

# 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 <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE	
PRIMARY EMPLOYER					Preferred Pharmacy: _____ Address: _____ City: _____ Phone: _____				
ADDRESS									
CITY, STATE ZIP									
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 <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE		
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/Hospitalizations**

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?

\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

### 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



## 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