Wellness At Century City

PATIENT REGISTRATION FORM

How did you hear about our office? _____

Chief Complaint for visit? _____

Additional complaints? _____

Please check all of Dr. Cho's services and procedures that interest you		
☐ Executive Comprehensive Physical	☐ Body Contouring — SculpSure	☐ Vitamin Shot Therapy
☐ Bio-Identical Hormone	☐ IV Vitamin Therapy	☐ Acupuncture & Cupping
☐ Medical Weight Loss	☐ Heavy Metal Chelation	☐ Consult — Focused

PATIENT INFORMATION

Last Name _____ MI _____ First Name _____

Date of Birth _____ Social Security Number _____

Home Address_____
Street *City* *State* *Zip*

Mailing Address if different_____
Street *City* *State* *Zip*

Cell Phone _____ Work Phone _____ Email _____

Gender:	**Employment Status:**	**Marital Status:**	**Preferred Contact:**
• Male • Female	• Employed • Unemployed • Full time student • Part time student • Other _____	• Single • Married • Divorced • Separated • Widowed • Life Partner	• Cell Phone • Work Phone • Email

Employment Information:

Occupation: _____ Employer Name: _____

Person to contact in case of emergency:

Name _____ Telephone # _____

Relationship to patient _____

MEDICAL INSURANCE INFORMATION

Name of Insurance _____

Member ID number _____ Group # _____

Name of Subscriber _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Partner ☐ Other

Address (if different from patient) _____
Street *City* *State* *Zip*

SECONDARY MEDICAL INSURANCE INFORMATION

Name of Insurance _____

Member ID number _____ Group # _____

Name of Subscriber _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Partner ☐ Other

Address (if different from patient) _____
Street *City* *State* *Zip*

Responsible person: (if different from patient)

Last Name _____ MI _____ First Name _____

Date of Birth _____ Telephone # _____

Address_____
Street *City* *State* *Zip*

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Partner ☐ Other

PHARMACY INFORMATION

Name of Pharmacy _____

Address_____
Street *City* *State* *Zip*

Telephone # _____

Medications – List all medications you take, prescription and non-prescription, and the dosage			
☐ I do not take any medications			
Medication	**Dosage**	**Medication**	**Dosage**

Allergies – List all known allergies (drugs, food, animals, etc.)	
☐ No Known Allergies	

Medical History – Check if you have ever experienced the following conditions, and year of onset			
Condition	**Year**	**Condition**	**Year**
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis - Type	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer – Type		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐	
☐ Diabetes		☐	

Surgical History – Please list any SURGERIES you have had and include month/year

Health Maintenance – Check if you have received the following and fill in date of most recent exam			
Exam	**Date**	**Exam**	**Date**
☐ None		☐ EKG	
☐ Breast Exam		☐ Eye Exam	
☐ Cardiac Stress Test		☐ Mammogram	
☐ Colonoscopy		☐ PAP Exam	
☐ DEXA Bone density Scan		☐ Physical Exam	
☐ Echocardiogram		☐ Prostate Exam	

Family History – Check if any family member has had any of the following			
Diagnosis	**Family Member**	**Diagnosis**	**Family Member**
☐ Alcoholism		☐ Mental Illness	
☐ Alzheimer's Disease		☐ Tuberculosis	
☐ Asthma		☐ Obesity	
☐ Blood Disease		☐ Osteoarthritis	
☐ CAD (Heart Attack)		☐ Osteoporosis	
☐ Cancer – Type:		☐ PVD	
		☐ Renal Disease	
☐ Depression		☐	
☐ Diabetes		☐	
☐ Hyperlipidemmia (High Cholesterol)		☐	
☐ Hypertension (High Blood Pressure)		☐	

For Females Only			
Date of Last Menstrual Period:		**History of Abnormal Pap (list date/s)?**	
No. of Pregnancies:	**Miscarriages:**	**Terminations:**	**Living children:**
Method of Contraception:			

Social History		
Tobacco Use **☐ No**	**☐ Daily ☐ Weekly** **☐ Former/Year quit:**	**☐ Chewing ☐ Pipe** **☐ Cigar ☐ Cigarette**
Alcohol Use **☐ No**	**☐ Daily ☐ Weekly** **☐ Former/Year quit:**	**☐ Beer ☐ Wine** **☐ Liquor ☐ Other:**
Drug Use **☐ No**	**If so, what type/s?**	**When?**
Exercise Activity	**☐ Moderate ☐ Vigorous ☐ Sedentary** **Days/Week:**	**Sleep Pattern:** **☐ Changes ☐ No Changes**
Caffeine Use **☐ No**	**☐ Daily ☐ Weekly**	**☐ Chocolate ☐ Soda** **☐ Coffee ☐ Tea** **☐ Other**

Immunizations—Check if you have received the following and fill in date of most recent exam	
Exam	**Date**
☐ Tetanus	
☐ Flu Shot	
☐ Pneumococcal	
☐ Hepatitis B	

DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS (FOR IN-NETWORK INSURANCE POLICY PLANS ONLY):

I hereby authorize direct payment of my insurance benefits to Wellness At Century City or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit.

DEDUCTIBLE/COPAY/COINSURANCE/OFFICE FEE:

The patient is responsible for any deductible/copay/coinsurance/office visit fee at the time of service.

AUTHORIZATION TO MAIL, CALL AND EMAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Wellness at Century City representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results.

NO SHOW POLICY:

As a patient in our practice, it will be your responsibility to keep scheduled appointments. Our office requires notification of cancellation at least by 8 AM one day prior to the appointment or earlier if possible. Please contact our office via phone or email to cancel and reschedule an appointment.

The practice will consider a "failed appointment" anytime a patient has not given the advance notice as stated above. A No Show charge will be applied to your account if advance notice is not given. The charge will range from $50.00/$85.00 depending on the type of appointment missed.

CONSENT TO TREATMENT:

I voluntarily agree to receive services from Wellness at Century City, and authorize the providers of Wellness at Century City to provide such care, treatment, or services as are considered necessary and advisable for me. I understand that I should participate in the planning for my care and that I have a right to refuse interventions, treatment, care, services or medications at any time to the extent the law allows. I know that the care I will receive may include tests, injections, and other medications, etc., that are based on established medical criteria, but not free of risk.

Signature of the patient (or person authorized to sign for patient) _____

Relationship to Patient _____ Date _____