

**NEW PATIENT
FORM**

Today's date:		Reason for Referral:	
Pharmacy Name, Address, Number:		Referring Doctor:	
		Primary Care Physician:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		Marital status (select one) Single Married / Divorced / Sep	
Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #:
Street address:			
City:		State:	ZIP Code
Email:		Home Phone	
Occupation:		Cell Phone:	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone Number:

MEDICATIONS

Are you currently taking any prescription or non-prescription medications? Yes No

If yes, please list your medications:

**MEDICAL HISTORY
FORM**

Patient Name: _____

ALLERGIES

Do you have any allergies to medications? Yes No

If yes, please list:

Do you have any of these medical conditions?

Asthma, Bronchitis, or Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness or Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness of Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss/Energy Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleeping Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bowel or Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clot/Emboli	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision or Hearing Difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression or Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer or Chemo/Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a pacemaker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use any illicit drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pins or Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any other information that you feel would assist us in your care:

PRIVACY PRACTICES

Use and Disclosure of Your Protected Health Information

The privacy of your medical information is important to us. Your protected health information will be used by Southern California ID Associates, Inc. and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Southern California ID Associates, Inc. may or may not agree to restrict the use or disclosure of your protected health information.

If Southern California ID Associates, Inc. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Southern California ID Associates, Inc. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Southern California ID Associates, Inc. to use and disclose my health information in accordance with it.

_____ **Printed Name**

_____ **Date**

_____ **Signature**

Email Use

The physician and office staff will use reasonable means to protect the security and confidentiality of email information sent and received. However, Southern California ID Associates, Inc. cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not direct result of intentional misconduct of the physician and staff. Thus, patients must consent to the use of email to disclose patient information.

Signature of Consent of Email Use_____

Date_____

FINANCIAL RESPONSIBILITY DISCLOSURE

Your signature below forms a binding agreement between Southern California ID Associates, Inc. and the Patient who is receiving medical services, or the Responsible Party for dependent patients. Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

Medical Insurance

We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. When we receive an explanation of benefits from your insurance company, any amounts that you need to pay will be billed to you.

Patient and/or Responsible Party must:

- Inform us of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that Southern California ID Associates, Inc. has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for dependent patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Printed Name

Date

Signature

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

How to Cancel Your Appointment

To cancel your appointment, please call 949-515-3590. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a 24 hour advance notice.

No Show Policy: A “no-show”, is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient’s chart as a “no-show”. This includes arriving 15 minutes after your scheduled appointment.

I am aware and understand the cancellation/no show fee is \$25.00

Patient Signature_____

Date_____