**LORENZO BROWN, M.D. A Professional Corporation**
**103 South Locust St Inglewood CA 90301 Phone (310) 412-3277 Fax (310) 412-3223**

**ASSIGNMENT OF MEDICAL BENEFITS**

I hereby request and authorize that insurance payments be made directly to **LORENZO BROWN, MD. INC.** for all medical and surgical services rendered to me or my dependents by **LORENZO BROWN, M.D.** in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I understand that I am financially responsible for payment should my insurance not be in effect at the times services are rendered.

**AUTHORIZATION FOR** RELEASE FOR INFORMATION

I hereby authorize *(leave blank)*_____ to release to **Lorenzo Brown, M.D.** any medical, financial or incidental information that may be necessary for treatment, payment or healthcare operations. I authorize release of all records and information that may be necessary for treatment, payment and/or healthcare operations. I authorize the release of those records by fax and electronic transmittal.

**CONSENT FOR TREATMENT**

I hereby authorize I hereby give my consent to treatment necessary for myself or my dependent. I certify that the information provided by me to secure payment for myself or my dependents by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

**These assignments and authorizations shall remain in effect for the duration of treatment until revoked in writing**. A photocopy of these assignments shall be valid as the original.

Patient (print)_____ Date_____

Parent/Guardian (print)_____ **SIGNATURE** _____

**PATIENT INFORMATION** **LORENZO BROWN, M.D. INC.**

NAME _____ Female _____ Male _____

Age _____ Date of Birth _____ Marital Status S M D W MINOR

Home Address _____
City State Zip Code

Statement Address _____

Home Phone ( ) _____ Work / Cell Phone ( ) _____

Social Security # _____ Drivers License # _____

Occupation _____ Employer _____

**PRIMARY INSURANCE** **Put "SAME" if information is the same as the Patient**

1. INSURED Name _____ Insured Date of Birth _____

Insured Social Security # _____ Insured Driver's License # _____

Home Address _____

**Employer** _____ **Address** _____

Occupation _____ **Work Phone # (** **)** _____ EXT _____

**Insurance Carrier** _____ **Insurance Phone #** _____

**Policy # / ID #** _____ **Insured Relationship to patient** _____

**SECONDARY INSURANCE** **Put "SAME" if information is the same as the Patient**

2. INSURED Name _____ Insured Date of Birth _____

Insured Social Security # _____ Insured Driver's License # _____

Home Address _____

**Employer** _____ **Address** _____

Occupation _____ **Work Phone # (** **)** _____ EXT _____

**Insurance Carrier** _____ **Insurance Phone #** _____

**Policy # / ID #** _____ **Insured Relationship to patient** _____

**PERSON TO BE CONTACTED IN AN EMERGENCY**

Name _____ Relationship to Patient _____

Phone # _____ Address _____

I understand that professional services rendered to the patient is PAYABLE AT THE TIME OF SERVICE and payment in full is my responsibility should my insurance fail to pay for services rendered.

I hereby assign all medical and/or surgical benefits to Lorenzo Brown, M.D. Inc. for professional services rendered. I authorize the release of all information necessary to secure payment. I certify that the above information is correct.

Signature _____ Date _____

Lorenzo Brown MD

Medical History 2017

**PATIENT** _____ **DOB**_____ **DATE:** _____

**Reason(s) for seeing doctor today**_____

**Today are you experiencing or complaining of any of the following symptoms? (circle)**

| | | | | | | |
|---|---|---|---|---|---|---|
| **GENERAL** | **Weight loss** | **Dizziness** | **Sleep Problems** | **Snoring** | **Sinus Problems** | **Thyroid Problem** |
| **EARS** | **Ear pain** | **Ear Discharge** | **Hearing Loss** | **Ear Infections** | **Ringing/buzzing in ears** | **Ear wax** |
| **NOSE** | **Nosebleeds** | **Nose Odors** | **Runny/Stuffy Nose** | **Nasal Sores** | **Nasal Growths** | |
| **THROAT** | **Hoarseness** | **Loss of Voice** | **Growths in Neck** | **Dry Cough** | **Sore Throats** | |
| | **Tonsillitis** | **Cancer of throat** | **Difficulty Swallowing** | **Tracheostomy** | **Difficulty speaking** | |
| **MOUTH** | **Loss of Taste** | **Dry Cough** | **Growths/Sores in mouth** | **Cancer of mouth** | **Difficulty Eating/Chewing** | |

**SOCIAL HISTORY:** (CIRCLE) **SINGLE MARRIED WIDOWED DIVORCED** _____

(CIRCLE) **UNEMPLOYED DISABLED RETIRED HOUSEMAKER WORKING OCCUPATION(S):** _____

**MEDICAL HISTORY** Do you have any of the following medical problems: (circle either) **YES or NO**

| | | |
|---|---|---|
| Y N **AIDS/HIV** | Y N **DEPRESSION** | Y N **HYPERTHYROID** |
| Y N ALCOHOLISM | Y N EMPHYSEMA | Y N HYPOTHYROID |
| Y N **ANEMIA** | Y N **EPILEPSY** | Y N **KIDNEY FAILURE** |
| Y N ANGINA | Y N GOITER | Y N **PACEMAKER** |
| Y N **ARTHRITIS** | Y N **HEPATITIS** | Y N SEIZURES |
| Y N ASTHMA | Y N HEART ATTACK | Y N **STROKE** |
| Y N **COPD** | Y N **HEARTBURN** | Y N **PROSTATE Problem** |
| Y N DIABETES | Y N HEART FAILURE | Y N **JEHOVAH'S WITNESS** |
| Y N **DRUG ABUSE** | Y N **HYPERTENSION/HIGH BLOOD PRESSURE** | |

**ALLERGIES or Other Medical Problems NONE** _____

**FAMILY MEDICAL HISTORY NONE** _____

**SMOKING Never Smoked Former Smoker –Year Stopped** _____ **Occasional smoker Amount/Day/Year** _____

**Daily smoker- #/day/years** _____

**ALCOHOL** _____ **NEVER** _____**DAILY** _____ **MONTHLY** _____ **SOCIALLY** _____

**DRUG USE** _____**NEVER** _____**FORMER** _____ **DECLINE TO ANSWER MARIJUANA COCAINE** _____

**MEDICATION ALLERGIES NONE PENICILLIN SULFA** _____

**MEDICATIONS MY LIST IS ATTACHED (___)** _____

_____

**PHARMACY**_____ **Phone #** _____ **ZIP CODE**_____

**PREVIOUS SURGERY NONE** _____

**PREVIOUS SURGERY PROBLEMS NONE BLEEDING YES NO OTHER PROBLEMS:** _____

**PREVIOUS HOSPITALIZATIONS NONE** _____

**DOCTORS** _____ * _____ * _____ * _____ * _____

| **PRIMARY M.D** | **CARDIOLOGY/HEART** | **PULMONARY/LUNG** | **KIDNEY/DIALYSIS** | **ONCOLOGY** |
|---|---|---|---|---|

**DATE REVIEWED** _____ _____ _____ **LORENZO BROWN MD**

*LORENZO BROWN, M.D., INC. 103 South Locust St Inglewood, CA 90301 (310) 412 3277*

## ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

**I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:**
***Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**
***Obtain payment from designated third-party payers.**
***Conduct normal health care operations such as quality assessments or evaluations and physician certifications.**

**I hereby acknowledge that I have received or have been given the opportunity to receive a copy of LORENZO BROWN, M.D., INC. Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.**

_____ _____
Patient Name (Type or Print) Patient's Date of Birth

_____ _____
Signature of Patient or Parent/Legal Guardian Date

## Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my healthcare. In that case, Lorenzo Brown, M.D., INC. will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Name _____ Relationship: _____

Name _____ Relationship: _____

Name _____ Relationship: _____

_____ _____
Patient Name (Type or Print) Patient's Date of Birth

_____ _____
Signature of Patient or Parent/Legal Guardian Date