Robert Ruder, MD
8816 Burton Way, Fl 1
Beverly Hills, CA 90211

Patient Information Form

*Name*_____ *Date of Birth:*_____ *Age:*____
Last name *First name* *M.I.*

*Social Security#:*_____ *Home#:*_____ *Work #:*_____

*Cell Phone:*_____ *Fax:*_____ *E-Mail:*_____

*Home Address:*_____ *City:*_____ *Zip Code:*_____

*Spouse's Name:*_____ *Wk Phone#:*_____

*Primary Physician:*_____ *Phone#:*_____

*Emergency Contact:*_____ *Phone#:*_____

*Referred by:*_____ *Phone:*_____

INSURANCE INFORMATION

Name of Policy Holder:_____

Primary Insurance Co.:_____ ***Group #***_____

Subscriber/Policy #:_____ ***Customer Service #***_____

Co-Payment:$_____

Secondary Insurance:_____ ***Group #***_____

Subscriber/Policy #:_____ ***Customer Service #***_____

Co-Payment:$_____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information and completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____
Signature *Date*

_____ _____
Parent (if minor) *Date*

Robert Ruder MD
8816 Burton Way 1st Floor
Beverly Hills, Ca 90211
310-285-9612

ELIGIBILITY CERTIFICATION

SUBSCRIBER_____

INSURANCE_____

SUBSCRIBER ID #_____

I , _____, am eligible for insurance benefits on or as of _____(DATE). I understand that PROSPECT HEALTHSOURCE MEDICAL GROUP is the medical group chosen for all members of the contact under which I am covered. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to the service provided to me. I agree that if the above is not true(or the person financially responsible for me) will pay in full all such charges.

_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

ID # (IF NOT SUBSCRIBER)_____

RELATIONSHIP TO SUBSCRIBER_____

DATE_____

Robert Ruder, MD
8816 Burton Way, Fl 1
Beverly Hills, CA 90211

NOTICE OF PRIVACY PRACTICES

To Our Patients:

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy:

Our practice is dedicated to maintain the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with following important information:

Use and Disclosure of Your Health Information in Certain Special Circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings is response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. Right to a copy of this notice. You are entitled to receive a copy of the Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with Secretary of the Department of Health and Human Services. To file a complaint with our practices, contact Robert Ruder, M.D. All complaints must be submitted in writing. You will not be penalized for filling a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the office of Robert Ruder, M.D.

I hereby acknowledge that I have been presented with a copy of Robert Ruder, M.D. Notice of Privacy Practices.

Name of Patient: _____

Patient Signature: _____

Date: _____

Robert Ruder, MD
8816 Burton Way, 1st Floor
Beverly Hills, CA 90211
Tel: (310) 285-9612

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement or our Financial Policy, which we require you to read and sign prior to any treatment.

1. All patients must complete our information sheet.
2. FULL PAYMENT IS DUE AT THE TIME OF SERVICE. IF YOU DO NOT HAVE INSURANCE.
3. We accept cash or checks.

Regarding Insurance

We bill insurance companies as a courtesy to our patients. However, the balance is your responsibility whether your insurance company pays or not. In order for us to bill your insurance, our patients must accept responsibility for providing the following documents:

a. A current doctor prescription ordering therapy stating diagnosis, frequency and duration; updated as necessary, unless not required by your insurance company.
b. Copy of insurance card.

Please be aware that this office will require payment in full treatment rendered if these documents are not provided. Your insurance policy is a contact between you and your insurance company. We are not a party to that contract. If your insurance company fails to pay the expected percentage or has not paid within 45 days, THE PATIENT IS RESPONSIBLE FOR THE ENTIRE UNPAID BALANCE. It is the patient's responsibility to follow up with the insurance company to ascertain the status of their claim.

If we are the participating provider for your insurance plan, you will be required to pay a co-payment/co-insurance for services rendered. You co-payment/co-insurance may be a fixed dollar amount per visit, or it may be a percentage of eligible charges. Since it is impossible to tell beforehand what your exact co-payment/co-insurance will be, we will bill you once we have received payment from your insurance company. If you have deductible, payment is expected at the time of service.

I understand that I am fully and completely responsible for the knowledge of my policy benefits and limits, including numbers of visits payable on my policy. I will stay within my financial capabilities in this regard.

MISSED APPOINMENT – LATE CANCELLATIONS

Unless canceled at least 24 hours in advance, our policy is to charge **$25.00 for missed appointments**. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of patient or responsible party Date

Dr. Robert Ruder, MD
8816 Burton Way
Beverly Hills, CA 90211

Name:_____ Date:_____

1. Do you have trouble with your hearing (loss, muffled, clogged)? Yes No
   Left Ear Right Ear
   Both Ears

2. Do you have ringing/ noise (tinnitus) in your ears? Yes No
   Left Ear Right Ear
   Both Ears

3. Have you ever been exposed to loud noise? Yes No

   Where? _____

4. Have you had ear infections? Yes No

5. Do you have ear pain? Yes No

6. Do you have dizziness? Yes No

7. Is there a history of hearing loss in your family? Yes No

   Who? _____

8. Have you ever had head trauma? Yes No

   Explain: _____

Medical History Questionnaire

Section 1- Review of Systems: Do you experience any of the following symptoms? Check all that apply:

Constitutional:
- □ Fever
- □ Chills
- □ Unintentional weight loss or gain
- □ Night sweats
- □ Unusual Fatigue

Eyes:
- □ Recent change in vision
- □ Double vision
- □ Eye pain
- □ Redness
- □ Discharge

Neurological:
- □ Drooped face
- □ Memory loss
- □ Numbness or tingling
- □ Weakness
- □ Slurred speech
- □ Imbalance
- □ Changes in gait

HENT:
- □ Headaches
- □ Ear Pain
- □ Ear Discharge
- □ Hearing loss
- □ Ringing in the ears
- □ Nasal Congestion
- □ Lesions
- □ Tooth pain
- □ Difficulty Swallowing
- □ Sore throat
- □ Lumps or swelling of the neck
- □ Neck pain

Cardiovascular:
- □ Heart racing
- □ Chest pain or discomfort
- □ Swelling of the legs
- □ Pain in the calves while walking
- □ Irregular heartbeat
- □ Blueness to the skin
- □ Varicose veins
- □ Lightheadedness
- □ Fainting

Respiratory:
- □ Cough
- □ Shortness of breath on exertion
- □ Wheezing
- □ Chest pain
- □ Coughing up blood
- □ Snoring
- □ Daytime sleepiness
- □ Shortness of breath

Genitourinary:
- □ Difficulty with urination
- □ Flank pain
- □ Burning while urination
- □ Blood in the urine
- □ Cloudy Urine
- □ Foul-smelling urine
- □ Urinary urgency or frequency
- □ Decrease in force of stream
- □ Vaginal or penile discharge
- □ Incontinence
- □ Changes in sex life
- □ Dissatisfaction with sex life
- □ Difficulty maintaining an erection
- □ Genital sores or lesions

Gastrointestinal:
- □ Heartburn
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Blood in the stool or toilet paper
- □ Black Stools
- □ White Stools
- □ Abdominal pain
- □ Change in the size of stools
- □ Yellow skin
- □ Changes in appetite/taste
- □ Unexplained GI distress
- □ Food Intolerance

Integumentary/Breast:
- □ Changes in skin color, texture or moisture
- □ Rashes
- □ Lesions
- □ Itching
- □ Hair loss or growth
- □ Change in hair texture
- □ Nail changes
- □ Breast swelling
- □ Breast tenderness
- □ Breast lumps
- □ Breast dimpling
- □ Breast discharge

Musculoskeletal:
- □ Pains in the joints
- □ Pains or cramping of the muscle
- □ Weakness
- □ Joint swelling or pain

Psychiatric:
- □ Depression
- □ Anxiety
- □ Thoughts of harming self/others
- □ Hallucinations
- □ Eating Disorder

Endocrine:
- □ Excessive urination
- □ Excessive hunger or thirst
- □ Heat or cold intolerances
- □ Hallucinations

Hematologic/Lymphatic:
- □ Easy bruising or bleeding
- □ Passing out or nearly passing out
- □ Enlarged lymph nodes

Allergy/Immunologic:
- □ Recurrent infections
- □ Eczema

Other unlisted symptoms:

Section 2: Medical Conditions- Have you had or do you currently have any of the following medical conditions.

Check all that apply:

Constitutional:
- □ Cancer Type: _____
- □ Vitamin deficiency
- □ Physician restricted activity level

HEENT:
- □ Head Injury
  - □Date:_____
- □ Wears corrective lenses

Neurologic:
- □ Seizures
- □ Stroke or TIA

Cardiovascular:
- □ History of heart murmur
- □ History of Rheumatic fever
- □ History of heart failure
- □ Congenital heart disease
- □ Pacemaker or AICD
- □ Heart Attack
- □ Heart Catheterization
- □ Bypass or other surgery
- □ High blood pressure
- □ High cholesterol level
- □ Poor circulation

Gastrointestinal:
- □ Malabsorption
- □ Reflux
- □ Ulcers
- □ Pancreatitis
- □ Diverticulitis
- □ Hepatitis

Endocrine:
- □ Diabetes or pre-diabetes
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Low blood sugar-Hypoglycemia

Respiratory:
- □ Bronchitis
- □ Pneumonia
- □ Asthma
- □ COPD or Emphysema

Hematologic/Immulogic:
- □ HIV/AIDS
- □ Anemia
- □ Mononucleosis

Genitourinary:
- □ Pregnant or less than 6 weeks post partum
- □ Hernia
- □ Premature Menopause
- □ Sexually Transmitted Infections

Musculoskeletal:
- □ Fibromyalgia
- □ Arthritis
- □ Bursitis
- □ Knee, ankle or foot problems or injuries
- □ Shoulder, elbow, wrist or hand problems or injuries
- □ Broken Bones
- □ Osteoporosis
- □ Back pain disorder or injury

Other Unlisted Medical Conditions:

_____

_____

_____

_____

Allergies:	**List:**	**Reaction:**
Food	_____	_____
Environmental	_____	_____
Drugs	_____	_____

Surgical History		**Hospitalization History**	
Procedure:	**Date:**	**Cause:**	**Date:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Section 3 - Medications, Herbals and Supplements

Name	Dose	Frequency

Section 4 - Social History:

Do you consume **caffeine**? □ No □ Yes

If yes, then amount per day? _____

Do you drink **alcohol**? □ No □ Yes

If yes, type of alcohol consumed: _____

Number of drinks per occasion: _____

Number of days per week: _____

One drink = 1oz hard liquor, 6 oz wine or 12 oz beer

Current Weight: _____

Weight range over the past 1 year: _____

Satisfaction with current weight:

□ Not Satisfied □ Fairly Satisfied
□ Satisfied □ Extremely Satisfied

Marital Status:

□ Married □ Divorced □ Single □ Life Partner

Have you ever used **tobacco**? □ No □ Yes

If yes, then age use started: _____

Age stopped: _____or current (circle)

Amount per day: _____

If yes, type of tobacco used: (Check)

□ Cigarettes □ Cigars □ Smokeless

Work and Home Environment

Occupation: _____ Physical Setting: _____

Mark all that apply: □ Close contact with persons who are health care professionals

□ Lives in a household with children

□ Frequently travel internationally or plan to travel internationally

Section 5 - Adult Immunization History

Check all that apply:	Check all that apply:
□ Recent exposure to measles	Have you ever had?
□ Lives in a community with mumps outbreak	□ Measles □ Mumps □ Rubella □ Chickenpox
	□ Shingles □ Unknown which one? _____

Age _____

Immunizations	**Circle one**	**Date of last immunization**
Seasonal Influenza	None Unknown	Date _____
Tetanus, Diphtheria, and Acellular Pertussis (Td/Tdap)	None Unknown	Date _____
Varicella (Chickenpox) Vaccination	None Unknown	Date _____
Human Papillomavirus (HPV) Vaccination	None Unknown	Date _____
Herpes Zoster Vaccination	None Unknown	Date _____
Measles, Mumps, Rubella (MMR) Vaccination	None Unknown	Date _____
Pneumococcal Polysaccharide (PPSV) Vaccination	None Unknown	Date _____
Meningococcal Vaccination	None Unknown	Date _____
Hepatitis A Vaccination	None Unknown	Date _____
Hepatitis B Vaccination	None Unknown	Date _____
Haemophilus Influenzae Type b (Hib) Vaccine	None Unknown	Date _____

Section 6- Are you interested in Cosmetic Surgeries / Procedures

Nose_____
Face_____
Eyes_____
Skin_____

Botox_____
Restylane_____
Collagen_____
Other_____

Are you happy with the appearance of your Nose? _____

Section 7 - Family History: Circle as applicable

Relative:	Age:	Living or Deceased:	Medical Conditions:	If deceased, cause of death:
Mother	____	L / D	_____	_____
Father	____	L / D	_____	_____
Brother/ Sister	____	L / D	_____	_____
Brother/ Sister	____	L / D	_____	_____
Brother/ Sister	____	L / D	_____	_____
Brother/ Sister	____	L / D	_____	_____
Brother/ Sister	____	L / D	_____	_____
Son/ Daughter	____	L / D	_____	_____
Son/ Daughter	____	L / D	_____	_____
Son/ Daughter	____	L / D	_____	_____

Heart attack or stroke in family member prior to age 50? Yes No

Other conditions that run in the family _____

If additional space needed, please continue on back

ALLERGY HISTORY

Date:

Patient's Name: Last First Initial Sex: Age:

Street City State Zip

Home Telephone No. Area Code Number

Parent's Name Last First Initial

To be filled out by patient Your answers to the following questions will help to determine the cause of your allergy symptoms. It is important to check (✓) each question as accurately as possible.

	YES	NO	Don't Know
Have trouble with your skin?			
Eczema			
Hives			
Have trouble with your ears?			
Popping			
Itching			
Hearing loss			
Fluid in ears			
Infection/Pain			
Have trouble with your throat?			
Frequently sore/drainage			
Itching throat/mouth			
Have trouble with your eyes?			
Redness			
Itching			
Tearing			
Puffiness			
Have trouble with your nose?			
Clear/colorless discharge			
Thick/colored discharge			
Nasal itching/rubbing			
Constant stuffiness			
Periodic stuffiness			
Sniffles			
Sneezing			
Mouth breathing or snoring			
Have troubles with your chest?			
Wheezing with colds			
Wheezing when exposed to dust, pollen, animal, etc.			
Wheeze/cough/after exercise			
Cough? What kind?			
Deep/or productive			
Loose			
Constant			
Dry/tight			
Daytime			
Nighttime			
Are your symptoms mild?			
Moderate			
Severe			
Present most of the time			
Present part of the time			
Present rarely			
Interfering with your life			
Preventing many normal activities			

Which of the following do you think cause your symptoms or make them worse?	YES	NO	Don't Know
Indoors			
Outdoors			
At home			
At work			
Morning			
Afternoon			
At night			
Weather change			
Wet weather			
Dry weather			
Windy day			
Hot day			
Cold day			
Air conditioning			
In barns			
Damp areas			
Hay, circus			
Mowing lawn			
Dusty environment			
High air pollution			
Animals			
Cooking odors			
Smoke			
Soap powder			
Insecticides			
Paint fumes			
Perfumes			
Cosmetics			
Wave sets			
Newspapers			
Wool			
Road dust			
Milk or milk products			
Eggs			
Wheat products			
Nuts, beans, or seeds			
Chocolate			
Fish			
Meat			
Fruit			
Vegetables			
Alcoholic beverages			
Cheese, mushrooms			
Beer			
Wine			
Aspirin			
Chemicals (list):			

Drugs (list):

During what months do you usually have symptoms?	YES	NO	Don't Know
All months			
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Describe what symptoms bother you most

When did your condition begin?

Do you use medication regularly for nasal symptoms?			
What medication?			
Does it help?			
Do any of your blood relatives have allergies?			
Have you ever had skin tests for allergies?			
Do you have allergies?			

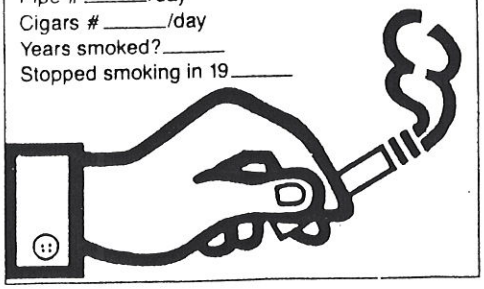
What are you allergic to?

Is there anything else about your problem which you think might be important or unusual?

More questions on reverse side...

	YES	NO	Do Kn;
Smokers in your home?			
Do you smoke?			

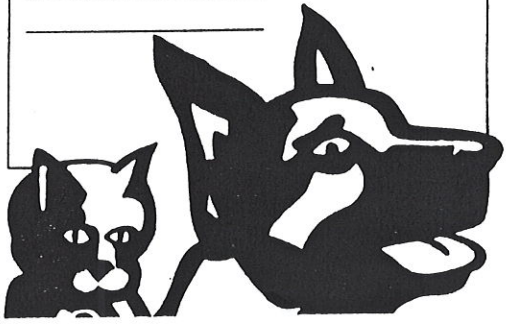
Cigarettes # _____/day
Pipe # _____/day
Cigars # _____/day
Years smoked? _____
Stopped smoking in 19 _____



Do you take medications daily or frequently?			
Aspirin			
Cortisone			
Laxatives			
Sedatives			
Birth control pills			
Vitamins			
Ointments			
Nose drops/sprays			
Hormones			
Others (list):			

Do you spend a good deal of time in activities?			
Photography			
Carpentry			
Camping			
Sewing			
Gardening			
Painting			
Cooking			
Movies			
Hobbies (list):			
Sports (list):			
Other (list):			

Do you have animals in your home?			
Have you ever had animals in your home?			
Dog			
Cat			
Bird			
Rodent			
Other (list):			

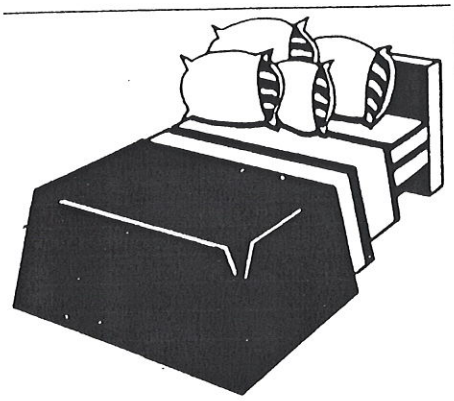


	YES	NO	Don't Know
Do you live in: House?			
Apartment?			
In the city?			
In the suburbs?			
Is your dwelling: New?			
3–10 years old?			
11–25 years old?			
> 25 years old?			

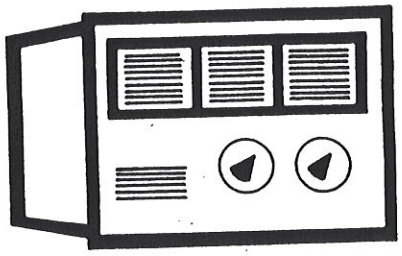
Have you had any of the following?			
High blood pressure			
Migraine headaches			
Skin disease			
Heart disease			
Frequent headaches			
Sinus disease			
Stomach disease			
Asthma			
Nasal polyps			
Emphysema			
Broken nose			
Overactive thyroid			
Bronchitis			
Nasal surgery			
Underactive thyroid			
Hay fever			
Deviated septum			
Hormonal difficulty			
Hives			
Food allergy			
Drug allergy (describe):			
Other conditions (describe):			
Are you taking medication for any of the previous conditions? (describe):			
Do you think your occupation has anything to do with your symptoms?			
Describe your occupation:			
Are any materials used in your occupation that you think have something *to do with your condition*? (describe):			
At work, are your symptoms better?			
Worse			
The same			

	YES	NO	Don't Know
Do you sleep with a pillow?			
Is it dacron?			
Is it foam rubber?			
Is it feather?			
Other (describe):			

Is your mattress cotton?			
Feather			
Foam rubber			
Horse hair			
Other (describe):			



Do you use a humidifier?			
Do you have an air conditioner?			
At work			
At home			
In bedroom			
Central			



Is your heating system oil?			
Gas			
Coal			
Electric			
Other (describe)			
Is heat delivered by blower?			
Radiators			
Electric panels			
Other (describe)			