PATIENT INFORMATION SHEET

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

SEX: *Male* *Female* AGE: _____

NATIONALITY (Please circle) *Caucasian* *Black* *Indian* *Asian* *Hispanic* *Other*_____

HOME ADDRESS: _____ CITY:_____ZIP:_____

CELL PHONE: _____
HOME PHONE: _____ SOCIAL SECURITY NO: _____

AGE: _____ LANGUAGE: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ BUS PHONE: _____

FOR MINORS AND CONSERVATEES RESPONSIBLE PARTY: _____

NAME AND PHONE NUMBER: _____

PLEASE: FAMILY OR FRIEND'S NAME AND PHONE NUMBER. THANK YOU!
EMERGENCY CONTACT AND PHONE NUMBER: _____

MEDICAL INSURANCE: (PRIMARY) _____POLICY NO:_____

SECONDARY: _____POLICY NO:_____

ADDRESS OF INSURANCE CO: _____ PHONE: _____

The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for service when rendered, unless arrangements are made in advance.

I hereby request and consent to diagnostic procedures, including CHDP examinations, XRAYS, blood tests, medical treatments, including immunizations.

I (self or parent/legal guardian) hereby authorize Allied Health Solutions to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the doctor all payments for Medical services rendered. I agree to settle all claims by arbitration.

PATIENT'S SIGNATURE: _____DATE:_____

Medical History
Historia Clinica

1. Name/ Nombre:_____ Age:_____
2. Marital Status/ Estado Marital:_____
3. Number of Children/ Cuantos Hijos Tiene:_____
4. Hospitalizations/ Hospitalizaciones:_____
5. Surgeries/ Sirugias:_____
6. What kind of surgeries? _____

   Que clase de sirugias?_____
7. Allergies:_____ Alergias:_____
8. Are you currently taking any medications:_____

   _____

   Esta tomando medicamentos en este momento:_____

   _____
9. Do you drink alcohol?_____ Do you smoke?_____

   Toma bebidas alcolicas?_____ Fuma cigarros?_____
10. When was your last TB shot?_____

    Cuando fue su ultimal vacuna del tuberculosis?_____
11. When was your last tetnus shot?_____

    Cuando fue su ultima vacuna del Tatano?_____

12. Have you had any of the problems below?

Chicken Pox_____
Ear infection_____
Sinus problems_____
Hay fever_____
Pneumonia_____
Sickell Cell_____
Frequent headaches_____
Anemia_____
Over weight_____

Underweight_____
Epilepsy_____
Seizure Disorders_____
Mumps_____
Bladder Infections_____
Eczema_____
Heart Murmur_____
Vision Problem_____
Wandering Eye_____

A tenido alguno de estos problemas?

Varicela_____
Infeccion de oidos_____
Problema de nariz_____
Fiebre de Heno_____
Dolores de cabeza_____
Neumonia_____
Depranocitema_____
Soplo al Corazon_____
Anemia_____

Peso bajo_____
Epilepsia_____
Ataques apopleticos_____
Paperas_____
Infeccion de vejiga_____
Eczema_____
Peso excesivo_____
Extrabismo/ Ojo Bajo_____
Problemas de la vista_____

Patients signature: _____ Date: _____

Firma del paciente: _____ Fecha: _____

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other (*Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Allied Health Solutions Medical Group

6333 Wilshire Blvd, Suite 411, Los Angeles, CA 90048
Tel: 323-944-0949, Fax: 323-782-0388

AUTHORIZATION TO RELEASE MEDICAL RECORDS

This authorization allows the healthcare provider (s) named below to release confidential information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION

I hereby authorize:_____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To:
Name: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____

Joseph E. Pierson M.D.
ALLIED HEALTH SOLUTIONS
6333 Wilshire Blvd., Suite 411
Los Angeles, CA 90048
Tel: 323-944-0949 Fax: 323-782-0388

The medical information will be used for the following purpose: _____
This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:
Drug/Alcohol/Substance Abuse_____(Initial) **Tests for Antibodies to HIV_____(Initial)**
Psychiatric/Mental Health _____(Initial) **HIV Diagnosis/Treatment _____(Initial)**

DURATION: This authorization shall be effective immediately and remain in effect until _____

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative **Relationship if other than patient**

_____ _____
Patient's Full Name **Date**

_____ _____
Patient's Social Security Number **Patient's Date of Birth**

NOTICE TO RECIPIENT(S) OF INFORMATION: Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2) which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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6333 Wilshire Blvd., Suite 411
Los Angeles, CA 90048
Physician/Healthcare Facility **Tel: 323-944-0949 Fax: 323-782-0388**

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To:
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
The medical information will be used for the following purpose: _____
This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

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_____ _____
Signature of patient or legal/personal representative Relationship if other than patient

_____ _____
Patient's Full Name Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

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