Marcella Bonnici, M.D.

Patient Registration Form

This information is necessary for our files and will be considered confidential.

Patient Name:

(Last) _____ (First) _____ (MI) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Preferred # Home or Cell

Birth date: _____ Age: _____ Gender: Male Female

Social Security: _____ Language: _____

Email: _____

Marital Status: Single Married Widowed Separated Divorced

Race: Caucasian Afr. Am. Asian Native Am. Pac Islander Other / Multi

Ethnicity: Hispanic / Non - Hispanic (Circle One)

Employment Information:

Patient Employer: _____ Occupation: _____

Work Phone: _____ Ext: _____

In Case of Emergency:

Primary contact: _____

Phone#: _____ Relationship: _____

2nd Contact: _____

Phone#: _____ Relationship: _____

Pharmacy Name: _____ Phone #: _____

Address: _____

Insurance Information: Medicare PPO HMO Triw None

Primary INS: _____

Subscriber Name: _____ Subscriber DOB: _____

ID # _____

Group #: _____ Copay Amt: _____

Relationship of Patient to Insured: Self Spouse Child (Circle One)

If Insurance is Through Employer: Employer Name: _____

Are you covered by another Insurance: Yes No (Circle One)

Secondary INS: _____

ID#: _____

Web View Patient Portal

Due to popular demand, we are now offering a Patient portal to send letters, reminders & test results to our patients. You may use this portal to communicate with our office for any non-urgent matters such as prescription refills and scheduling office visits. Any urgent matter should still be communicated via telephone, as messages via the portal may take 48-72 hours to be received and responded to.

If you are interested in this portal, please provide us with your email address, and we will provide you with a user name and temporary password which you will change upon your initial log in. We will also need a security question for the rare occasion that you may forget your password.

This is just one of the many ways to communicate with your doctor's office. If you have any questions, please feel free to ask!

***** EMAIL ADDRESS IS REQUIRED IN ORDER TO SIGN UP*****

****Email:** _____

(Please write DECLINE if desired)

Web View Security Questions: Please choose one.

1. What is your Mother's maiden name:_____
2. What High school did you attend: _____
3. What was the Street name you grew up on: _____
4. What was\is your favorite Pet's name: _____

Assignment of Benefits and Authorization to Release Information:

I hereby authorize payment of any medical insurance benefits arising from services rendered by Marcella Bonnici, M.D. and to be made directly to Marcella Bonnici, M.D. I understand that I am financially responsible for all charges incurred by the above patient for medical services whether or not they are covered by insurance. I hereby authorize Marcella Bonnici, M.D. to release all information necessary to secure the payment of benefits from my insurance company. I further agree that a photocopy or facsimile of this agreement shall be as valid as the original.

Name: _____ Signature: _____ Date: _____

FINANCIAL POLICY IS PAYMENT AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Marcella Bonnici, M.D. is dedicated to protect your "nonpublic personal health information." This notice is to tell you how and why we collect that information, and who has access to that information. If you would like a full notice of this policy, please check our website at www.marcellabonnicimd.com or ask one of our staff members.

HOW WE COLLECT YOUR INFORMATION:

Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and may ask for a copy of your insurance card. This insures you that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to the office, we will ask you to fill out our information sheet to insure that the information we received from the hospital was correct.

We may also ask a doctor or other health care provider who referred you to this practice to give health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:

We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:

To insure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of our Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:

We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities who need this information for claims processing have access to your Protected Health Information.

YOUR RIGHTS:

You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your record.

If you leave this practice, your Protected Healthcare Information will continue to receive the protection outlined in this notice.

COMPLAINT/COMMENTS:

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W. Room 509F, HHH Building, Washington D.C. 20201. You also may contact the Privacy Officer at this practice at (951) 816-3233

THIS PRACTICE reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

This notice is effective as of January 1, 2011.

I acknowledge receipt of a copy of this Privacy Information.

_____

Patient or Responsible Party

_____

Signature

_____

Date

Marcella Bonnici, M.D.
36320 Inland Valley Drive Suite 206
Wildomar, CA 92595
951-816-3233

Marcella Bonnici, MD

ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND INSTRUCTIONS FOR RELEASE OF PERSONAL HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH_____

I acknowledge that I have received a copy of the Dr. Marcella Bonnici's Notice of Privacy Practices.

I give permission to Marcella Bonnici, M.D. to release and discuss my personal health information to/with:

Name: _____Relationship: _____
Name: _____Relationship: _____
Name: _____Relationship: _____

I give permission to Marcella Bonnici, M.D. to communicate messages regarding **appointments** as follows:

___You may leave a message on my answering machine / Cell Phone
___You may leave a message with:

Name: _____Relationship: _____
Name: _____Relationship: _____
Name: _____Relationship: _____

I give permission to Marcella Bonnici, M.D. to communicate messages regarding **referrals to another physician** as follows:

___You may leave a message on my answering machine / Cell Phone
___You may send a letter via U.S. mail
___You may send an email to: _____

I give permission to Marcella Bonnici, M.D. to communicate messages regarding **lab results, x-rays, and other tests** as follows:

___You may leave a message on my answering machine / Cell Phone
___You may send a letter via U.S. mail
___You may send an email to: _____

Other Instructions for the release of personal health information: _____

_____

Patient/ Guardian's Name_____

Signature of Patient or Legal Guardian: _____ Date: _____

Marcella Bonnici, MD

Office Policies

Policies are subject to change without notice

Welcome to our office. We are honored you have chosen us as your healthcare provider.

Office Visits:

- Please bring in all of your current medication bottles or an accurate list of every medicine you are taking
- We require that a parent or legal guardian accompany all minor patients. In case of an emergency, please fill out consent for minor treatment. This form may be found on www.marcellabonnicimd.com or you may call our office for a copy of this form.
- Please be on time for your office visit. If you can not make your appointed time, please advise us as soon as possible so that we may reschedule your visit. If you are late arriving for your appointment, and still expect to be seen, every patient scheduled after you will be delayed as well.

Cancellation/No Show Policy: $50.00 fee

- Cancellations must be 24 business hours in advance
- No shows are patients who fail to show for appointments without notifying the physician's office at least 24 business hours in advance

Laboratory/Radiology/Other Test Results:

- Our office policy regarding all test results is to notify the patient by telephone, letter or email
- If you have not received your test results after **30 (thirty) days** please contact us
- You may be asked to schedule a follow up visit to discuss results

Prescription Refill Policy:

- No prescriptions will be provided after hours or weekends
- No refills of anti-biotics will be provided without an appointment
- Please contact your pharmacy for all prescription refill requests. The pharmacy should contact us directly.
- Some medication refills may require an office visit, so please don't wait until you are almost out to call these in.

Telephone Calls/Messages:

- Phone calls & messages may take up to 24 hours to return.
- If it is an urgent matter, please schedule an appointment so the doctor may address it.

I have reviewed and the read the above office policies and do hereby acknowledge that I will abide by these policies.

Patient's Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Marcella Bonnici, MD
Financial Policy

Please **carefully read** the following statement of our financial policy prior to treatment. Feel free to speak to our financial personnel if you have any questions.

It is your responsibility to be aware of your benefits.

Exclusions, pre-existing conditions, and terminated benefits may nullify insurance coverage and transfer full responsibility to the patient. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage.

This office is not in the practice of changing or re-coding claims once they have been billed. This constitutes fraud; this will not be done or tolerated.

All insurance cards must be provided at the time of service.

If the insurance information is not provided at time of service the patient will be seen on a cash basis.
I understand that if I provide false insurance information I can be held accountable and prosecuted as law provides.

Copay is due in full at time of service

- For any returned checks a $50.00 returned check fee will apply.
- Your first and second billing statements will be sent to you at no charge
- If more than two statements need to be sent, a $10.00 fee is assessed
- If Money is owed it will be collected prior to seeing the physician. If unable to provide payment, then your appointment may have to be rescheduled
- No show's or Cancellations are assessed a $50 fee
- All paperwork needing to be filled out by provider is $25 fee with or without an appt

It is your responsibility to notify our office if there is a change of name, insurance coverage, Residence, and/or phone number.

I have read the above Financial Policy. I understand and agree to abide by the terms of this policy.

Patient Name: _____ Signature: _____ Date: _____

Authorization/Request for Medical Records

Marcella Bonnici, MD
36320 Inland Valley Drive, Suite 201
Wildomar, CA 92595
Office 951-816-3233 Fax 951-816-3240

"This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42DFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is NOT sufficient for this purpose."

Patient Information:

Patient's Name: _____ DOB: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____

Requested Records From:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Records Released To:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Reason for request/disclosure of records:

Reason for Request:
___ Changing of Physician
___ Insurance Request
___ Moving out of Geographical Area
___ Specialist Request for Treatment
___ Parent/Legal Guardian's Copy
___ Other: _____

Records to be included:
___ All Records *
___ Immunization Records
___ Progress Notes
___ Lab Reports
___ Radiology Reports
___ Other: _____

*All records to be disclosed will include communicable disease information, e.g. AIDS information or others. This information gives consent to inspect and copy medical records whose confidentiality is protected by Federal laws which include special authorization to release medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and the comprehensive alcohol abuse and alcoholic prevention, treatment and rehabilitation act amendments of 1974 (9.L. 93-282).
The undersigned hereby authorizes and consents to the disclosure by the above named clinic to the above named company or persons, or their representatives, or the bearer of this instrument of any and all information, records, documents, reports, clinical abstracts, histories, and charts, of every kind and description relating to my condition, care, confinement and treatment, and consent to the furnishing them of photo static copies or other copies of same.
BE IT FURTHER KNOWN that this consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If personally requesting a copy of complete medical records, there will be a $25 fee. Records to other physicians will be sent as a free courtesy for the first copy. Subsequent copies may incur a $25 fee.

I, _____ (patient, parent or legal guardian), am authorizing release of medical records as specified. This request is in effect for one year unless otherwise stated.

Signature: _____ **Date:** _____

Marcella Bonnici, MD

Consent for Treatment for a Minor

Patient Name: _____ D.O.B: _____ Today's Date: _____

1) I, the undersigned parent/guardian of _____, a minor, do hereby authorize and direct Marcella Bonnici, MD and the staff at Dr. Bonnici's to provide ongoing routine and emergency health care. This consent shall remain in effect until _____ or until revoked in writing.
Parent's/Guardian's Name_____ Signature _____Date _____
Witness' Name: _____ Signature: _____ Date: _____

2) I, the undersigned parent/guardian of _____, a minor, do hereby authorize _____, to bring my child to their doctor's appointments. This consent shall remain in effect until _____ or until revoked in writing.
Parent's/Guardian's Name_____ Signature _____Date _____
Witness' Name: _____ Signature: _____ Date: _____

3) The patient has been deemed qualified to consent to his/her own health care services. Emancipation or legal exceptions have been established based on the following:
___ Emancipation, self-supporting, free or parental care, custody and control
___ Married, or previously married minor
___ Family Planning Services
___ Diagnosis/treatment for venereal disease
___ Under the influence of a dangerous drug or narcotic
___ Meets mature minor criteria
___ Other (explain): _____
Clinician's Name: _____ Signature: _____ Date: _____
Patient's Name: _____ Signature: _____ Date: _____

4) Due to the following situation, administrative/legal approval has been obtained for _____ (treatment/procedure), by _____, Administrator.
___ Unavailable parents/guardian
___Abandoned Minor

5) Telephone Consent
1. Consent by telephone may be obtained when prompt treatment is needed or desirable if an adult patient is unable to give consent, or the patient is a minor.
2. Telephone consents require two witnesses.
3. Whenever possible, telephone consent should be follow up with a signature or fax. The fax should be attached.
Consent obtained from: Name _____Relationship: _____
Date: _____ Telephone #: _____
Witness' Name: _____ Signature: _____ Date: _____
Witness' Name: _____ Signature: _____ Date: _____

Marcella Bonnici, MD

Pediatric Medical History Form

Ages: 0-12

Name: _____ D.O.B. _____ Age:_____ Sex: M F

Person filling out form: _____ Relationship to pt: _____

Chief Complaint:

What brings you/the child to our office? _____

Birth History:

1. Birth Weight: _____ Length: _____ Head Circumference: _____
2. Was the birth: On Time Early (how many weeks) _____ Late (how many weeks) _____
3. Was the delivery: Natural C-Section
4. Any Complications during Pregnancy: _____
5. Any Complications during delivery: _____
6. Did the baby go home with mom? Yes No
   If no, how many days/weeks did the baby stay in the hospital: _____

Past Medical History:

1. Is the child in good health at the present time? Yes No
2. Any Diagnosed Medical Problems: Yes No
   Specify: _____ Date: _____
   Specify: _____ Date: _____
   Specify: _____ Date: _____
3. Any Medications taken on a regular basis: Yes No
   What: _____ Dosage: _____
   What: _____ Dosage: _____
   What: _____ Dosage: _____
4. Any allergies to any medications, foods, latex, adhesive tape, bee stings, etc.? Yes No
   What: _____ Reaction: _____
   What: _____ Reaction: _____
   What: _____ Reaction: _____
5. Serious Injuries, including loss of consciousness: Yes No
   Specify: _____ Date(s): _____
   Specify: _____ Date(s): _____
   Specify: _____ Date(s): _____
6. Any Surgery: Yes No
   Specify: _____ Date: _____
   Specify: _____ Date: _____
7. Any Hospitalizations: Yes No
   Specify: _____ Date: _____
   Specify: _____ Date: _____

Has the child ever had any problems with the following? (If Yes, Please explain)

Eyes/Vision: Yes No _____

Feet: Yes No _____

Digestion/Nutrition: Yes No _____

Ears/Hearing: Yes No _____

Urine/Kidneys: Yes No _____

Joints: Yes No _____

Skin: Yes No _____

Lungs: Yes No _____

Teeth: Yes No _____

Heart: Yes No _____

Seizures: Yes No _____

Repeated Infections: Yes No _____

Social History:

1. Please list all of the people in the household:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

2. Does the child go to a baby sitter, day care, or pre-school regularly: Yes No

3. Is the child in school? Yes No

Name of school: _____ Grade: _____

4. Have there been any recent stressors/changes in the child's life: Yes No

Please explain: _____

Family History:

FAMILY MEMBER:	LIVING/DECEASED	MEDICAL PROBLEMS
FATHER		
MOTHER		
BROTHERS		
SISTERS		
PATERNAL GF		
PATERNAL GM		
MATERNAL GF		
MATERNAL GM		

Past Medical History: (Circle all that apply)

Allergies	Cancer
Anemia	Chicken Pox
Anxiety/Depression	Diabetes
Asthma	Heart Valve Disorder
Bleeding Disorder	Pneumonia
Blood Transfusion	Rheumatic fever

Development:

Do you have any concerns about the following: (If Yes, Please Explain)

Development: Yes No _____

Behavior: Yes No _____

Eating Habits: Yes No _____

Sleeping Habits: Yes No _____

School Experience: Yes No _____

Bathroom/Toilet Habits: Yes No _____

Discipline: Yes No _____

Other(explain): Yes No _____

FEMALE ONLY- Menstrual: Age of Onset (menarche): _____

Duration: _____

Are they Regular: Yes No

Are they: Light Moderate Heavy

Pain Associated: Yes No

Last Menstrual Period: _____

Immunizations: (please fill out below or attach a copy of your immunization record)

Dtap	1.	2.	3.	4.	5.
IPV	1.	2.	3.	4.	
Hepatitis A	1.	2.			
Hepatitis B	1.	2.	3.		
Hib	1.	2.	3.	4.	
RV	1.	2.	3.		
PCV	1.	2.	3.	4.	
MMR	1.	2.			
Varicella	1.	2.			
Meningococcal	1.	2.			
HPV	1.	2.	3.		
TD/Tdap	1.				

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.