SOUTH COAST FAMILY
MEDICAL CENTER, INC.

PATIENT INFORMATION REGISTRATION

Today's date: _____ Date of birth: _____ Age: _____ Gender: _____

First Name: _____ Middle name: _____ Last name: _____

Address: _____ Phone: _____

_____ Email: _____

PARENT/GUARDIAN OF MINOR (WITH PATIENT TODAY)

First Name: _____ Last name: _____ Date of birth: _____

Relationship: _____ Address (if different): _____

PRIMARY INSURED

First Name: _____ Last name: _____ Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____ DOB: _____

EMPLOYER

Employer: _____ Phone: _____

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ASSIGNMENT OF BENEFITS

I directly assign all medical benefits to South Coast Family Medical Center, Inc. and understand **that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize SCFMC to release all information necessary to secure payment benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

HIPAA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

With your consent, South Coast Family Medical Center, Inc. may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 25500 Rancho Niguel Rd Suite 100, Laguna Niguel, CA 92677.

With your consent, South Coast Family Medical Center, Inc. may mail to your home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

I give my consent to electronically send or fax my records for the purpose of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third party. In the event that this should occur, I absolve South Coast Family Medical Center, Inc. of all liability.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extend we have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

ELIGIBILITY WAIVER FORM

I understand that if my insurance is not active or I am not eligible under the terms of my employer's medical and subscriber agreement or if South Coast Family Medical Center, Inc. is out of network, **I am responsible for all charges for services rendered.** I agree to pay in full for all services rendered within thirty (30) days of receiving a bill from South Coast Family Medical Center, Inc. I also understand that it is my responsibility to know what services will be covered and not covered under my policy.

_____ _____ _____
Printed name Signature Date

I give my consent for examination/treatment of myself and all minor children listed above. _____ _____
Signature Date

SOUTH COAST FAMILY
MEDICAL CENTER, INC.

PHONE MESSAGE CONSENT FORM

Your physician(s) and other staff members will, at times, need to contact you. Unless we have your written permission to do so, we will not leave a detailed voicemail or send you a detailed text to you or any family member. Please read below and consider carefully whom you want to have access to your medical information.

I, _____ (patient name or guardian name) give South Coast Family Medical Center, Inc. my permission to leave phone messages regarding the medical care and test results for the following patient: □ self (see patient name)

□ name of minor: _____. I also give South Coast Family Medical Center, Inc to leave detailed information with the individuals listed below. I understand that this consent will remain in effect until revoked in writing.

Phone number: _____ Relationship: ☐ Self ☐ Other: _____
☐ Cell ☐ Home ☐ Work ☐ Other: _____

Phone number: _____ Relationship: ☐ Self ☐ Other: _____
☐ Cell ☐ Home ☐ Work ☐ Other: _____

Phone number: _____ Relationship: ☐ Self ☐ Other: _____
☐ Cell ☐ Home ☐ Work ☐ Other: _____

Phone number: _____ Relationship: ☐ Self ☐ Other: _____
☐ Cell ☐ Home ☐ Work ☐ Other: _____

Patient or guardian printed name	Signature	Date

PARTNERSHIP AGREEMENT

At South Coast Family Medical Center, Inc, we intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your physician. As our "partner in health," we ask that you help us in the following way:

1. Schedule annual visits with us for your routine physical examination and other recommended health screenings.
   - I understand that my doctor will explain the regular recommended health screenings that are appropriate for my age, gender and personal/family history. I will complete these screenings as these health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits are not the time to discuss other medial issues except those pertaining to preventative medicine and vaccinations.
2. Return to care based on the recommendations discussed during your office visit.
   - I understand that my doctor will want to know how my condition progress after I leave the office. Returning to my doctor as instructed given him or her the opportunity to check my condition and my response to treatment. During a follow-up visit, my doctor might order tests, refer me to a specialist, prescribe medications, or even discover and treat a serious health condition. If I do not follow up as instructed in the original office visit, I run the risk that my physician will not be able to detect and treat or properly manage a serious health condition. I will make every effort to follow-up as instructed by my physician.
3. Call the office when you do not hear the results of labs and other tests.
   - I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within two weeks, I Will call the office for my results.
4. Inform us if you decide not to follow the recommended treatment plan.
   - I understand that after examining me, my doctor may make certain informed recommendations based on what he or she feels is best for my health. This might include prescribing medications, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that NOT following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide NOT to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health condition, please ask.

Patient or guardian printed name	Signature	Date

Dr. Christopher Davis, DO

Dr. Lauren Davis, DO

SOUTH COAST FAMILY MEDICAL CENTER, INC.

MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Today's date: _____

Pharmacy name and city: _____

Mail order pharmacy name, if applicable: _____

MEDICATIONS ☐ I do not take any medications ☐ No change since last visit

Medication name + dose + frequency (how often); Please include prescription, over-the-counter (OTC), birth control, vitamins, herbal supplements.

ALLERGIES (drug, food, latex) and reaction ☐ I do not have any allergies

_____ _____

_____ _____

CHRONIC MEDICAL PROBLEMS/YEARS OF ONSET

	Year		Year		Year
☐ Heart disease/heart attack	_____	☐ Cancer	_____	☐ Depression	_____
☐ High blood pressure	_____	☐ Asthma or COPD	_____	☐ Anxiety	_____
☐ High cholesterol	_____	☐ Allergies/hay fever	_____	☐ Other:	_____
☐ Diabetes	_____	☐ Vascular disease	_____	_____	

PRIOR SURGERIES AND HOSPITALIZATIONS / YEAR: _____

_____

_____

_____

FAMILY HISTORY ☐ Unknown ☐ Adopted

Please check if any family member has had any of the following conditions:

Father	□ Good health	□ Other:
Mother	□ Good health	□ Other:
Sibling	□ Good health	□ Other:
	□ Good health	□ Other:
	□ Good health	□ Other:

SOCIAL HISTORY (ALL OF THIS IS CONFIDENTIAL) AND MISC

1. Occupation: _____
2. Tobacco use: ☐ Never ☐ Current ☐ Former Cigarettes/day: ____ Yrs used: ____ Yr quit: ____
3. Alcohol use: ☐ Yes ☐ No ☐ Former Drinks/day: _____ ☐ Daily ☐ Social
4. Exercise/activity: ☐ Yes ☐ No Type: _____ Days/wk: ____ Hours per week: _____
5. Recreational drugs: ☐ No ☐ Yes ☐ Former Drug type/frequency: _____
6. Do you have concerns for your safety? ☐ No ☐ Yes: _____
7. Recently have you been bothered by any of the following problems?

	Not at all	Some Days	Nearly ½ the Days	Every Day
Little interest or pleasure in doing things.	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed or hopeless.	☐ 0	☐ 1	☐ 2	☐ 3

PREVENTATIVE MEDICINE

Please list other physicians/health care providers you see and the reason you see them.

_____

_____

Please list the last time you received the services below to the best of your memory.

Mammogram:	normal? ☐ Yes ☐ No:	Flu vaccine:
Pap:	normal? ☐ Yes ☐ No:	TD/TDaP:
Bone Density:	normal? ☐ Yes ☐ No:	HPV:
Colonoscopy:	normal? ☐ Yes ☐ No:	Shingles:
Skin CA check:	normal? ☐ Yes ☐ No:	Pneumonia:

Reviewed by: _____ Date: _____

□ Dr. Chris Davis. DO □ Dr. Lauren Davis. DO □ Dr. Diane Daniels. FNP □ Other:

Telemedicine Informed Consent Form

I _____[name of patient] hereby consent to engaging in telemedicine with Dr. Chris Davis, Dr. Lauren Davis, or Dr. Diane Daniels as part of my medical treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.
I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of Dr. Chris Davis, Dr. Lauren Davis, and/or Dr. Diane Daniels, FNP, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my healthcare provider believes I would be better served by face-to-face services, I will be asked to come into the office. Finally, I understand that there are potential risks and benefits associated with any form of medical therapy, and that despite my efforts and the efforts of Dr. Chris Davis, Dr. Lauren Davis, and/or Dr. Diane Daniels, my condition may not be improve, and in some cases may even get worse. If I do not improve with the treatment initiated in my telemedicine visit, I will come into the office for a face-to-face encounter.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

(6) I understand that my insurance will be billed in the same way as I would be billed in a face-to-face encounter and that I will be financially responsible for my copay and my remaining balance following my normal insurance write-offs. If Dr. Chris Davis, Dr. Lauren Davis, or Dr. Diane Daniels recommend I come in for a face-to-face visit in their office, I will not be charged for my telemedicine visit, unless I fail to come in as recommended. If I fail to pay my bill in a timely manner, I understand that I will be sent to collections.

I have read and understand the information provided above. I have discussed it with Dr. Chris Davis, Dr. Lauren Davis, and/or Dr. Diane Daniels. All of my questions have been answered to my satisfaction.

_____ _____
Signature of patient/parent/guardian/conservator If signed by other than patient indicate relationship

_____
Date

_____ _____
Dr. Chris Davis, DO Dr. Lauren Davis, DO