Glenna Tolbert, M.D., Q.M.E
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Spinal Cord Medicine
Assistant Clinical Professor, UCLA

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.

the Center
for rehabilitation and wellness

Glenna Tolbert, M.D., Q.M.E
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Spinal Cord Medicine
Assistant Clinical Professor, UCLA

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.

17609 Ventura Blvd., Suite 114 I Encino, CA 91316 I 818.784.7197 I www.tolbertrehab.com

the Center
for rehabilitation and wellness

Glenna Tolbert, M.D., Q.M.E
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Spinal Cord Medicine
Assistant Clinical Professor, UCLA

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: ______________

the Center
for rehabilitation and wellness

Glenna Tolbert, M.D., Q.M.E
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Spinal Cord Medicine
Assistant Clinical Professor, UCLA

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

GENERAL
☐Chills
☐Depression
☐Dizziness
☐Fainting
☐Fever
☐Forgetfulness
☐Headache
☐Loss of sleep
☐Loss of weight
☐Nervousness
☐Numbness
☐Sweats

MUSCLE/JOINT/BONE
Pain, weakness, & numbness in:
☐Arms ☐Hips ☐Back
☐Legs ☐Feet ☐Neck
☐Hands ☐Shoulders

GENITO-URINARY
☐Blood in urine
☐Frequent urination
☐Lack of bladder control
☐Painful urination

GASTROINTESTINAL
☐Appetite poor
☐Bloating
☐Bowel changes
☐Constipation
☐Diarrhea
☐Excessive hunger
☐Excessive thirst
☐Gas
☐Hemorrhoids
☐Indigestion
☐Nausea
☐Rectal bleeding
☐Stomach pain
☐Vomiting
☐Vomiting blood

CARDIOVASCULAR
☐Chest pain
☐High Blood Pressure
☐Irregular heartbeat
☐Low blood pressure
☐Poor circulation
☐Rapid heartbeat
☐Swelling of ankles
☐Varicose veins

EYE, EAR, NOSE, THROAT
☐Bleeding gums
☐Blurred vision
☐Crossed eyes
☐Difficulty swallowing
☐Double vision
☐Earache
☐Ear discharge
☐Hay fever
☐Hoarseness
☐Loss of hearing
☐Nosebleeds
☐Persistent cough
☐Ringing in ears
☐Sinus problems
☐Vision- Flashes
☐Vision- Halos

SKIN
☐Bruise easily
☐Hives
☐Itching
☐Change in moles
☐Rash
☐Scars
☐Sore that won't heal

MEN ONLY
☐Breast Lumps
☐Erection difficulties
☐Lump in testicles
☐Penis discharge
☐Sore on penis
☐Other

WOMEN ONLY
☐Abnormal Pap Smear
☐Bleeding between periods
☐Breast Lump
☐Extreme menstrual pain
☐Hot flashes
☐Nipple discharge
☐Painful intercourse
☐Vaginal discharge
☐Other ______________

Date of last menstrual period?
____

Date of last Pap smear? ________

(Check Y for YES. Leave blank for No.)
☐Have you had a mammogram?
☐Are you pregnant?
Number of children?__________

CONDITIONS CHECK (☑) CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST

☐AIDS
☐Alcoholism
☐Anemia
☐Anorexia
☐Appendicitis
☐Arthritis
☐Asthma
☐Bleeding Disorders
☐Breast Lump
☐Bronchitis
☐Bulimia
☐Cancer
☐Cataracts
☐Chemical Dependency
☐Chicken pox
☐Diabetes
☐Emphysema
☐Epilepsy
☐Glaucoma
☐Goiter
☐Gonorrhea
☐Gout
☐Heart Disease
☐Hepatitis
☐Hernia
☐Herpes
☐High Cholesterol
☐HIV Positive
☐Kidney Disease
☐Liver Disease
☐Measles
☐Migraine Headaches
☐Miscarriages
☐Mononucleosis
☐Multiple Sclerosis
☐Mumps
☐Pacemaker
☐Pneumonia
☐Polio
☐Prostate Problem
☐Psychiatric Care
☐Rheumatic Fever
☐Scarlet Fever
☐Stroke
☐Suicide Attempt
☐Thyroid Problems
☐Tonsillitis
☐Tuberculosis
☐Typhoid Fever
☐Ulcers
☐Vaginal Infections
☐Venereal Disease

MEDICATIONS LIST MEDICATIONS YOU ARE CURRENTLY TAKING	**ALLERGIES** to meds or substances

the Center
for rehabilitation and wellness

Glenna Tolbert, M.D., Q.M.E
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Spinal Cord Medicine
Assistant Clinical Professor, UCLA

Relation	Age	State of Health	Age at Death	Cause of Death	Check ([) 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. ____________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

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

☐	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

the Center
for rehabilitation and wellness

Glenna Tolbert, M.D., Q.M.E
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Spinal Cord Medicine
Assistant Clinical Professor, UCLA

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)

Glenna Tolbert, M.D., Q.M.E
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Spinal Cord Medicine
Assistant Clinical Professor, UCLA

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)

Glenna Tolbert, M.D., Q.M.E
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Spinal Cord Medicine
Assistant Clinical Professor, UCLA

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: _____________________

Glenna Tolbert, M.D., Q.M.E
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Spinal Cord Medicine
Assistant Clinical Professor, UCLA

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: ____

2002, 2003 by PrivaPlan Associates, Inc and the California Medical Association
Patent Pending- All rights Reserved
2.1.2003