

**GLENNA TOLBERT, M.D**  
Qualified Medical Examiner

**Dr. Glenna Tolbert** is a board-certified physician who has specialized in physical medicine and rehabilitation and spinal cord injury medicine since 1993. She has demonstrated progressive leadership in this highly specialized field through assuming key positions such as:

- Chief, Adult Brain Injury Service in the Neuro-trauma Division at Rancho Los Amigos Medical Center
- Co-director, Physical Medicine and Rehabilitation Residency Training Program at the UCLA Multicampus Program
- Medical Director of the Casa Colina Childrens' Center
- Director, EMG Laboratory at Orthopedic Hospital
- Chief, Spinal Cord Injury Outpatient Clinic at the Department of Veterans Affairs
- Team Physician, Wheelchair Sports Department, Department of Veterans Affairs

**Dr. Tolbert's** contributions to the advancement of managing the care of persons with injuries exceed far beyond the clinical setting. She spends a significant amount of her time educating physicians, allied health care professionals, and the public about non-surgical orthopedics and neurological rehabilitation. **Dr. Tolbert** currently is in private practice and serves as Assistant Clinical Professor of Medicine, David Geffen School of Medicine University of California, Los Angeles. She has also participated on a multitude of committees, societies, projects, task forces, and boards focusing on improving the quality of life for spinal cord injury patients and their families. **Dr. Tolbert** has lectured extensively in both the health care facility and community settings.

In addition to her commitment as an outstanding leader and advocate in her field of expertise, **Dr. Tolbert** has shown tremendous dedication to her husband of over 25 years, a successful entrepreneur who specializes in real estate and financial management, and their three sons. Her hobbies include ballet, skiing, hiking, and participating in church and sporting activities.

**VERY IMPORTANT NEW PATIENT INFORMATION**

**Please complete the enclosed paperwork and bring it to your appointment.**

## **Welcome!**

I look forward to working with you towards improving your quality of life.

I will pre-register you and verify any healthcare coverage information you have provided.

If I am unable to verify your insurance coverage, I do accept cash and credit cards. The fee for a new patient consultation is \$300, and payment is due the day of the visit.

None of us like unpleasant financial surprises, so I recommend verifying what portion of the \$300 your insurance will cover, as well as your deductible and/or co-payment responsibility. Your deductible and/or co-payment will be collected the day of your visit as well.

If you have other questions or concerns, please contact me prior to your visit.

Yours in rehabilitation,

Glenna Tolbert, M.D. Q.M.E.

## New Patient Form

Reason for visit? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

What phone no. may we leave a message for you? (Please circle selection above)

Date of Birth: \_\_\_\_\_ Social Security#: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

Drivers License#: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance: Primary \_\_\_\_\_ Policy# \_\_\_\_\_

Secondary \_\_\_\_\_ Policy# \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_

Do you have a Co-pay? \_\_\_\_\_ Amount of Co-pay: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Pharmacy Name/ Phone: \_\_\_\_\_

Workers Comp: \_\_\_\_\_ Claim#: \_\_\_\_\_

Adjustor: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional service rendered. I have read all the information on this sheet and have 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 health status on the above information. I hereby consent to treatment.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parents of responsible party's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIAL HEALTH HISTORY**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birth-date: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

**SYMPTOMS: CHECK (☑) SYMPTOMS YOU HAVE CURRENTLY HAVE OR HAVE HAD IN THE PAST**

<p><b>GENERAL</b></p> <p><input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats</p> <p><b>MUSCLE/JOINT/BONE</b> Pain, weakness, &amp; numbness in: <input type="checkbox"/> Arms   <input type="checkbox"/> Hips   <input type="checkbox"/> Back <input type="checkbox"/> Legs   <input type="checkbox"/> Feet   <input type="checkbox"/> Neck <input type="checkbox"/> Hands   <input type="checkbox"/> Shoulders</p> <p><b>GENITO-URINARY</b></p> <p><input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination</p>	<p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins</p>	<p><b>EYE, EAR, NOSE, THROAT</b></p> <p><input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision- Flashes <input type="checkbox"/> Vision- Halos</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal</p>	<p><b>MEN ONLY</b></p> <p><input type="checkbox"/> Breast Lumps <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other _____</p> <p><b>WOMEN ONLY</b></p> <p><input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other _____</p> <p>Date of last menstrual period? _____ Date of last Pap smear? _____</p> <p>(Check Y for YES. Leave blank for No.) <input type="checkbox"/> Have you had a mammogram? <input type="checkbox"/> Are you pregnant? Number of children? _____</p>
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**CONDITIONS CHECK (☑) CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST**

<p><input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts</p>	<p><input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriages <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease</p>
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<b>MEDICATIONS LIST MEDICATIONS YOU ARE CURRENTLY TAKING</b>	<b>ALLERGIES to meds or substances</b>

Relation	Age	State of Health	Age at Death	Cause of Death	Check (I) if, your blood relatives had any of the following: Disease                      Relationship to you	
Father					Arthritis	
Mother					Asthma, Hay Fever	
Brother					Cancer	
Brother					Chemical Dependency	
Brother					Diabetes	
Brother					Heart Disease, Stroke	
Sister					High Blood Pressure	
Sister					Kidney Disease	
Sister					Tuberculosis	
Sister					Other	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year Outcome	Hospital	Reason for Hospitalization and	Birth Year	Sex of birth	COMPLICATION IF ANY

**Have you ever had a blood transfusion?**  Yes  No  
If yes, please give approximate dates. \_\_\_\_\_

**HEALTH HABITS**  
Check (☑) which substances you use & describe how much use.

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME	Caffeine
			Tobacco
			Drugs
			Other

**OCCUPATIONAL CONCERNS**  
Check (☑) if your work exposes you to the following:

Stress
Hazardous Substances
Heavy Lifting
Other
Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of his form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

Glenna Tolbert, M.D.  
Center for Rehabilitation & Wellness  
17609 Ventura Blvd. #114  
Encino, CA. 91316  
(818) 784.7197 Fax (818) 784.3060

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE**

I hereby request that you forward a summary of my medical information which you have compiled while I was under your care. Please include most recent comprehensive exam, lab, x-ray findings and significant consultation reports.

PLEASE SEND THE SUMMARY TO:

GLENNA TOLBERT, M.D.  
CENTER FOR REHABILITATION & WELLNESS  
17609 VENTURA BLVD. #114  
ENCINO, CA. 91316

The information released is for use in medical diagnosis and/or treatment. This authorization expires in 60 days from signature date.

SPECIFIC REQUEST IS MADE FOR:

NAME: \_\_\_\_\_  
SS #: \_\_\_\_\_  
DOB: \_\_\_\_\_

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(WITNESS)

\_\_\_\_\_  
(TITLE)

**PHARMACY**

Glenna Tolbert, M.D.  
Center for Rehabilitation & Wellness  
17609 Ventura Blvd. #114  
Encino, CA. 91316  
(818) 784.7197 Fax (818) 784.3060

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE**

I hereby request that you forward a summary of my medical information which you have compiled while I was under your care. Please include the last year prescription medicine history/record.

PLEASE SEND THE SUMMARY TO:

GLENNA TOLBERT, M.D.  
CENTER FOR REHABILITATION & WELLNESS  
17609 VENTURA BLVD. #114  
ENCINO, CA. 91316

The information released is for use in medical diagnosis and/or treatment. This authorization expires in 60 days from signature date.

SPECIFIC REQUEST IS MADE FOR:

NAME: \_\_\_\_\_  
SS #: \_\_\_\_\_  
DOB: \_\_\_\_\_

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(WITNESS)

\_\_\_\_\_  
(TITLE)

## Our Financial Policy

Please read and initial each line, and sign below:

\_\_\_\_\_ I understand that I am required to pay for all charges on the date services are rendered unless I am covered by a PPO policy for which Dr. Tolbert is a contracted provider.

\_\_\_\_\_ I understand that Glenna Tolbert, M.D. will accept payment by personal check, money order, cash or by credit card. If the bank returns my checks as un-payable, I will be charged a \$30.00 service fee that will be due and payable within three days along with the amount of my original check.

\_\_\_\_\_ I understand that if I receive a statement in the mail, the amount stated as my responsibility is due within 10 days.

\_\_\_\_\_ If my account exceeds 90 days, I understand that I am in collection status and a finance charge equal 1-\_\_% per month may be added to my account.

## Medical Insurance Policy

\_\_\_\_\_ I understand that I am ultimately responsible for my account in full, even though I have medical insurance. Should my insurance not pay in a timely manner or the correct amount, I agree to pay the doctor and settle my differences with my insurance company.

\_\_\_\_\_ I will pay all co-pays, deductibles or percentages due on the date of service

\_\_\_\_\_ I hereby authorize payment directly to Glenna Tolbert, M.D. the insurance benefits otherwise payable to me. I also authorize that a photographic copy of this authorization as valid as the original.

\_\_\_\_\_ I hereby authorize the disclosure of medical information to my stated insurance company for the purpose of obtaining payment for services rendered.

Printed Name: \_\_\_\_\_ Signature \_\_\_\_\_

Date: \_\_\_\_\_



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Glenna Tolbert, M.D.**  
**17609 Ventura Blvd. #114**  
**Encino, CA 91316**  
**818 784 7197**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Private Practices by e-mail at: \_\_\_\_\_  
\_\_\_\_\_.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Name and Address of Patient: \_\_\_\_\_

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