Gordon Tang, MD
East Bay Neurosurgery and Spine
A Medical Corporation

REGISTRATION FORM

Reset Form | Save Form | Print Form

LAST NAME	FIRST NAME	DATE OF BIRTH	GENDER ☐ Male ☐ Female	TODAY'S DATE

ADDRESS: (NO. / STREET)	CITY	STATE	ZIP

EMAIL ADDRESS (FOR ACCESS TO OUR PATIENT PORTAL)	SSN

To protect your privacy and allow for efficient scheduling, please answer the following:

☐ No, it is not ok to leave messages or voicemails. I wish to be contacted personally.

☐ Yes, it is ok to leave messages or voicemails

Please write all your contact numbers where we may leave a message

☐ Home: ☐ Mobile: ☐ Work: ☐ Other:

	Name	Contact No.
Primary Care Doctor		
Referring Doctor		
Emergency Contact		

Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Neighbor ☐ Other:

PHARMACY INFORMATION

NAME	PHONE

ADDRESS: (NO. / STREET)	CITY	STATE	ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
☐ HMO ☐ PPO ☐ Medicare ☐ Medi-cal	☐ HMO ☐ PPO ☐ Medicare ☐ Medi-cal
SUBSCRIBER NAME / DATE OF BIRTH	SUBSCRIBER NAME / DATE OF BIRTH
RELATIONSHIP ☐ Self ☐ Spouse ☐ Parent ☐ Other:	RELATIONSHIP ☐ Self ☐ Spouse ☐ Parent ☐ Other:
COPAY ☐ No ☐ Yes $	COPAY ☐ No ☐ Yes $

WORKER'S COMPENSATION ONLY

INSURANCE	DATE OF INJURY

	Name	Contact No.
Adjustor		
Employer		

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MEDICAL HISTORY FORM

LAST NAME	FIRST NAME	AGE	HEIGHT	WEIGHT	TODAY'S DATE

Describe the main problem that brings you here today:

How long have you had this problem? _____ ☐ Year(s) ☐ Month(s) ☐ Week(s)

Rate your pain most of the time (check one): ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Worse)

Where is your pain?

What makes your pain better?

What worsens your pain?

Do you have (check): ☐ Weakness ☐ Numbness ☐ Incontinence ☐ Balance Problems

What have you tried (check): ☐ Therapy ☐ Injections ☐ Other:

Are you (check): ☐ Right handed ☐ Left handed

Past or current medical problems: ☐ Check box if NONE

List all current medications and DOSAGES (or provide a list): ☐ Check box if NONE

Medicine	Dosage	Medicine	Dosage
1.		4.	
2.		5.	
3.		6.	

Allergies: ☐ No known drug allergies

Alcohol Use (check): ☐ Never ☐ Occasional ☐ Frequent ☐ Heavy

Smoking (check): ☐ Never ☐ Quit Current: # of Packs/day _____ for _____ years

Occupation: If not working, date last worked:

Marital Status (check): ☐ Single ☐ Married ☐ Divorced ☐ Widowed Do you live alone? ☐ Yes ☐ No

Family history of brain or spine problems: ☐ No ☐ Yes

Do you have (check): ☐ Check box if NONE

☐ Dizziness	☐ Diabetes	☐ Swelling of Legs
☐ Vision Problems	☐ Fevers	☐ Frequent Urination
☐ Headache	☐ Recent Weight Loss	☐ Sleep Apnea
☐ Hearing Problems	☐ Recent Weight Gain	☐ Constipation or Diarrhea
☐ Fatigue	☐ Chest Pain	☐ Erectile dysfunction
☐ Nausea/Vomiting	☐ Breathing Problems	☐ Depression
☐ Heart Problems	☐ Arthritis	☐ Problems with Anesthesia
☐ High Blood pressure	☐ Abdominal Pain	☐ Bleeding Problems

2999 Regent Street, #715 Berkeley, CA 94705 Office (510) 841-8700 Fax (510) 495-1440

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FINANCIAL POLICY FORM

Copay, coinsurance and deductible: All copays are due at the time of service. A processing fee of $10 may be assessed if you do not satisfy your insurers copay requirements at your office visit.

Surgery Deposits: A deposit for surgical services is required when a surgery date is scheduled

Balance Due on Prior Service: Payment of an outstanding balance is expected in advance of your next office visit.

Returned Check Fee: $35 fee for all returned checks. If your check is returned from the bank, future payments must be made with cash, money order or credit card.

Medical Records: $20-$30 fee to obtain a paper copy of your medical records. There is no fee for medical records transmitted through our Patient Portal. Your email is required to access our Patient Portal

Disability Forms, DMV Placards: $20 charge for each form filled out for patients or caretakers.

Collections: $35 fee for accounts turned over to the collection agency. You will be responsible for the outstanding balance in addition to the legal fees associated with the collection process.

Appointment Based Fees

Office Visit Cancellation within 24 hours of appointment	$25.00
Office Visit No Show	$50.00

HIPAA PRIVACY POLICY: Your name and signature below indicates that you have been provided our Notice of Privacy Practices on the date below. If you would like a copy, please ask the patient care coordinator.

COVERAGE AND BENEFITS: We are contracted with multiple insurance plans. It is the undersigned's responsibility to know and verify benefits and coverage. The undersigned agrees to reimburse ENBS for any deductible, copay, or coinsurance due. For non-emergency services, it is the undersigned's responsibility to ensure the insurance company has authorized the requested services and that denial of payment for lack of an authorization will be considered a denial for a noncovered benefit and payable by the undersigned.

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE: I, the undersigned, authorize payment of medical benefits to East Bay Neurosurgery and Spine, Inc. for any services furnished me by the physician. I understand that my agreement with my insurance company is a separate agreement between myself and my insurance company and that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims or benefits. I understand that in the event I have no insurance coverage, I am responsible for all billed charges.

MEDICATE / MEDI-CAL AUTHORIZATION / INFORMATION RELEASE: I request that payment of authorized Center for Medicare and Medicaid Services (CMS) and its agents benefits be made on my behalf to East Bay Neurosurgery and Spine, Inc. for any services furnished me by EBNS. I authorize release of medical information about me to CMS and its agents to determine these benefits payable for related services.

I have read and understand the above Financial Policy, HIPPA Notice of Privacy Practices, Verification of Coverage/Benefits, and Assignment of Benefits/Information Release.

NAME	SIGNATURE	DATE