Aliso Viejo Family Medicine

26671 Aliso Creek Rd 101
Aliso Viejo, CA 92656

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE HOME PHONE
	☐ Full-Time ☐ Part-Time				

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
		$	
CITY, STATE ZIP	PHONE	DEDUCTIBLE	
		$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
		$	
CITY, STATE ZIP	PHONE	DEDUCTIBLE	
		$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I hereby assign my insurance benefits to be made directly to my physician or assisting physicians, for services rendered. I attest that the above information is accurate. I understand that I am responsible for knowing my benefits/coverage and will be financially responsible for all charges not covered by my insurance company. I authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I agree that a photocopy of this agreement shall be as valid as the original. All charges are the direct responsibility of the patient. I understand that services cannot be rendered on the assumption that charges will be paid by the insurance company. If there are problems collecting payment, attorney's fees, collection agency costs and any related fees will be added to my bill. I acknowledge that I have read, understand and agree to give consent to assess, treat, test.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

HEALTH QUESTIONNAIRE

Name: _____ Date: _____
Birthdate: _____

Medications
Please list any medications that you currently take regularly (including non-prescription) _____

_____

Allergies
Please list any allergies to medications or foods _____

_____

Medical History

Illnesses/Conditions
Do you have or have you ever had any of the following:

		Year
_____	Anemia	_____
_____	Anxiety	_____
_____	Arthritis	_____
_____	Asthma	_____
_____	Birth Defects	_____
_____	Cancer ( )	_____
_____	Colitis	_____
_____	Concussion	_____
_____	Depression	_____
_____	Diabetes	_____
_____	Emphysema	_____
_____	Heart Attack/Heart Disease	_____
_____	High Blood Pressure	_____
_____	High Cholesterol	_____
_____	Kidney Disease	_____
_____	Liver Disease	_____
_____	Low Blood Sugar	_____
_____	Mitral Valve Prolapse/Murmur	_____
_____	Osteoporosis	_____
_____	Pneumonia	_____
_____	Rheumatic Fever	_____
_____	Seizure Disorder	_____
_____	Sexually Transmitted Disease	_____
_____	Stroke	_____
_____	Thyroid Disorder	_____
_____	Tuberculosis	_____
_____	Ulcer	_____

Surgical Procedures/Hospitilizations Year

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Childhood Diseases Year

_____ Chickenpox _____
_____ Measles _____
_____ Mumps _____
_____ Polio _____

Gynecological History (women only)

Are you pregnant? _____
Are you breast feeding? _____
Last menstrual period _____
How many pregnancies have you had? _____
How many children do you have? _____
At what age did you start having periods? _____

Family History

Has any blood relative ever had any of the following :

	Relative (mother, father, sister, etc.)
Bleeding problems	_____
Cancer ( )	_____
Diabetes	_____
Heart Attack	_____
Heart Disease	_____
High Blood Pressure	_____
Mental Illness	_____
Seizures	_____
Stroke	_____
Other	_____

Health Maintenance Continued

_____
Name

When, if ever, did you last have any of the following:
(MM/ DATE/YEAR)

_____ Cholesterol check
_____ Colonoscopy
_____ EKG/Cardiogram
_____ Mammogram
_____ Pap Smear
_____ Prostate exam
_____ Treadmill stress test

Social History

_____ Are you married?
_____ Do you have children? How many? _____
_____ Are you employed? In what field? _____
_____ Do you smoke or chew tobacco? How many/day? _____
_____ Do you use illegal drugs? _____
_____ Do you drink alcohol? How often? _____
_____ Have you been exposed to toxic substances? _____
_____ Do you drink caffeine daily? How much? _____
_____ Do you exercise regularly? What type/how often? _____
_____ Do you wear seat belts?
_____ Do you use car seats for your children if under 60 lbs?
_____ Do you have a living will?
_____ What is your highest level of education? _____

Review of Symptoms (Please circle any of the following that you experience?)

General	Fatigue	Fever	Hopelessness	Hot flashes	
	Insomnia	Night sweats	Poor Concentration	Recent weight loss or gain	
Skin	Change in pigmentation		Hives	Rashes	
ENT	Change in vision		Enlarged glands	Glaucoma	Headaches
	Hearing loss		Neck stiffness		
Respiratory	Coughing up blood		Frequent cough	Shortness of breath	
Cardiac	Chest pain		Difficulty walking 2 blocks		Palpitations
	Swelling of hands or feet				
Gastrointestinal	Abdominal pain		Bloody or dark stool	Change in bowel habits	
	Frequent indigestion		Vomiting blood		
Genitourinary	Difficulty urinating		Frequent urination	Unable to control bladder	
	Unsatisfactory sex life				
Musculoskeletal	Calf pain	Joint pain	Joint swelling	Muscle cramping	

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OFFICE POLICIES

Welcome to your First Visit...

Thank you for choosing to visit our office. We would like you to know that we are committed to providing you with the best possible medical care.

- **Appointment Cancellations:** Please call at least 24 hours prior to your appointment time to cancel your appointment. We have many patients waiting for appointments who would like the opportunity to be seen sooner. We appreciate your thoughtfulness. Please see Financial Policy about cancellation charges.

- **Laboratory & Radiology Results:** We recommend that you make a follow-up appointment to review your results in 1-2 weeks. In some instances, if your results are normal, we may call you with in 2 weeks. If your results are abnormal, we may call you sooner to make an appointment. If you have not heard from us in 2 weeks and would like a copy of your test results, it will be available for pick-up only at the front desk. Due to confidential nature of testing for STD's (Sexually Transmitted Diseases), we require an appointment to review the results.

- **Medical Records:** If you have chronic medical problems, we recommend that you have your medical records transferred from your previous doctor(s) with medical records release.

WAIVER FORM

I understand that verification of coverage by my insurance cannot fully be determined until the claim is received and processed. I wish to receive medical services from Aliso Viejo Family Medicine. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

_____ _____
Print Patient's Name Date

_____ _____
Patient/Representative's Signature (Print Name and Relationship if Representative)

CONSENT TO TREAT A MINOR

I give my consent for any needed medical care/treatment for my son or daughter that is deemed necessary. This authorization will remain in effect until written retraction.

_____ _____
Print Patient's Name Date

_____ _____ _____
Guardian's Signature Print Guardian's Name Relationship to Patient

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FINANCIAL POLICY

It is the responsibility of the patient to know and understand the policies and benefits of their insurance plan. This includes co-payments, deductibles, contracted providers (physicians, hospitals, laboratories, radiology, etc.) and the current claims address. Your insurance is a contract between you and your insurance company. We cannot be held responsible for information received when verifying insurance benefits since it is not a guarantee of payment or eligibility. We **strongly encourage** you to contact your insurance company to confirm benefits and coverage. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor.

- **PPO Plans:** We have agreed to take a discount from your insurance company. Your **deductible, co-insurance, and co-payments** are due at the time of treatment.

- **HMO Plans (Greater Newport Physicians)**: All **co-payments** must be paid at the time of your visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. You are responsible for obtaining approval for treatment with your Medical Group or PCP prior to treatment.

- **Medicare:** We accept assignment from Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy. However, you are responsible for the balance regardless of payment from a secondary insurance.

- **Cash Patients:** Payment is due in full prior to services rendered.

- Partial payments for services rendered are not accepted. **Any partial payments on an outstanding balance will be subjected to a monthly fee of $25.00 until the balance is paid in full.**

- We accept cash, Visa, MasterCard, Discover, and American Express. We can only accept checks after the first visit. A $25.00 charge will be applied for any returned check.

- Typical items that may not be covered by insurance: Physical exams (Routine, Pre-Employment, School, Sports), Vaccinations, Orthopedic Supplies (Crutches, Shoes, Slings, Splints, ACE bandage, etc.), Form Completion Fees

- If your visit includes lab tests, x-rays, biopsies, pap smears or cultures, you will receive separate billing from the laboratory performing the tests (e.g. Hoag Radiology, Westcliff Lab, Quest Diagnostics, etc.).

- **Cancellation of Appointment**: If you should need to cancel an appointment, we require **24-hour notice**. Failure to give our office a 24-hour notice will result in you (not your insurance company) being charged a **fee of $25.00**.

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____	_____	_____
Signature	Printed Name	Date

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NOTICE OF PRIVACY PRACTICES

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the invoice.

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information For:
    - Treatment
    - Payment
    - Health Care Operations
    - Notifications
    - Marketing
    - Research
    - Special Circumstances and the Law
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this letter. If it was not, please contact our office manager at the address or phone number shown at the top of this page to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements.

If, after reviewing the notice, you decide that you do not want to retain your paper copy, please return it to your receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices:

_____	_____	_____
Signature	Printed Name	Date