

NORTHERN CALIFORNIA ARTHRITIS CENTER

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PATIENT INFORMATION SHEET

DATE: _____

Patient Home Phone: () _____

Cell Phone: () _____

Work Phone: () _____

NAME: _____

Please circle preferred phone number for reminder calls or to discuss treatment.

Address: _____

Birthdate: ___ / ___ / ___

Sex: M F Marital Status: S M D W Race: _____ Ethnicity: _____

Preferred Language: _____

Emergency Contact Person: _____ Phone: _____

Insurance: _____

Subscriber Name: _____ Subscriber Date of Birth ___ / ___ / ___
(if other than self)

Referring Physician Name: _____
(if your referring physician is not local, please provide their phone number)

Primary Care Physician Name: _____
(if different than referring physician)

We will make every effort to protect your privacy. Do we have your permission to leave messages regarding your appointment and/or treatment on your voicemail? ___ Yes ___ No

Please provide the names of persons allowed to receive information regarding your visits and/or treatment by our physician(s). _____ Relationship: _____

_____ Relationship: _____

Patient Portal: You can enroll in our Patient Portal just by asking a staff member to give you a token number. You can log in to www.NextMD.com, click on "Enroll Now" and follow the steps. By doing this you can:

- Quickly and securely access your health information.
- Reduce wait time before your appointment.
- Easier prescription refills.
- Instantly request and reschedule appointments.
- Send secure messages to our clinical staff.