Hiler & Kohlbrenner MDs
Diplomates, American Board of Surgery
3838 California Street, Suite 612, San Francisco, CA 94118
415-666-9905 Fax 415-666-9910

Patient Information Form

Name: ______________________________ **Birthdate:** ____________

Address: ______________________________ **City:** ________________

State: ______ **Zip Code** _________ **Email Address:** ____________________

Home Phone: ____________________ **Cell Phone:** ____________________

Marital Status: _________________ **Occupation:** ____________________

Employer: ____________________ **Primary Language:** ____________________

Emergency Contact: ____________________ **Relationship:** ______________

Emergency Contact Number: ________________ **Patient Portal: Yes ☐ No ☐**

Preferred Pharmacy: ______________________ **Pharmacy Phone:** _________

Who is your referring Physician: ______________________________________

I authorize insurance payment directly to my physician as well as the release of any information acquired in the course of my examination and treatment as permitted by the law and the Health Information Protection and Portability Act (HIPPA).

Signed: ______________________________ **Date:** ____________________

Patient Medical History Questionnaire

Name: ______________ (First) ______ (MI) ______________ (Last) **Birth Date:** ☐☐/☐☐/☐☐

Reason for Visit: ______________________________ **Onset:** ______________

DO YOU HAVE A HISTORY OF: (Please check all that are applicable)

Arthritis	☐	Diabetes	☐	Arterial Disease	☐
Asthma	☐	Diverticulosis	☐	Venous Disease	☐
Back Problems	☐	Esophageal Reflux (GERD)	☐	Stroke	☐
Bladder Problems	☐	High Cholesterol	☐	Seizures	☐
Blood in Stools	☐	Problems with anesthesia	☐	Thyroid Disease	☐
Breast Cancer	☐	Hypertension	☐	Stomach Ulcer	☐
Colon Cancer	☐	Kidney Disease	☐	Blood Transfusions	☐
Other Cancers	☐	Liver Disease/Hepatitis	☐	Tuberculosis	☐
Cardiac Arrhythmias	☐	Gout	☐	Bleeding Problems	☐
Heart Disease	☐	HIV Disease	☐	Chemical Dependence	☐

Have you had a colonoscopy? Yes ☐ No ☐ When? ______________

Please list all past Operations and serious illnesses: None: ☐

Operation or Illness	Year

List all Medications, Herbs or Supplements you are currently taking: None ☐

Medicine	Dose	Frequency

Please list all medications that your are allergic or react badly to: None: ☐

Medication	Reaction

Do you smoke ? Yes: ☐ No: ☐ How many packs per day? ______ For how many years? ________

Do you drink alcohol? Yes: ☐ No: ☐ How much per week? ____________________

Family Health History: (Please indicate problems your parents, grandparents, brothers, sisters, aunts, or uncles have had)

Problem	Relative	Problem	Relative
Diabetes		Kidney Disease	
Heart Disease		Arthritis	
High Blood Pressure		Asthma	
Breast Cancer		Tuberculosis	
Colon Cancer		Hernia	
Lung Cancer		Bleeding Problems	
Other Cancer (list type)		Hepatitis	
Stroke			

Review of Systems: (please circle symptoms that apply to you) **None of the symptoms below:** ☐

General Symptoms:
Severe Headaches Dizzy spell Fatigue
Weakness Night Sweats Fevers
Marked weight change Heat/Cold sensitive

Ears:
Loss of hearing Ringing in ears
Ear Drainage Earache
Room Spins

Mouth:
Sore mouth Sore gums
Sore tongue Bleeding gums
Dental problems Tooth ache

Breasts:
Lumps Discharge
Soreness Fibrocystic Disease

Lungs:
Persistent Cough Productive cough
Bloody Sputum Wheezing
Bronchitis Emphysema
Asthma Pulmonary embolus

Gastrointestinal:
Constipation Diarrhea Gallstones
Heartburn Hiatal hernia Nausea
Loss of appetite Vomiting Black stools
Jaundice Stomach ulcer Colon polyps

Skin:
New Rash Change in hair Acne
Psoriasis Change in nails Skin Cancer
Ulcerations Change in color or shape of mole

Eyes:
Need glasses Vision Change
Wear contacts Eye pain
Blindness Cataracts
Seeing Double Eye drainage

Nose:
Loss of smell Frequent colds
Snoring Nosebleeds
Allergies Sinus infections

Throat:
Postnasal drainage Sore Throat
Hoarseness Voice Change
Neck swelling Trouble swallowing

Heart:
Chest pain Palpitations
Shortness of Breath Prior Heart Attack
Can't sleep laying Flat Ankle Swelling
Calf pain with walking Pacemaker

Muscular:
Muscle cramps Muscle weakness
Joint pain Joint swelling
Back pain Neck pain

Urinary:
Incontinence Frequency Blood in urine
Infections Painful urinations
Loss of sex drive Slow stream

Neurologic:
Dizziness Memory Loss Migraines
Depression Anxiety Sleeplessness
Poor Balance Paralysis Seizures

Reviewed with patient by: ____________________
Kevin R. Hiler MD

atient Name: ____________________

Date: __________

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Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: ______________________________.

Signed: ______________________________ Date: ___________________________

Print Name: ___________________________ Telephone: ______________________

If not signed by the patient, please indicate your relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: ____

For Office Use Only:

- ☐ Signed form received by: _______________________________
- ☐ Acknowledgment refused:

Efforts to obtain:

____

____

Reasons for refusal:

____

____

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Arbitration Agreement

ARTICLE 1

It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2

a. Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Provider" as used in this Agreement includes the undersigned doctor, nurse practitioner, nurse midwife, or other health care provider and his or her professional corporation or partnership, and any employees, agents, successors-in-interest, heirs, and assigns of the foregoing individuals or entities. The provider signing this Agreement signs it on behalf of all the foregoing individuals and entities, and intends to bind each of them to arbitration to the full extent permitted by law.

b. Treatment Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Provider and Patient will be subject to compulsory, binding arbitration.

c. Other Providers (If Applicable). Patient understands that he or she may at times receive treatment from one or more health care providers who take call for, render medical services by arrangement with, or otherwise substitute for the undersigned Provider. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such health care providers will also be subject to compulsory, binding arbitration.

d. Coverage of Prenatal Claims (If Applicable). Patient understands and agrees that, if Provider treats her during pregnancy, any dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

ARTICLE 3

a. Informal Resolution of Disputes. In the event Patient feels that an issue has arisen in connection with the medical care rendered by Provider, Patient will promptly notify Provider so that the parties may have an opportunity to resolve the matter informally.

b. Method of Initiating Arbitration. If the issue cannot be resolved informally, Patient may initiate arbitration by sending a written demand to the Provider briefly describing the nature of his or her claim. Patient and Provider shall each designate an arbitrator to act as their respective party arbitrators. If more than two parties participate in the arbitration, parties aligned with Patient shall select one party arbitrator, and parties aligned with Provider shall select the other party arbitrator. The two party arbitrators shall select a third person to serve as a neutral arbitrator, and the decision of the three arbitrators shall be final and binding upon the parties.

c. Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d. Interpretation of Agreement. If any part of this Agreement is held unenforceable, it shall be severed and shall not affect the enforceability of the remainder. This Agreement supersedes and replaces any previous arbitration agreement between Provider and Patient and applies to all care previously rendered by Provider to Patient.

ARTICLE 4

a. Rescission. Once signed, this Agreement governs all subsequent medical services rendered by Provider to Patient until or unless rescinded by written notice within 30 days of signature. Written notice may be given by a guardian or conservator of Patient if Patient is incapacitated or a minor.

NOTICE; BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient's Name *(Please Print)*: ______________________________

Dated: ______________________ Signed: ______________________________

Provider's Name *(Please Print)*: ______________________________

Dated: ______________________ Signed: ______________________________