WESLEY A. KING, M.D.

8436 W. 3rd STREET SUITE 800
LOS ANGELES, CALIFORNIA 90048
TEL: 310.385.1918 FAX3 :323.433.7016

NEUROLOGICAL SURGERY

NAME:_____ AGE:_____ DATE OF BIRTH:_____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HANDEDNESS: RIGHT_____ LEFT_____ SEX: MALE_____FEMALE_____

MOBLIE NUMBER:_____ BUSINESS:_____

HOME:_____ E-MAIL:_____

S.S. NUMBER:_____ DRIVER'S LICENSE:_____

OCCUPATION:_____ EMPLOYER:_____

EMERGENCY CONTACT:_____

PHONE NUMBER:_____ RELATIONSHIP:_____

REFERRING PHYSICIAN

NAME:_____

ADDRESS:_____

_____

PHONE:_____

PRIMARY PHYSICIAN

NAME:_____

ADDRESS:_____

_____

PHONE:_____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE:_____

ID NUMBER:_____

GUARANTOR:_____

GUARANTOR S.S. #_____

INSURANCE PHONE:_____

SECONDARY INSURANCE: _____

ID NUMBER:_____

GUARANTOR:_____

GUARANTOR S.S. #_____

INSURANCE PHONE:_____

REASON FOR VISIT? (CHIEFT COMPLAINT)

_____

Place an X in the appropriate box if the patient has been diagnosed with any of the following illnesses:

NEUROLOGICAL PROBLEMS (BRAIN/ SPINE)

STROKE	YES ____ NO ____
SEIZURES	YES ____ NO ____
TUMOR	YES ____ NO ____
DICS DISEASE	YES ____ NO ____

CARDIOVASCULAR PROBLEMS (HEART)

CONGENITAL HEART DEFECT	YES ____ NO ____
HEART MURMUR	YES ____ NO ____

RESPIRATORY PROBLEMS (LUNGS)

ASTHMA/ WHEEZING	YES ____ NO ____
PNEUMONIA	YES ____ NO ____

ENDOCRINE PROBLEMS (HORMONES)

THYROID	YES ____ NO ____
DIABETES	YES ____ NO ____
GROWTH DELAY	YES ____ NO ____

GASTROINTESTINAL PROBLEMS (STOMACH/ COLON)

REFLUX (spitting up)	YES ____ NO ____

GENITOURINARY PROBLEMS

RENAL DYSFUNCTION	YES ____ NO ____
KIDNEY INFECTIONS	YES ____ NO ____
URINARY TRACT INFECTIONS	YES ____ NO ____

DERMATOLOGY PROBLEMS (SKIN)

RASH	YES ____ NO ____
ECZEMA	YES ____ NO ____

OPHTHALMOLOGY PROBLEMS (EYES)

STRABISMUS (eye crossing)	YES ____ NO ____
NYSTAGMUS (eye shaking)	YES ____ NO ____
BLURRED VISION	YES ____ NO ____

HERMATOLOGICAL PROBLEMS (BLOOD)

BLEEDING PROBLEMS	YES ____ NO ____
ANEMIA	YES ____ NO ____

OTOLARVNGOLOGY PROBLEMS (EAR, NOSE, AND THROAT)

EAR INFECTIONS	YES ____ NO ____
SINUS PROBLEMS	YES ____ NO ____

MUSCULOSKELETAL PROBLEMS

FRACTURES	YES ____ NO ____

PHYCHIATRIC PROBLEMS

DEPRESSION	YES ____ NO ____
ADD/ ADHD	YES ____ NO ____

RISK FOR EXPOSURE TO HIV	YES ____ NO ____
PAST HISTORY OF HEPATITIS	YES ____ NO ____
PAST BLOOD TRANSFUSIONS	YES ____ NO ____
POSSIBLE PREGNANCY (women of childbearing age)	YES ____ NO ____

SIGNATURE OF PATIENT/ PARENT: _____ DATE:_____

MEDICAL HISTORY

WERE YOU EVER HOSPITALIZED? IF SO WHEN? _____

WERE THERE ANY COMPLICATIONS?_____

WERE YOU IN THE ICU? YES____ NO____
ARE YOU ALLERGIC TO LATEX? YES____ NO____

PAST SURGERIES? _____

_____

CHRONIC MEDICAL CONDITIONS: _____

ALLERGIC TO ANY MEDICATION: _____

CURRENT MEDICATIONS: (if more space is needed., please use the back of this sheet)

NAME	DOSAGE FREQUENCY	REASON FOR TAKING
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY: (what illnesses run in your family?)

_____

_____

WHAT PROCEDURES HAVE YOU HAD FOR THE TREATMENT OF YOUR CURRENT PROBLEM? PLEASE CIRCLE ALL THAT APPLY.

1. SURGERY
2. NERVE BLOCKS
3. TEROID INJECTIONS
4. PHYSICAL THERAPY
5. TENS UNIT
6. PSYCHOLOGICAL COUNSELING
7. RELAXATION TRAINING
8. BIOFEEDBACK
9. CHIROPRACTIC TREATMENT

SOCIAL HISTORY

MARITAL STATUS: SINGLE ____ MARRIED ____ DOMESTIC PARTNER ____ SEPARATED ____ DIVORCED ____ WIDOWED ____

DO YOU SMOKE? YES ____ NO ____ HOW MANY DAYS? _____ HOW MANY YEARS? _____

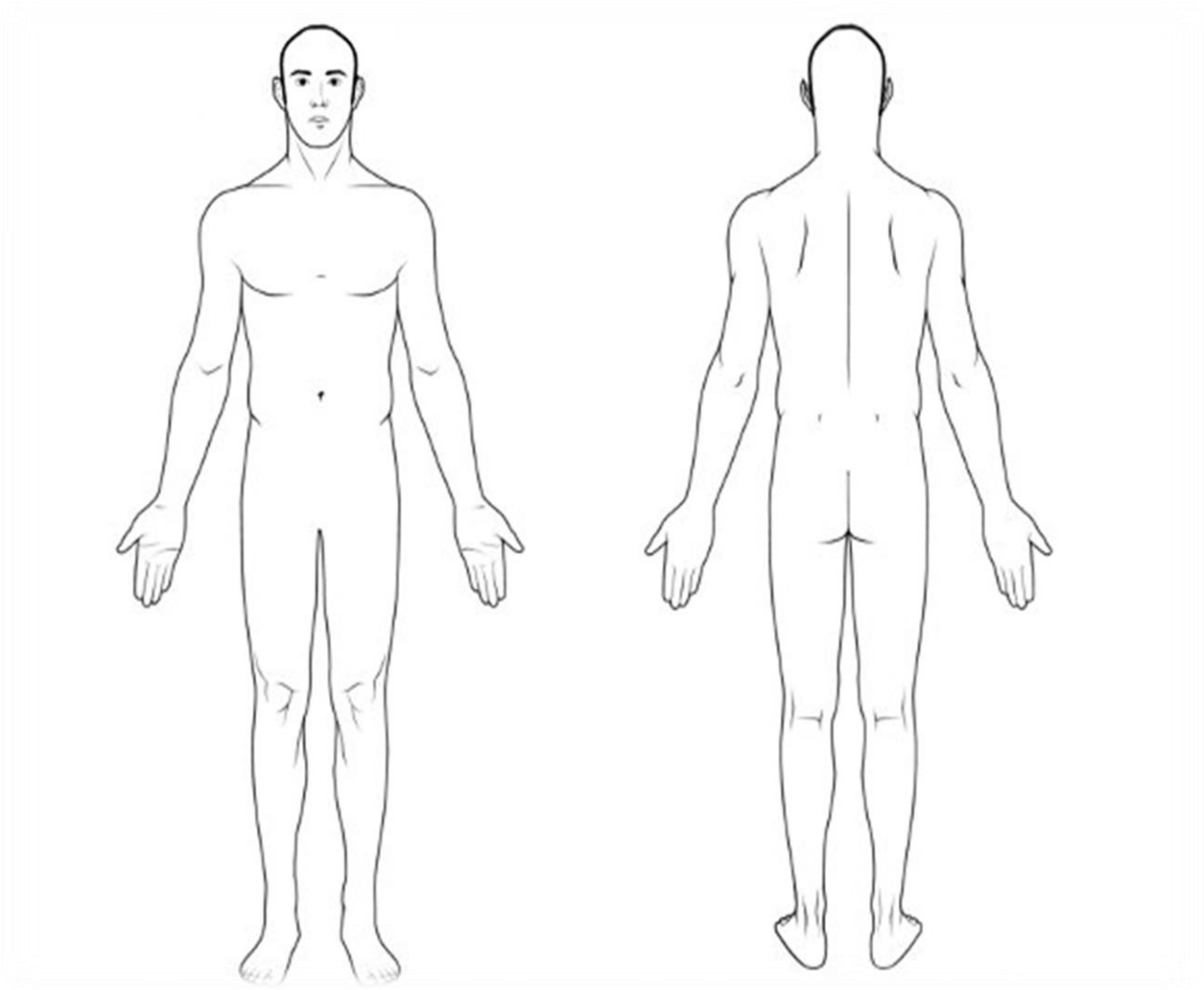
DO YOU CONSUME ALCOHOL? YES ____ NO ____ HOW OFTEN? _____ HOW MANY YEARS? _____

BODY SHEET

1. PLEASE INDICAATE THE LOCATION OF YOUR PAIN. USING THE SYMBOLS BELOW, MARK WHICH AREA(S) OF THE BODY ARE INVOLVED.

000 - PINS & NEEDLES
XXX - BURNING
/// - STABBING
*** - ACHING
~~~ - NUMBNES

RIGHT LEFT LEFT RIGHT



FRONT BACK

2. ON THE PAIN SCALE AND THE FACE SCALE BLOEW, CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR PAIN.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OUT OF NETWORK BENEFITS

I understand that I have an insurance policy, which allows me to use both in network and out of network providers.

X At this time, I am choosing the OUT OF NETWORK benefits of my insurance policy. Where I can choose any doctor of my choice with no authorization. I fully understand that I may be responsible to pay a yearly deductible, co-payments, and any portion that is not covered by my insurance company.

X At this time, I am choosing the PPO portion of my policy. I understand that I may be responsible for a deductible, co- payments, and any portion that is not covered by my health insurance company.

NON- PROVIDER

X At this time, I am choosing Dr. King as my neurosurgeon. I am fully aware Dr. King is a non-provider for my for my insurance company. Therefore I may be responsible for a higher co- payment, deductible, or any portion not covered by my insurance company.

SIGNATURE:_____ DATE:_____

PRINT NAME:_____

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our us or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You may submit your request in writing to Wesley A. King, M.D. Telephone: (310) 385-1918.

4. You may ask to amend your health if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment your request must be made in writing and submitted to Wesley A. King, M.D. 8436 W. 3rd St. Suite 800, Los Angeles, CA 90048. Telephone: (310) 385-1918. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Wesley A. King, M.D. 8436 W. 3rd St. Suite 800, Los Angeles, CA 90048.
   Telephone: (310) 385-1918. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide and 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 Wesley A. King, M.D. 8436 W. 3rd St, Suite 800, Los Angeles, CA 90048. Telephone: (310) 385-1918

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NEUROLOGICAL SURGERY

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 because of the Health Insurance Portability Act of 1996 (HIPAA).

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 the following important information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

THE FOLLOWING CIRCUMSTANCES MAY REQUIRE US TO USE OF DISCLOSE YOUR HELATH INFORMATION:

1. To the public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and the 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. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

I HEREBT ACKNOWLEDGE THAT HAVE BEEN PRESENTED WITH A COPY OF WESLEY A. KING, M.D. NOTICE OF PRIVACY.

SIGNED: _____ DATE: _____

PRINT NAME: _____

RECORD RELEASE AUTHORIZATION

TO: _____

_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY RECORDS TO:

WESLEY A. KING, M.D.

8436 W. 3rd STREET SUITE 800
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To complete history records in your possession, concerning my illness and/or treatment during the period from _____ to _____ .

PATIENT NAME: _____

ADDRESS: _____

_____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

I understand that I have a right to receive a copy of my Medical Records, with this authorization, if requested by me.

NOTE TO THE PROVIDER: Failure by a physician or podiatrist to provide the requested records within 15 days of receipt of the request and authorization may be construed to be a violation of section 2225.5 of the Medical Practice Act and may result in further action by the Medical Board.

This authorization will expire 90 days from the signature date.

I understand that I have the right to revoke this authorization at any time. By signing below, I revoke the above signature to release records to the physician listed.

SIGNATURE: _____ DATE: _____

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AUTHORIZATION, ASSIGNMENT OF BENEFITS AND ACKNOWLEDGMENTS

I hereby authorize payment by my insurance carrier(s) directly to Wesley A. King, M.D., A Medical Corporation and any and all medical associated, for medical services rendered and all major medical benefits.

I understand and agree that I am financially responsible for all charges regarding the servicing of my health care needs regardless of any insurance claims or coverage. Should the insurance carrier fail to pay any portion of my charges, I understand and agree that I will be responsible for the remaining charges and agree to pay the charges in timely manner. I do hereby waive and fully give up my right to claim that these charges are not collectible by any reason of any applicable statute of limitations or by any applicable bankruptcy filing or defense.

I agree that any payment made directly to me from the insurance carrier will be signed over to Wesley A. King, M.D., A Medical Corporation, within 7 days of receipt.

If my account is referred to an attorney for collection or other local action, I agree to pay all reasonable attorney fees and expenses of collection services. I understand and agree that a late charge of 1.5% or $10.00 per month (whichever is greater) will be charged on accounts past due 60 days or more.

I certify that the insurance information contained on the Patient Information Sheet is accurate and correct and that the insurance coverage set forth on such is in effect as of the date of this form.

I authorize Wesley A. King, M.D., A Medical Corporation, to release any information or medical records which are reasonably necessary to process any claim which may have a bearing on benefits payable by any carrier or benefit plan.

I agree that a photocopy of this signed form is valid as the original and may be used in place of the original signed form.

PATIENT SIGNATURE: _____ DATE:_____

PRINT NAME: _____