Melanchton A. Mangoba M.D.

Internal Medicine

Thank you for choosing Dr. Mangoba Internal Medicine! We strive to provide the best medical care. It is our pleasure to welcome you as a potential patient.

Before you arrive, please review the New Patient instructions and bring the following to your first appointment:

- Filled out New PATIENT PACKET that is attached. If you do fill out the New Patient Packet prior to your appointment time, please arrive 15 minutes early to complete the registration and intake any paperwork prior to seeing the physician.

- If you are unable to complete the New Patient Packet, please arrive 30 minutes prior to your scheduled appointment time to complete the New Patient Packet required for your Electronic Health Record. This avoids having to reschedule the appointment.

- You will be required to provide current insurance cards and a current photo for identification.

- Please bring in any Medical records and a list of your current medication. (A records release can be sent over to your previous doctor or bring with you to your appointment.)

- Co-payment, co-insurance and/or deductible are due on the day of the visit. All payments will be collected prior to seeing the physician. If you are unable to obtain payment on the day of your visit, please call the office to reschedule your appointment.

If you have any questions our form's or your appointment, call us at (909) 686-3437. We look forward to meeting you!

Disclaimer: Please be advised that completing preliminary health and insurance questionnaire/form does not establish a physician-patient relationship with this practice. Dr. Mangoba will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice accepts you as a patient.

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Welcome to our office. We appreciate your selection of this office to serve your health needs. Please provide us with the following information so that we may get to know you better.

Patient Information

Whom may we thank for referring you? _____ Today's date: _____

Name: _____ Last Name: _____

Date of Birth: _____/_____/_____ SS:_____

Address: _____ City: _____ St: ____ Zip Code: _____

Home phone: _____ Cell phone: _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Pharmacy: _____ Address: _____ Phone: _____

Emergency Contact: Name: _____ Relationship: _____

Address: _____ City: _____ St: ____ Zip: _____

Home phone: _____ Cell phone: _____

- **Dr. Mangoba does not prescribe controlled medication on the first visit for new patients**

INSURANCE INFORMATION AND EDUCATION

We encourage you to educate yourself on your Insurance plan(s). Remember that most insurance companies have co-payments, co-insurances and sometimes deductibles. It is our policy at Dr. Mangoba's Internal Medicine office to collect any out of pocket expenses, such as copay, deductible, co-insurance or any previous outstanding balances at the time of your visit.

Primary Insurance: _____ Policy Holders Name: _____DOB: _____

Policy Holders Insurance ID#: _____Relation To insured: _____

Secondary Insurance: _____Policy Holders Name: _____DOB: _____

Policy Holders Insurance ID#: _____Relation To insured: _____

Financial Policy

- As a Courtesy to our valued patients that have insurance plans, our office will file insurance claims for reimbursement for all rendered services. Actual benefit payments are determined only when the claim is processed by your insurance company. Therefore, it is the insurance company that makes the final determination of benefits. If the insurance payment does not fully reimburse for the treatment rendered, the financially responsible person is responsible for the remainder of the balance.

- I certify that I have coverage with and assigned directly to Dr. Mangoba all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. Mangoba's Internal Medicine Office does not process any Third-Party insurance companies that we are not credentialed with.

- I understand the office will charge me for filling out forms or other required by my employer, insurance, or other, without an appointment scheduled. Dr. Mangoba is not a "disability physician", therefore does not fill out Disability forms. Nor is Dr. Mangoba certified to fill out Medical Examination Report form for commercial driver medical certification. All forms will not be released without payment.

- **Self-Pay** patients should be prepared to pay at each visit.

- **Missed Appointments:** I understand a $25 fee will be charged for a missed appointment without a (24) hours' notice prior to appointment time. This fee will NOT be covered by your insurance. Your cooperation in canceling your scheduled appointment well in advance of the appointment time allows us the opportunity to offer your appointment to another person who needs Medical care. Patients will receive a phone call one day before the appointment prior to your appointment time. It is your responsibility to provide us with a correct contact number.

- **Collection Agency/Unpaid Balances:** In the event my account is unpaid for 90 days, I understand it will be placed with a collection agency and may be reported to credit bureaus. I agree to be responsible for the collection fees, reasonable attorney fees and court costs. (If the account is placed with a collection agency, the patient may be dismissed from the practice.)

- Labs, Radiology, and other Tests. Medical tests or procedures that are done outside our clinic. These procedures are seen as necessary for your health, but they may not always be covered by your Insurance Policy. Therefore, it is recommended that you are a good consumer and understand your policy.

I, as the patient, financially responsible person and/or guardian for this account, certify that I have read, understood, and agreed to this financial policy.

Signature of Patient or Legal Representative_____ Date_____

Legal Representative's Relationship to Patient_____ Date_____

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CONSENT TO MEDICAL SERVICES BY PHYSICIANS

The undersigned consents to authorize said Physician to administer and perform any and all medical examination, treatments, diagnostic procedures and immunizations against diseases which may now or during the course of the patient's care be deemed advisable by the physician.

INTIALS _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health Information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

INTIALS _____

PRIVACY NOTICE ACKNOWLEDGMENT

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communicating among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a notice of privacy practices (Privacy Notice) which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this acknowledgment. I understand that the organization reserves the right to change their notice and practices and that prior to implementation will mail a copy of the revised notice to me at the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.

INTIALS _____

Signature of Patient or Legal Representative_____ Date_____

Legal Representative's Relationship to Patient_____ Date_____

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ADVANCE DIRECTIVE STATUS

I have been informed of my right to formulate and Advance Directive, and I have been provided with information regarding the execution of an Advance Directive.

(Please check one of the following)

- ☐ I have previously completed an Advance Directive and have provided a copy for inclusion in my chart.
- ☐ I will provide a copy of my previously executed Advanced Directive for inclusion in my chart.
- ☐ A copy of my Advance Directive is on file with _____
- ☐ I have not executed an Advance Directive and I am not interested in any further information.
- ☐ I am interested in formulating an Advance Directive and will discuss my options with my primary care provider.

_____ _____

Patient Signature **Date**

COMMENTS:

_____

_____

- ☐ **The patient was given a brochure / information on Advance Directive.**

_____ _____

Staff Signature **Date**

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AUTHORIZATION FOR RELEASE OF INFORMATION

First: _____ Last: _____ Date of Birth: ____/____/_____ SS: _____

Address: _____ City: _____ St: ____ Zip: _____

Purpose for Record Request: **CONTINUATION OF CARE**

I hereby request and authorize: (Location) _____

(Address) _____

(Phone#) _____ (Fax#) _____

To release all my Medical Record(s) to: Melanchton Mangoba M.D.
6377 Riverside Ave Suite B-101
Riverside, CA 92506
Phone: (951) 686-3437 Fax: (951) 686-8155

I understand the information may include information regarding drug or alcohol abuse, mental health and/or HIV related information. I release the above from all legal responsibility or liability that may arise from the act I have authorized.

I understand that this authorization is valid for one year after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action has already been taken to comply with.

Signature of Patient or Legal Representative_____ **Date**_____

Legal Representative's Relationship to Patient_____ **Date**_____

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REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

I give permission to Mangoba's Internal Medicine Office to discuss my protected health information (PHI) and communicate regarding payment history, or for scheduling and canceling appointments with the named person below.

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

NOTE: This request will remain in effect until you notify us of a change.

Signature: _____ Date: _____

Relationship (Authority to Sign if Not Patient): _____ Date: _____

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Patient Past Medical History

Head
- ☐ Trauma

Eyes
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wears glasses/contacts

Ears
- ☐ Hearing aids

Nose/Sinuses
- ☐ Allergic Rhinitis
- ☐ Sinus infections

Mouth/Throat/Teeth
- ☐ Dentures
- ☐ Laryngitis
- ☐ Tonsillitis
- ☐ Pharyngitis

Skin
- ☐ Dermatitis
- ☐ Mole(s)
- ☐ Psoriasis

Endocrine
- ☐ Goiter
- ☐ Hyperlipidemia
- ☐ Hypothyroidism
- ☐ Thyroid disease
- ☐ Thyroiditis
- ☐ Type I DM
- ☐ Type II DM
- ☐ Osteoporosis
- ☐ Obesity

Cardiovascular
- ☐ Aneurysm
- ☐ Angina
- ☐ Deep vein thrombosis
- ☐ Dysrhythmia
- ☐ Hypertension
- ☐ Murmur
- ☐ Myocardial infarction (Heart Attack)
- ☐ Palpitations
- ☐ Other heart disease:

_____

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Bronchitis/Emphysema
- ☐ Pleuritis
- ☐ Pneumonia

Neurological
- ☐ Dementia
- ☐ Diabetic neuropathy
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Severe headaches, migraines
- ☐ Stroke
- ☐ Transient Ischemic Attack

Hematology/Oncology
- ☐ Anemia
- ☐ Cancer: Type Explain:

_____

Infectious
- ☐ AIDS
- ☐ HIV
- ☐ Herpes
- ☐ STDs
- ☐ Tuberculosis (dz)
- ☐ Tuberculosis (exposure)

Gastrointestinal
- ☐ Cirrhosis
- ☐ GERD
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Jaundice
- ☐ Ulcer

Musculoskeletal
- ☐ Arthritis
- ☐ Carpal tunnel syndrome
- ☐ Bursitis
- ☐ Gout
- ☐ Tendinitis
- ☐ Osteoarthritis
- ☐ Psoriatic Arthritis
- ☐ Reactive arthritis
- ☐ Rotator cuff tear

Genitourinary
- ☐ Hernia
- ☐ Incontinence
- ☐ kidney stones
- ☐ Nephrolithiasis
- ☐ pelvic inflammatory disease
- ☐ UTI(s)
- ☐ Other kidney disease:

_____

Psychiatric
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Hallucinations, delusions
- ☐ Suicidal ideation
- ☐ Suicide attempts

Colonoscopy

Date of last Colonoscopy: _____

Other Past medical history not listed above please explain below:

_____

_____

_____

_____

_____

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Past Surgical History

Please check all that apply

✓	Surgery Description	Year	✓	Surgery Description	Year
	Aneurysm repair			Inguinal hernia repair	
	Appendectomy			Knee arthroplasty	
	Back surgery			LASIK	
	Bariatric surgery/gastric bypass			Laminectomy	
	Bilateral tubal ligation			Nasal surgery	
	Breast resection/mastectomy			Percutaneous Transluminal Coronary Angioplasty and Percutaneous Coronary Intervention	
	Coronary artery bypass surgery			Pacemaker/defibrillator	
	Carotid endarterectomy/stent			Prostate surgery	
	Carpal tunnel release surgery			Prostatectomy	
	Cataract/lens surgery			Rotator cuff surgery	
	Cesarean section			Sinus surgery	
	Cholecystectomy/bile duct surgery			Skin cancer excision	
	Dilation & curettage			Spinal fusion	
	Hemorrhoid surgery			Total Abdominal Hysterectomy and Bilateral Salpingo-Oophorectomy	
	Hip arthroplasty			Transurethral resection of the prostate	
	Hip replacement			Tonsillectomy/Adenoidectomy	
	Hysterectomy			Vasectomy	

Other surgery not listed above, please explain below please indicated description/year of procedure:

_____

_____

_____

_____

_____

Women Only

☐ Date of last Mammogram Screening: _____ ☐ Abnormal ☐ History of Breast Lumps ☐ Nipple Discharge

OB & Pregnancy History

OB History

Age Onset of Menses: ☐ **Years**

Age at Menopause: ☐ **Years**

Date of last Menstrual Period: _____

Date of last Pap Smear: _____

- ☐ History of Hormone Replacement Therapy
- ☐ History of abnormal PAP smear
- ☐ History of cervical dysplasia
- ☐ History of fertility drugs
- ☐ History of irregular menses

Pregnancy History

Total Pregnancy: ☐

Full Term: ☐

Pre-Term: ☐

Miscarriages: ☐

Living: ☐

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Family History

☐ **Family History Unknown**		Please check below if Alive or deceased	
☐ **Arthritis**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Asthma**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Bleeding Disorder**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Coronary artery disease**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Chronic Obstructive Pulmonary Disease**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
Diabetes	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Type I DM**			
☐ **Type II DM**			
☐ **Heart Attack**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Heart Disease**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **High Cholesterol**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Hypertension**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Mental Illness**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Osteoporosis**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Rheumatoid Arthritis**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Stroke**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Thyroid disease**	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ **Other/Explain:** _____	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased

Cancer-Family History

☐ Colon Cancer	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ Breast Cancer	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ Ovarian Cancer	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ Prostate Cancer	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ Uterine Cancer	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased
☐ Other Type of Cancer Explain: _____	☐ Mother ☐ Father ☐ Other Prease explain:	Alive	Deceased

Social History

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ Are you Sexually Active? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If so, How Much? _____How many Years? _____
(If you quit smoking) How many years did you smoke? _____How Much? _____Years Quit? _____

Drug Abuse: ☐ Yes, Illicit drug use ☐ No, illicit drug use If yes, Explain? _____

Alcohol: ☐ Do not drink ☐ Drink daily ☐ Frequently drink ☐ History of Alcoholism ☐ Occasional drink

Cardiovascular: ☐ Eat healthy meals ☐ Regular exercise ☐ Take daily aspirin

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ADULT TB EXPOSURE RISK ASSESSMENT

(Evaluation Questionnaire to determine if Mantoux Tuberculin Skin Test, TST is indicated)

NAME OF PATIENT _____ TODAY'S DATE _____

DATE OF BIRTH _____ AGE _____

The health care worker (HCW) is to ask the following questions during each periodic health assessment.

QUESTIONS	YES	NO
1. Have you or anyone you see regularly have been diagnosed or suspected of being sick with active TB (Tuberculosis) disease?		
2. Do you have family members or frequent visitors who were born in high TB prevalent countries (most countries from Asia, Africa, Latin America and parts of Eastern Europe?		
3. Were you born in or travel to high prevalent countries (most countries from Asia, Africa, Latin America and parts of Eastern Europe?		
4. Do you live in out of home placements such as board and care or residential facilities?		
5. Do you have HIV or any other immunosuppressive condition?		
6. Do you live with someone with HIV seropositivity?		
7. Do you live or frequently visit with persons who have been incarcerated in the last five years?		
8. Do you live among or been frequently around individuals who are homeless, migrant workers, users of street drugs or residents in nursing homes?		
9. Do you consume alcohol?		

INSTRUCTIONS TO HEALTH CARE WORKERS

Administers the Mantoux TB skin test to all adults who have any of the above risk factors indicated by YES response UNLESS:

1. The patient has a previously DOCUMENTED* positive Mantoux TST or
2. The patient has had a TST within the last year.

Note: Trained medical personnel must read the skin test.

- DOCUMENTED – record indicated the date of Mantoux and millimeter results.

HEALTHCARE WORKER
COMPLETING FORM: _____ **DATE:** _____

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Allergies to Medication? ☐ No ☐ Yes If yes, please list below: _____

_____

MEDICATION LOG

List all prescriptions, over-the-counter drugs, vitamins and herbs.			How much and how often?				
Name of Medication	Dose of Medication	This Medicine is for:	Morning	Noon	Evening	Bedtime	When do you take it?
Example: Simvastatin	Example: mg, ml, etc..	Example: High Cholesterol	Example: 1 Pill	Example: 1 Pill	Example: 1 Pill	Example: 1 Pill	Example: After 1 brush my teeth