician: _____ Address: _____

Pharmacy Name: _____ Phone Number: ____-____-_____

Reason for today's visit: _____

Please describe this problem: _____

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non-prescription) that you take. *Include herbal remedies, vitamins, over-the-corner, street drugs, prescriptions etc.*

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin?** ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES** (Please explain below)

ALLERGY		REACTION

Do you smoke? ☐ **NO** and Never have ☐ **Yes** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ **NO** and Never have ☐ **Socially Only** ☐ **Daily** ☐ **Beer/ Wine** ☐ **Hard Liquor**
Occupation: _____ Hand Dominance: ☐ **RIGHT** ☐ **LEFT**

Please describe any family health issue below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESS/ REASON FOR DEATH
Mother			
Father			
Sibling(s)			
Other hereditary illness			

Patient Signature: _____ **Date:** _/____/____

Physician Signature: _____ **Date Reviewed:** ____/____/____

NEW PATIENT HEALTH HISTORY PART 2

Do you have or have you ever had any of the following:

Symptoms/ Illness	NO	YES, Explain	Symptoms/ Illness	NO	YES, Explain
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hermatologic			**Last Mammogram**		**Date: ___/___/___**
Hepatitis			Changes in Moles		
HIV/ Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endrocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**GENITOURINARY**		
Mobility/ Joint Problems			Genital or Oral Herpes		
GASTROINTESRINAL			S.T.D.'s		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/ Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
CARDIOVASCULAR			**Eyes**		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/DVT			**ENT**		
Blood Clots in Lungs/ Legs			Hearing Problems		
High Blood Pressures			Sinsus Problems		
RESPIRATORY			**PSYCHIATRIC**		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/ Depression		

Please list any other conditions/ illnesses not indicated above: _____

_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: _____ Date: _____/_____/_____

Physician Signature: _____ Date Reviewed: _____/_____/_____

David Resneck-Sannes M.D.
5403 Scotts Valley Dr., Suite A
Scotts Valley, CA 95066
PH (831) 438-5222 | FAX (831) 438-5229

APPOINTMENT CANCELLATION POLICY

To facilitate the best possible care and smooth patient flow, we do our best to not overbook appointments.

We will do our best to not keep you waiting, and we ask that you be prompt for your appointments.

It is extremely important that you keep your scheduled appointments.

In consideration of other patients and staff, and in an effort to work efficiently, we

require at least 24-hour notice for cancellations.

There is a $50 charge for cancellations without a 24-hour notice.

It is very important that you call us if you are unable to keep your appointment.

Our phone number is **831-438-5222** and you may leave a message 24 hours a day.

Insurance does not pay for missed or canceled appointments fee, so please call us and let us have the opportunity to make your schedule work.

Patient Signature _____ *Date* _____

Print Name _____

David Resneck-Sannes, M.D.
5403 Scotts Valley Dr., Suite A
Scotts Valley, CA 95066
PH (831) 438-5222 | FAX (831) 438-5229

FINANCIAL PAYMENT AGREEMENT

I understand that Dr. Resneck-Sannes expects payment at the time services are rendered.

I further acknowledge that I am fully responsible for payment of all charges at the time they are incurred It must be fully understood that the contract is between you and your insurance company and that you are fully responsible regardless of your coverage. We will however be willing to file your claim with your insurance company and assist you in whatever way we can.

Our office does not guarantee that your insurance company will pay. If you are having problems with your claim, we ask that you contact your insurance company directly. It is a state law that your insurance company make a payment or acknowledges your claim within 30 working days form the date we bill them. If they have not paid within 60 days from the date the services were rendered, we ask that you pay the balance due. You will be reimbursed by your insurance company when and if they pay. We will make every attempt to assist you in rebilling your claim when and if a problem should occur. We will not however rebill a claim and change codes. If you were seen for that procedure or exam then you will be billed for that procedure or exam.

Payment may be made by CASH, CHECK, or CREDIT CARD.

For all patients without insurance, we are not accepting any
CENTRAL COAST ALLIANCE, and MEDI-CAL. Any patient looking for coverage under any of these providers will be responsible for payment after service is rendered. You will be held fully reliable for payment and any reimbursement will be between yourself and your insurance provider.

Please understand that our office bills your insurance company as a convenience to you, the patient If you agree and understand the above policies please print and sign your name as well as today's date.

_____	_____	_____
Print Name	*Signature*	*Date*

David Resneck-Sannes, M.D.
5403 Scotts Valley Dr., Suite A
Scotts Valley, CA 95066
PH (831) 438-5222 | FAX (831) 438-5229

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES FOR DR. RESNECK-SANNES, M.D.

Date: _____ Time: _____

Printed Name: _____

Patient Signature: _____

(If patient/Representative/Spouse/Financially Responsible Party)

If signed by someone other than the patient, please state your legal relationship to the patient: _____

Note: If in future you would like your medical records please be informed of our office policy — you will need to sign a records release form and pay the $25 fee OR have your new medical facility fax us a signed request at 831-438-5229. Thank you for your understanding.