Ted Shen M.D., Inc.

301 S. Fair Oaks Ave
Suite 406
Pasadena, CA 91105
Phone (626) 737-6200

225 S. First Ave
Suite 201
Arcadia, CA 91006
Fax (626) 737-6202

Patient Information Date: ______________________

Patient Name: ____
LAST FIRST MIDDLE

Address: ____
STREET & APT # CITY STATE ZIP

Home Ph#: ______________ Mobile Ph#: ______________ Other Ph#: ______________

Any restrictions for contacting you? ❑ No ❑ Yes: ______________________

May we leave detailed messages on your voicemail or answering machine? ❑ No ❑ Yes

Email: ______________________

Birthdate: _____ / _____ / ________ Age: ______ SSN: ______________ Sex: ❑ Male ❑ Female

Race: ______________________ Primary Language______________________

Marital Status: ❑ Single ❑ Married to: ______________ ❑ Other: ______________

Referred by: ______________________Primary Care Physician:______________________

Employer/School: ______________________ Occupation: ______________

Work Ph #: ______________ Ext: ________ Is it ok to call you at work? ❑ Yes ❑ No

Emergency Contact: ______________________ Relationship: ______________

Home #: ______________ Mobile #: ______________ Other #: ______________

Preferred Pharmacy Name: ______________

Pharmacy Address: ______________________ Pharmacy Phone #: ______________

I hereby authorize direct payment of surgical/medical benefits to Ted Shen M.D., Inc. for services rendered by Dr. Shen or persons under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.
I hereby authorize Ted Shen M.D., Inc. to release any medical/incidental information that may be necessary for medical care or in the processing of applications for financial benefit.
I certify that all the information given by me in applying for payment is correct. I authorize release of all records upon request.
I request that payment of authorized benefits be made on my behalf.
I understand that office visit charges are payable on the day service is rendered. I authorize Ted Shen M.D., Inc. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. If my balance is not paid within 120 days of service date, it will be sent to collections and a 15% fee will be added to the total.

I hereby acknowledge that I have been presented with a copy the Notice of Privacy Practices of Ted Shen M.D., Inc 225 S. First Ave #201, Arcadia, CA 91006; Fax: 626.737-6202.

Signature: ______________________ Date: ______________

Name (if Signed By Parent/Guardian): ______________________

Patient Questionnaire

Patient Name: ___________________________ Today's Date: ___________________

Birthdate: _______________________

Allergies: List all medications and foods as well as reaction to them ❑ No Known Allergies

_______________________________ _______________________________ _______________________________

_______________________________ _______________________________ _______________________________

Medications: List current medications and dosage if possible ❑ None

_______________________________ _______________________________ _______________________________

_______________________________ _______________________________ _______________________________

Past medical history: List all medical condition ❑ None

_______________________________ _______________________________ _______________________________

_______________________________ _______________________________ _______________________________

Past Surgical History: List all prior surgeries ❑ None

_______________________________ _______________________________ _______________________________

_______________________________ _______________________________ _______________________________

Family History: Pleases list medical conditions of blood relatives ❑ None

_______________________________ _______________________________ _______________________________

_______________________________ _______________________________ _______________________________

Social History:

Tobacco Usage:

❑ Never Smoker
❑ Current Someday Smoker
❑ Current Every day Smoker
❑ Vape Smoker
❑ Former Smoker

Alcohol Usage:

❑ None
❑ Occasional (1-2 drinks)
❑ Social (1-2 drinks)
❑ Daily 1-2 drinks
❑ Daily 2-5 drinks
❑ Daily >5 drinks
❑ Daily Alcoholic

Recreational Drug Usage:

❑ None
❑ Marijuana
❑ Other: ____________

Have you experienced any falls or problems with balance in the last year? ❑YES ❑NO

Height ___'____" Weight _______ lbs.