Glenn Martin Lipton MD AMC

Welcome! We are excited to have you as a patient. We have enclosed our "New Patient" packet. This packet must be completed prior to your appointment. If you arrive for your appointment and the packet is incomplete, we may need to reschedule your appointment. We urge you to include recent MRI and/or Xrays with your paperwork. Please bring your insurance card and photo ID and copayment, if applicable.

Office hours are by appointment only Monday thru Friday 8:30am to 5:00pm. The office is closed on Fridays and major U.S. holidays. If you have an emergency after hours, call 911. Parking is available at both of our offices. The Marina Del Rey office has a parking structure that you can enter from Lincoln. The parking is free for the first 15 minutes, $3.50 for the first 30 minutes, $5.00 for the first 45 minutes, and $7.50 for the first hour. After the first hour, parking will be $11. The Santa Monica office also has parking available, please enter from 23rd street. Parking is $1.75 for every 15 minutes with a maximum of $12.

We appreciate 24 hours notice for cancelled appointments. ***No Shows*** for initial consultations will not be rescheduled. Established patients that ***no show*** are subject to a fee. Multiple no shows will result in cancellation of all appointments. Late arrivals may have to be rescheduled. We place reminder calls to all patients the day before their scheduled appointment; Monday's patients are called on Friday. Should you need to cancel after hours, please leave message on our answering machine.

If you are ill, we ask that you reschedule your appointment for the health of the staff and other patients. Our procedures cannot be performed on individuals with fever, chills, vomiting, diarrhea, or coughing or those taking antibiotics.

All copayments are due at the time of service; we are unable to waive any copayments. If you have insurance and do not have your card with you, you could be responsible for payment in full at time of service. Please inform us of any changes in name, address, or insurance. Non covered services are the patient's responsibility.

Workman's Compensation patients must supply our office with all necessary information to process claims, such as case worker's name and telephone number, address, case number and authorization number. Failure to provide this information prior to your appointment will result in cancellation of your appointment until this information is received and verified. We do not accept out of state Workman's Compensation. We do not perform disability exams.

Insurance authorizations can take up to 21 business days to approve depending on insurance carrier. We accept a wide variety of insurances and will keep you informed of our progress or problems we may encounter during the authorization process.
Phone messages are picked up throughout the day and returned in 24 hour or next business day. Please be sure to leave your full name, phone number and nature of your call. Avoid leaving multiple calls.

Thank you and we look forward to seeing you soon.

Appointment Date______________________________ Time:______________________

4644 Lincoln Blvd Suite 530
Marina Del Rey, Ca 90292

Phone: 310-997-2383
Fax: 310-507-7950

2222 Santa Monica Blvd Suite 200
Santa Monica, Ca 90404

Glenn Martin Lipton MD AMC

PATIENT DEMOGRAPHICS

Patient Name:____Date______________
(LAST, FIRST)

Home Address:____
STREET CITY STATE ZIP CODE

Home Phone: ________________ Work Phone: ______________ Cell Phone: ________________

Fax #: ____________________ E-mail: ______________________________________

Can we leave a message? Yes / No Preference ☐ Email ☐ Phone (Circle one) Cell/Home/Work

Date of Birth: ______________ Age: ______SS #: _______________ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partnership

Occupation: _____________________________ Employer:______________________________

Employer Address: ____________________________________ Phone:_____________________

Emergency Contact: __________________________________ Phone: ____________________

Relationship:____

INSURANCE INFORMATION

Primary Insurance: __________________________ID#:________________________________

Insurance Address: ____
STREET CITY STATE ZIP CODE

Insurance Phone: ______________ Group#: _______________ ☐ HMO ☐ PPO ☐ POS ☐ EPO

Relationship to Patient (choose One) ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holders Name: ______________________________DOB: ________SS#_________

Secondary Insurance: __________________________ID#:_________________________

Insurance Address: ____
STREET CITY STATE ZIP CODE

Insurance Phone: ______________ Group#: _______________ ☐ HMO ☐ PPO ☐ POS ☐ EPO

Relationship to Patient (choose One) ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holders Name: ______________________________DOB: ________SS#_________

****PLEASE PROVIDE YOUR INSURANCE CARD(S) FOR US TO MAKE COPIES****

Glenn Martin Lipton MD AMC

Is this a Workman's Comp Claim: Yes / No Is this from an Automobile Accident: Yes / No

Name of Company: ____ Phone #: __________________

Claim Number: ______________________ Date of injury/incident_____________________________

Case Worker Name: ____
____

How were you referred to Dr. Lipton? ☐Existing Patient / Friend ☐Online ☐Advertisement ☐Physician

Please explain: ____

PHYSICIAN INFORMATION

Primary Care Physician: ____ Phone: _______________

Cardiologist: ____ Phone: _______________

Other Specialist: ____ Phone: _______________

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information acquired in the course of treatment required to process this claim or to provide information for my further and continued treatment.

Patient/Legal Guardian____ Date________________

Printed Name____ Date________________

MRN_______________

Glenn Martin Lipton MD AMC

AUTHORIZATION FOR MEDICAL CARE AND BILLING

I do hereby consent to such medical and/or surgical examination and treatment as necessary, and I authorize Dr. Glenn Martin Lipton MD AMC to release to third party sources information to obtain payment for services rendered.

I also consent and/or authorize Dr. Glenn Martin Lipton MD AMC to release to any referring health care professional and/or any entity information necessary for evaluation and treatment.

I certify that the information I have given Dr. Glenn Martin Lipton MD AMC is true and correct to the best of my knowledge. I understand that supplying false information may deny myself treatment and potentially result in my discharge from this medical practice.

Authorized Signature____

Witnessed by____

Date: ____

NOTE: Anyone other than patient may sign as Witness

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HIPPA AUTHORIZATION

For Use or Disclosure of Health Care Information

By signing this form, I ____ authorize the use of disclosure of my health information as described below:

Description of Information:

_______ Medical Records _______ Radiology _______ Other

Name or Class of person(s) authorized to make the use or disclosure:

_______ Self _______ Spouse _______ Family _______ Trustee _______ Other

Name or identification of person(s) authorized to receive the information:

_______ Spouse _______ Primary Physician _______ Family _______ Other

Expiration Date (if any): ____

Description of each purpose of the requested use or disclosure: ___________________________

____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this information, I must do so in writing and send it to: 2222 Santa Monica Blvd Suite 200, Santa Monica, Ca 90404

I understand that it is possible that information used or disclosed with me permission may be re-disclosed by the recipient and no longer protested federal Privacy Standards.

____ ______________________________

Signature of Patient or Guardian** Date

____ ______________________________

Print Name of Patient Print Name of Guardian

***If an authorization is signed by an individual's personal representative, the representative's authority is based on :

____

(e.g. State law, court order, etc.)

// Glenn Lipton, M.D.
Board Certified in Pain Management & Anesthesiology
Fellowship in Interventional Pain Management
ABA-PM, DABPM, ABIPP

TIN:45-4328319

Release of Information & Assignment of Benefits Form & Receipt of Privacy Policy

Name of Insured (print): ____

Social Security Number: ____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Glenn Lipton, MD, Inc. for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/ or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I either received a copy of the organization's Notice of Privacy Practices or that I am aware of them. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights. You are entitled to a copy of this consent after you sign it.

Name of person signing below (print): ____

Relationship to Insured: ____

Signature of Insured or Parent/Guardian: ____

Date: ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Release of Information, Assignment of Benefits form, and Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please specify):

Glenn Martin Lipton MD AMC

Initial Evaluation

Date _________________

Name: _______________________________________Date of Birth: _______________________

How long have you had pain? _______ Days _______ Weeks _______ Months _______ Years

Please circle all that apply:

Where is your Pain Located:
Low Back Legs Buttocks Hips
Mid-Back Feet Neck Shoulders
Arm Hand Other: _________________

How would you describe your pain:
Sharp Aching Throbbing Burning
Shooting Stabbing Stinging Tingling
Chronic Acute

What makes your pain better?____

What makes you pain worse? ____

How would you rate the severity of your pain? _1-2 Mild _3-4 Moderate _5-6 Severe _7-10 Very Severe

Do you have pain all the time or does it come and go? __________________________________

Have you had any difficulty controlling your bowel or bladder? __________YES __________NO

What brought on your pain? ____

What Triggers your Pain? ____

Is your pain worse at rest or with activities? (Circle one)

What over the counter medication have you tried for your pain? _________________________

What prescribed medications have you tried for your pain? _____________________________

Have you tried?

Hot/Cold Packs	____Yes ____No	
Physical Therapy	____Yes ____No	If Yes When_____________________
Steroid Injections	____Yes ____No	If Yes When_____________________
Nerve Blocks	____Yes ____No	If Yes When_____________________
Nerve stimulation-TENS unit	____Yes ____No	If Yes When_____________________
Surgery	____Yes ____No	If Yes When_____________________
Acupuncture	____Yes ____No	If Yes When_____________________
Chiropractic	____Yes ____No	If Yes When_____________________
Massage Therapy	____Yes ____No	If Yes When_____________________

Herbal Supplements/alternative treat meant? Please Explain: ___________________________________

____

How has the intensity of your pain changed: ____

____

Did your pain come: Sudden Onset __________ Over Time __________

What usual activities are you unable to do because of your pain?________________________________

____

Does your pain interfere with your daily activities? If so, which activities:

_____ Job Duties _____ Sleeping _____ Walking _____ Standing _____ Sitting _____ Personal Care
_____ Interactions with others _____ Other (______________________)

Have you had this pain before? ______Yes ______No

Do you have any weakness, numbness or tingling in your extremities? (Circle one)

If so which? ___ RT Arm ___ LT Arm ___RT Leg ___LT Leg

Have you had any of the following performed?

X-ray ____Yes ____No If Yes When: _____________Where:______________________

CT Scan ____Yes ____No If Yes When: _____________Where:______________________

MRI ____Yes ____No If Yes When: _____________Where:______________________

Myelogram ____Yes ____No If Yes When: _____________Where:______________________

Nerve Conduction Studies ____Yes ____No If Yes When: __________________ Where: ______________

Are you currently or could you possibly be pregnant? ______Yes ______No

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Past Surgical History:

Surgeries	Year	Surgeries	Year

Have you ever had general anesthesia: ___Yes ___No Did you have problems with it: ____Yes ______No
If Yes, describe: ____

Medications:

Please list all current medications, dosage, how many you take daily, and estimated start date:

Medication	Dose	Qty	Est Start Date

Do you take Blood Thinners:

_____ Coumadin/Warfarin ____ Plavix ____ Pradaxa ____ Aggrenox _____ Eliquis _____ Xarelto
_____ Aspirin 325mg

Medical Allergies (circle) YES NO

If yes, please list medical allergies and your reaction to the medication(s):

Allergies	Reaction	Allergy	Reaction

Any problems with nonsteroidal anti-inflammatory drugs such as Motrin, Aleve, Ibuprofen, Aspirin:
YES, NO
If yes, please describe: ____
____

Glenn Martin Lipton MD AMC

Family History:

Do any diseases run in your biological family? If yes, please list below

Problem	Problem

Social History: (circle all that apply)

Single Married Divorced Separated Widowed

Exercise: Level: Daily Weekly Monthly Rarely Never
Type: Walking Gym Hiking Swimming Aerobics Bicycling Running
Other: ____

Tobacco Usage:

Product/Usage:	Daily	Packs/Day	Occasional/Social	How Many Years
Cigarettes	__________	____________	__________________	________________
Pipe	__________	____________	__________________	________________
Cigar	__________	____________	__________________	________________
Chewing Tobacco	__________	____________	__________________	________________

If Stopped tobacco use:

When did you quit:___________________

Number of Years Used: _______________

Alcohol Usage:

Product/Usage:	Daily	Weekly	Occasional	Social	If you stopped, When:
Beer	_______	_______	_______	_______	____________________
Wine	_______	_______	_______	_______	____________________
Hard Liquor	_______	_______	_______	_______	____________________
No Alcohol Use	__________________				

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Past Medical History: (Please check any of the following which you had)

- ☐ Urinary Problems
- ☐ Heart Disease
- ☐ Arthritis/Gout
- ☐ Cancer
- ☐ Liver Problems
- ☐ Hypertension
- ☐ Kidney Problems
- ☐ Diabetes/Hypoglyc emia
- ☐ Drug Abuse/Alcohol Abuse
- ☐ Gastrointestinal Problems/Ulcers
- ☐ Depression or Psychological Problems
- ☐ Problems with Ears, Eyes, Nose, Throat
- ☐ Respiratory Circulatory/CVA Problems

Please explain any of the checked above: ____

____

____

____

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PAIN DESCRIPTION

Where is your pain right now?

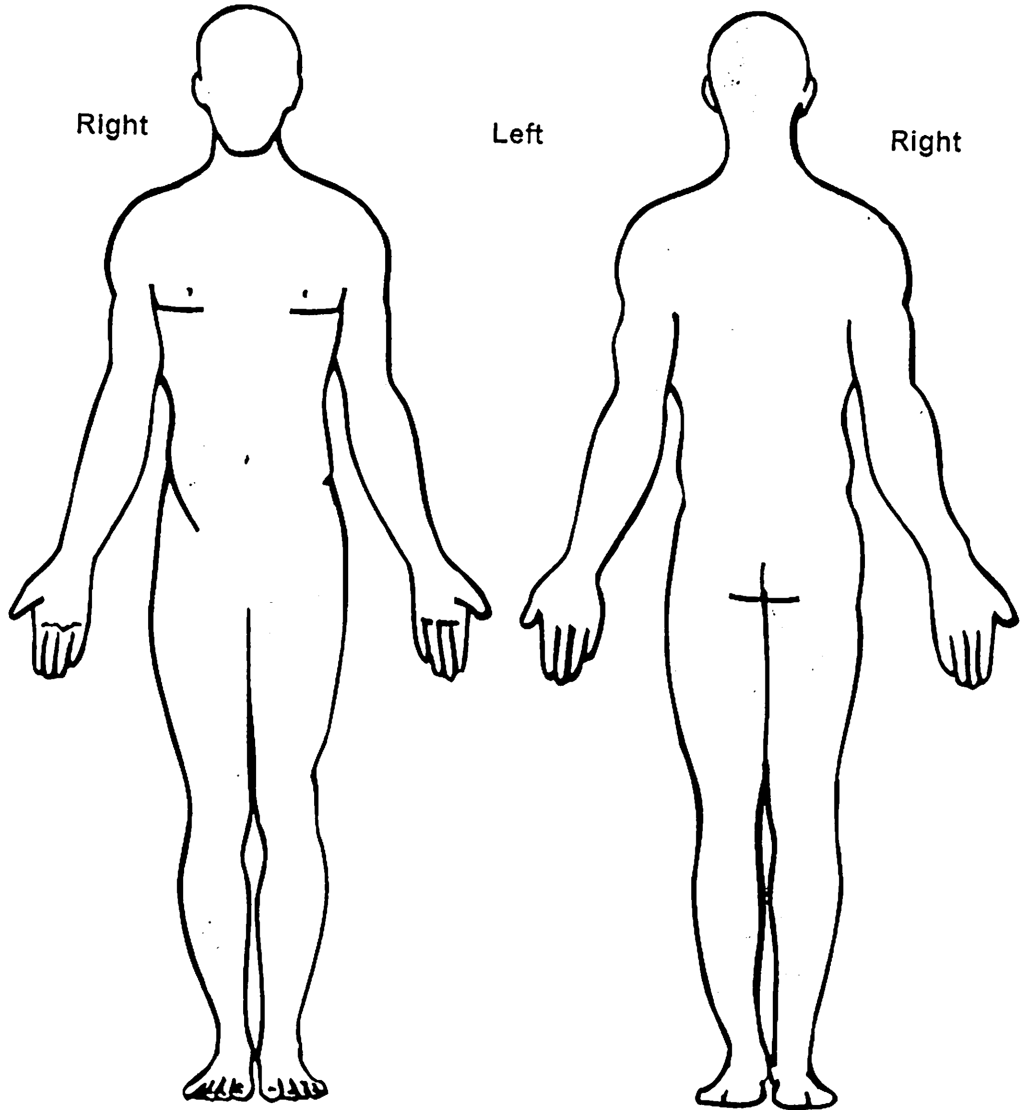
INSTRUCTIONS: Mark the areas on the body below where to where you hurt. (If the right side of your neck hurt, mark the drawing on the right side of the neck, etc.) Please indicate which sensations you feel by referring to the key below.

KEY	
ΛΛΛ	Ache
000	Numbness
■■■	Pins & Needles
XXX	Burning
///////	Radiating Pain

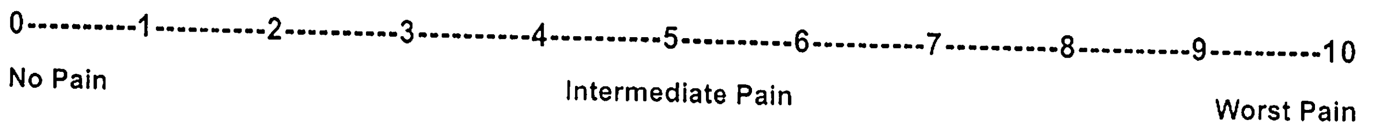
I can tolerate my pain at a pain score of:

Please check the box the best indicates the duration of your pain:

- ☐ Continuous
- ☐ Positional
- ☐ Intermittent (on/off)
- ☐ Unable to Rate



How bad is your pain right now? (indicate on the line)



PATIENT'S SIGNATURE

DATE

Glenn Martin Lipton MD AMC

Review of Systems: Are you currently having or have you ever had problems with:

HEAD:
____ Lymph Node Swelling
____ Tumors

EARS:
____ Hearing Loss
____ Tinnitus

NOSE:
____ Seasonal Allergies
____ Nasal Obstruction
____ Nose Bleeds

CHEST:
____ Shortness of Breath
____ Asthma
____ COPD/Emphysema
____ Pulmonary Embolus

CARDIAC:
____ High Blood Pressure
____ Stroke
____ Mini Strokes
____ Heart Attack
____ Chest Pain
____ Coronary Artery Dz
____ High Cholesterol
____ Atrial Fibrillation
____ Arrhythmia
____ Peripheral Vascular Dz
____ Congestive Heart Failure
____ Stent Placement
____ Pacemaker
____ Defibrillator
____ Blood Clots

URINARY:
____ Incontinence
____ Frequent Urination
____ Kidney Stones
____ Testicular Pain
____ Renal Failure
____ Dialysis
____ Enlarged Prostate

ORTHOPAEDIC:
____ Joint Pain
____ Joint Swelling
____ Joint Replacement
____ Muscle Tenderness
____ Muscle Spasms
____ Osteoporosis
____ Osteopenia
____ Arthritis – Rheumatoid
____ Arthritis – Osteo

NEUROLOGICAL:
____ Blacking Out
____ Seizures
____ Headaches
____ Difficulty Walking
____ Balance Problems
____ Multiple Sclerosis
____ Cerebral Palsy
____ Parkinson's
____ Other Neurological Problems

PSYCHOLOGICAL:
____ Claustrophobia
____ Anxiety
____ Depression
____ Bi-Polar Disorder
____ Post Traumatic Stress Disorder

CANCER:
____ Breast
____ Lung
____ Colon
____ Bladder
____ Prostate
____ Other

ENDOCRINE:
____ Diabetes
____ Thyroid

ABDOMEN:
____ Acid Reflux
____ Constipation

MISCELLANEOUS:
____ Fibromyalgia
____ Chronic Fatigue Synd
____ Lupus

DO YOU USE:
____ Cane
____ Walker
____Wheelchair
____ Power Scooter
____ Other

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Physical Examination: **Physician Use Only – DO NOT WRITE ON THIS PAGE**

Chief Complaint:____
____

General: ________ Age _______Male _______Female

Vital Signs: Ht:__________ Wt:__________ B/P:_______/_______ P:_______ R:_______
Skin:____
HEENT:____

	Left Right
Neck:____	__________________
Chest:_______________________________________	__________________
Heart:_______________________________________	__________________
Abdomen:_____________________________________	__________________

Musculoskeletal:_______________________	Facet:	____________	Flex:__________
	Facet Load:	____________	Extension:______
	SI:	____________	
Extremities:__________________________	G/T:	____________	
	Patricks:	____________	
	SLR's:	____________	

Neurological:_____________________________________

Data:____

Impression:____
____

Plan:____
____
____