H. MILANO MELLON, M.D., INC.
915 Myrtle Ave.
Inglewood, CA 90301
Phone: (310) 673-3133
Fax: (310) 673-4277
E Fax: (888) 730-4070

ASSIGNMENT TO PAY PHYSICIAN DIRECTLY

I HEREBY AUTHORIZE AND REQUEST PAYMENT DIRECTLY TO:
H. MILANO MELLON, M.D., INC.
THE MONETARY REIMBURSEMENTS OTHERWISE PAYABLE TO ME UNDER TERMS OF MY HEALTH INSURANCE POLICY.

THIS IS A LIEN, IT IS NOT REVOKABLE.

_____ _____/_____/_____
LEGAL SIGNATURE OF INSURED DATE

_____ _____
NAME OF PATIENT WITNESS

_____
RELATIONSHIP IF DIFFERENT FROM
THE PATIENT

Check the disease against which you have been immunized and give the year of the last immunization. (marque las immunizadiones que a recibido Y en que ano).

___Polio/Yr ___Hepatitis/Yr ___Rubella/Yr ___Influenza/Yr
___Pneumonia/Yr ___Tetanus/Yr ___Mumps/Yr ___Measles/Yr
If received during childhood, please check here_____.

Please identify current prescriptions and non-prescription medications, including vitamins, nutritional supplements and oral contraceptives (por favor indique medicamientos que este tomando incluyendo vitaminas, suplementos de nutricion y contraceptivos orales.

Medication (medicamiento)	**Dose** (dosis)	**Frequency** (frequencia)	**Medication** (medicamiento)	**Dose** (dosis)	**Frequency** (frequencia)
1)			2)		
3)			4)		
5)			6)		
7)			8)		
9)			10)		

*Please identify other medications you have used recently. (por favor indique otros medicamients que haya tomado anteriormente):_____
_____

Allergies (alergias): Have you had allergies or sensitivity to medicine or other substances (a tenido alergia o sensibilidad a medicamientos o otras substancias)? ___Yes (si) ___No
If yes, please list and describe reaction (si contesto si indique las reacciones):
_____

Have you taken cortisone-type drugs (a tomado drogas typo-cortizone)? __Yes (si)__No ____Date

Have you received a blood transfusion (a recibido transfusion de sangre)? __Yes (si)___No ___Date

Menstrual history (historia menstrual) Age of onset (edad que empeso) _____
Last period (ultimo periodo _____Periods are (periodo es) Regular _____Irregular_____
Last pap smear (ultimo papanicolao)_____# of pregnancies (# de embarazos)_____
# of miscarriages/abortions (abortos)_____#of living children(# de hijos vivos)_____

YOUR Medical History: Please check illnesses or conditions **YOU** have or have had (historia del paciente, por favor marque las enfermedades o condiciones que **usted** tiene o a tenido).

__Bleeding disorder (desorden de la sangre)	__Glaucoma (glacoma)	__Rheumatic fever (fiebre reumatica)	__Cancer
__Kidney disease (enfermedad de rinon)	__Stroke (apoplejia)	__Syphilis/gonorrhea	__Pneumonia
__High blood pressure (alta preccion)	__Heart disease (enfermedad del corazon)	__Hepatitis	__Asthma
		__Arthritis	__TB

Please list any of your other medical problems not listed above._____

_____

_____

Have you had any injuries, broken bones, etc. (a tenido alquna herida seria, fractura, etc?)
___Yes (si) ___No
Type of injury When?
_____/_____
_____/_____

Please list any operations you ever had. (por favor escriba alquna cirugia que a tenido):
Type (tipo) When (cuando)? Where (donde)?
1)_____/_____/_____
2)_____/_____/_____
3)_____/_____/_____

Please list any hospitalizations you ever had. (por favor escriba hospitalizaciones que a tenido):
Why (porque)? When (cuando)? Where (donde)?
1)_____/_____/_____
2)_____/_____/_____

*Do you use tobacco? ___Yes (si) ___No Type (tipo)_____
Avg daily amount (cantidad diaria)_____How long (cuanto tiempo)?_____
Have you quit (ha pardao)?__Yes (si) __No How long ago (hace cuanto tiempo)?_____
Age when started (edad que empeso)_____
Total years smoked (total de anos)_____

*Do you use alcohol beverages (usa bebidas alcolicas)? ___Yes (si) ___No
Type (tipo) _____Avg.daily amount (cantidad diaria)_____
Have you quit (ha pardao)?__Yes (si) __No How long ago (hace cuanto tiempo)?_____
Age when started (edad que empeso)_____
Total years drinking (total de anos)_____

Name (Nombre)_____ Date (fecha)_____
Home# (telefono de casa)_____Work#(trabajo)_____Cell#_____
Place of Birth (pais de nacimiento)_____Religion_____
Race or nationality of parents (raza o nacionalidad de padres)_____

Do you have a living will or other advanced directive? (Tiene un testamento o otras direccione?)
Yes (si) _____ No _____

Education, highest level (ultimo grado de educacion)_____Occupation (Ocupacion)_____
Did a physician send you? (Fue referido por un doctor?) Yes (si)_____No_____
Physician Name (nombre del doctor)_____
Address (domicilio)_____City(ciudad)_____Zip_____

IF REQUESTED, MAY WE FORWARD YOUR MEDICAL INFORMATION (INCLUDING PSYCHOLOGIC, SICKLE CELL ANEMIA AND ALCOHOL/DRUG ABUSE AND TREATMENT TO OTHER HEALTHCARE PROVIDERS? Yes (si)_____No_____
Signature (firma)_____

Present marriage (year married)_____Previous marriage(year & duration)_____
Matrimonio presenete(ano de casamiento)_____Matrimonio anterior(ano y duracion)_____

Family History/Historia Familiar

Living (Yes/No) Viven (Si/No)	**ages or ages at death (edades o edades al fallecer)**	**present health or cause of death (estado de salud o causa de muerte)**
Father (padre)_____	_____	_____
Mother(madre)_____	_____	_____
Brothers(hermanos)_____	_____	_____
Sisters(hermanas)_____	_____	_____
Children(Hijos)_____	_____	_____
Spouse(Marido/a)_____	_____	_____

Have any of the below illnesses occurred in any of your blood family members (algunas de edtas enfermedades an occurido en su familia de sangre)?

__Bleeding Disorder (desorden de sangre)
__Stroke (apoplejia)
__High Blood Pressure (alta presion)
__Allergies (alergia)
__Nerve Disorder (desorden de los nervios)
__Kidney Disease (enfermedad del rinon)
__Heart Disease (enfermedad del corazon)
___TB (tuberculosis)
___Diabetes

Please list other family medical problems not listed above

_____
_____
_____

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Name_____ Birth_____ Sex_____
Address_____ City_____ St____ Zip____
Telephone(Home)_____ (Work)_____ (Cell)_____
SSN_____ CDL_____
Employer_____ Address_____
Occupation_____ Marital Status_____

Insured Person (if not Patient)
Name_____ Birth_____ Sex_____
Address_____ City_____ St____ Zip____
Telephone(H)_____ (W)_____ (C)_____
SSN_____ CDL_____
Employer_____ Address_____
Occupation_____ Marital Status_____
Type of Insurance
Insurance Company_____ ID#_____ Group#_____
Telephone#_____

Emergency Contact (not living with you)_____
Name phone#

Acknowledgement and Authority for Treatment

I consent to treatment as necessary or desirable to the care of the patient whose name is mentioned above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, his nurses or qualified designate. I also acknowledge full responsibility for the payment of such service, unless other arrangements are made with Dr. Mellon.

_____
Patient Signature

Referred By:_____ Date_____