TEMECULA VALLEY
PRIMARY CARE PHYSICIANS

40285 Winchester Rd., Ste 103
Temecula, CA 92591
Ph: 951-296-5844
Fax: 951-296-5840
www.temeculaprimarycare.com

PATIENT DEMOGRAPHICS

Last Name_____ **First Name**_____ **MI** _____

Date of Birth _____/_____/_____ **Sex**: M / F **Social Security** _____ **Marital Status** _____

Race (check all that apply)

- o American Indian or Native Alaskan
- o Asian
- o Native Hawaiian or Other Pacific Islander
- o African American
- o White
- o Hispanic
- o Other
- o Refuse to Report

Ethnicity (please select one)

- o Hispanic or Latino
- o Not Hispanic or Latino
- o Refuse to Report

Primary Language _____

If your primary language is NOT English: Do you require an interpreter? (please circle) YES NO

Address _____ **City**_____ **State**_____ **Zip**_____

Email Address _____ **Preferred Telephone #** (____) _____

Secondary Telephone # (____) _____ **Please circle your cell phone preference:** Voice Text

How did you hear about our office? _____

EMERGENCY CONTACT / FAMILY INFORMATION

Emergency Contact Name _____ **Relationship to patient**_____

Emergency Contact Telephone # (____) _____

May we Release Medical Information to your Emergency Contact? (please circle one) YES NO

Spouse's Name _____ **Spouse's Telephone #** (____) _____

May we Release Medical Information to your Spouse? (please circle one) YES NO

Parent or Legal Guardian Name (Minors only) _____ **Telephone #** (___) _____

PATIENT PHARMACY INFORMATION

Primary Pharmacy Name_____ **Telephone #** (____) _____

Address _____ **City**_____ **State**_____ **Zip**_____

Secondary Pharmacy Name_____ **Telephone #** (____) _____

Address _____ **City**_____ **State**_____ **Zip**_____

REASON FOR VISIT

What is the reason for your visit today? _____

_____

_____

-Paper work continued on page 2-

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EMPLOYMENT / INSURANCE INFORMATION

Type of Employment_____ **Work Telephone #** (____) _____

Is it ok to contact you at work? (please circle one) YES NO FOR EMERGENIES ONLY

Current Insurance Company _____ **Relationship to the Policy Holder**_____

-PLEASE PRESENT YOUR INSURANCE CARD TO THE FRONT OFFICE AT THE TIME OF YOUR VISIT-

ALLERGIES

Please list all medications you are allergic:

_____

_____

_____

_____

_____

Please list all other allergies you have:

_____

_____

_____

_____

_____

CURRENT MEDICATIONS

Please list all medications you are currently taking (both prescribed and over the counter)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

-Paper work continued on page 3-

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PAST MEDICAL HISTORY

Please circle all that apply:

Diabetes	Current	Past	N/A
Hypertension	Current	Past	N/A

Other (please explain below)

_____

_____

When was your last Dental Exam? _____ **When was your last Eye Exam?** _____

When was your last Tetanus Shot? _____

For Children under 6 years of age:

Does the child live in or spend time in a building that was built prior to 1960 or that has peeling paint? YES NO

Is the child in a state funded program? YES NO

SURGICAL HISTORY

Please list all surgeries and their dates:

_____

_____

_____

FAMILY MEDICAL HISTORY

Please list any family members with the following:

Diabetes _____

Hypertension _____

Cancer (please list type as well) _____

Other (please list condition and relation)_____

SOCIAL HISTORY

Do you use Alcohol? YES NO **If yes, please indicate the type, amount & frequency of use.**

_____

Do you use Tobacco? YES NO **If yes, please indicate the type, amount & frequency of use.**

_____

Do you use any illegal drugs? YES NO **If yes, please indicate the type, amount & frequency of use.**

_____

TUBERCULOSIS (TB) RISK SCREENING

Are you a health care provider? YES NO **Do you have contact with a person known to have TB?** YES NO

Do you have contact with a homeless, illegal drug user or migrant worker? YES NO

Do you live in or visit a group home or prison? YES NO

Have you spend extended time in Asia, Africa or South America? YES NO

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ADVANCED DIRECTIVE STATUS

An Advanced Directive is a document that allows you to give instructions about your health care or name another person to make health care decisions for you.

This practice respects your right to make your own health care decisions. We comply with state and federal laws regarding advanced health care directives. We do not discriminate against anyone based on the status of their Advanced Directive.

Patient Last Name_____ **First Name**_____ **MI** _____

Date of Birth _____/_____/_____

Do you have an Advanced Directive? YES NO **If yes, please list who has a copy below.**

_____

Would you like to receive information about Advanced Directives? YES NO

FOR OFFICE USE ONLY:

Patient was given information on Advanced Directives? YES NO

Patient provided an Advanced Directive for their medical record? YES NO

Staff signature_____ Date _____/_____/_____

CONSENT FOR USING AND PROCTECTING HEALTH CARE INFORMATION

-Privacy practices are posted in the patient waiting area. You may request a printed copy. –

May this office call the telephone numbers listed on page 1 and leave a voice message regarding your appointments and medical care? (please circle one) YES NO

May this office send mail to the address listed on page 1 regarding your appointments and medical care? (please circle one) YES NO

My protected health information will be used strictly to carry out my treatment, health care operations and receive payment for medical services provided.

Patient Name_____

Patient Signature _____

OR

Parent/Legal Guardian Name_____

Parent/Legal Guardian Signature_____

I have the right to refuse to sign above and not allow this practice to use my protected health information to carry out my treatment, healthcare operations and receive payment for medical services provided. My healthcare provider may consider this request but is not required to agree. If the provider does not agree with your request, you will be given 30 days to secure a new medical provider. Medical records will be copied upon request.

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IMMUNIZATIONS

Immunization records are needed for all patients. Please provide your immunization record or request a copy from your previous provider. Records requests are available in the front office.

FINANCIAL AGREEMENT

Please provide your insurance card, co-pay and valid state ID at the time of your visit. A photo ID will be taken and attached to your medical record. All unpaid insurance claims and balances will be billed to the patient.

AUTHORIZATION TO BILL INSURANCE

I authorize the practice to send medical claims, medical information and collect payment from my insurance carrier. I will provide a copy of proof of insurance for both office visits and pharmacy benefits if under a separate plan.

CONSENT TO TREAT

I give my consent for a medical examination, evaluation, treatment and review of my prescriptions. I have the right to understand and agree to my plan of care. I have the right to refuse care. I have the right to request language interpretation.

Patient Name_____

Patient Signature _____

OR

Parent/Legal Guardian Name_____

Parent/Legal Guardian Signature_____

-Please complete the attached Staying Healthy assessment for your age group-

DAVID ZEBRACK, D.O.
DOUGLAS WISE, D.O.
DANIELLE THOMAS, N.P.

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◆◆◆

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FINANCIAL POLICY

It is the patient's responsibility to notify the staff of a change in insurance and provide their new insurance card.

We accept PPO insurance plans, Medicare, Tricare and Primecare HMO. Patients with HMO insurance must be assigned to Dr. Zebrack or Danielle Thomas, N.P. but may see any TVPCP providers.

For patients who do not have insurance, payment will be due in full at the time of service.

Co-pays are required at the time of service. This is the amount you owe for the services provided on that date. For your convenience, we accept Visa/MasterCard/Discover/AMEX, debit cards, checks or cash. If you chose to pay by cash, please try to have exact change.

There is a $35.00 Non-Sufficient Funds (NSF) charge for all checks returned by your financial institution.

There is a missed appointment fee of $25.00 for No-Shows.

If you are unable to keep your appointment, please call our office 24 hours in advance in order to avoid a missed appointment fee of $25.00.

For patients that require the provider to fill out forms, there will be a charge of $30.00 per set. This includes but is not limited to Physicals, Disability, FMLA, and other similar forms not mentioned.

For request of medical records by the patient or insurance company, there will be a $20.00 copying fee for the first 25 pages and a charge of $0.25 per page after that.

For letters request, there will a minimum fee of $20.00 depending on how detailed the letter is.

Insurance coverage for lab tests varies by insurance company and plan. You may wish to contact your Health insurance provider before you have provider ordered lab test drawn to ensure that you are going to the correct lab facility.

Annual physical examinations are covered without a co-pay. If patients have any other treatment or procedure other than the physical, the patient will be charged their co-pay.

If you are being seen for an injury, please understand that we do not accept third party insurances such as auto insurance or liens of any kind. Please notify the front desk if this is the case and you will need to pay cash for the treatment and seek reimbursement from the appropriate parties involved. We cannot treat any kind of work related injuries.

Patient Name: _____

Patient/Guardian Signature: _____ **Date:** _____