

**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: \_\_\_\_\_

2<sup>nd</sup> 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](http://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.

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Patient or Responsible Party

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Signature

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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](http://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 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 (42CFR 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**  
Adolescent Medical History Form  
Ages 13-17

*As you make the transition from pediatric to adult health care, you will be assuming more responsibility for your health care. When you go to your new adult doctor (or other health care provider), you will be asked about major health events in your life. **Have a parent help you fill out this form and take it with you when you go to your new adult care doctor (or other health care provider) and you will be prepared for the questions that you will be asked.***

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

**Chief Complaint**

What brings you to our office? \_\_\_\_\_

**Present Status:**

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No  
If yes, for what? \_\_\_\_\_

3. Are you taking any medications at the present time? (Include OTC meds, Supplements)  
Yes No

What: \_\_\_\_\_ Dosage: \_\_\_\_\_

What: \_\_\_\_\_ Dosage: \_\_\_\_\_

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: \_\_\_\_\_

**Past Medical History:**

1. Did your mother have any problems with her pregnancy or delivery of you? Yes No  
What were they? \_\_\_\_\_

2. Were you hospitalized at the time of your birth? Yes No  
How many days? \_\_\_\_\_ weeks? \_\_\_\_\_

3. Did you have any problems at birth? Yes No  
What were they? \_\_\_\_\_

4. As a child or teenager, were you diagnosed with any major health problems? Yes No

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

5. Serious injuries, including loss of consciousness: Yes No

Specify: \_\_\_\_\_ Date(s): \_\_\_\_\_

Specify: \_\_\_\_\_ Date(s): \_\_\_\_\_



6. Any Surgery: Yes No

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

7. Any Hospitalizations: Yes No

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

8. Have you ever had the following? (Circle that apply)

Allergies	Blood Transfusion	DVT	Lung Disease
Alcohol Abuse	Blood Pressure	Eating Disorder	Nervous Breakdown
Anemia	Cancer	Headaches/Migraine/Tension	Pneumonia
Anxiety	Chicken Pox	Heart Valve Disorder	Psychiatric Illness
Arthritis	Depression	High Cholesterol	Rheumatic fever
Asthma	Drug Abuse	Kidney Disease	Thyroid Disease
Bleeding Disorder	Diabetes	Liver Disease	Tuberculosis

Other: \_\_\_\_\_

If the answer is yes to any of the above conditions, please use this space to make any additional comments about the conditions. For individuals with seizures, describe the seizures and include how often the seizures occur, how long they last, and when was your last one.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What tests have previously been done for these conditions? (MRI, CT, EEG, EKG, Genetic Testing, Blood Tests, Psychological Testing, etc...) \_\_\_\_\_

What were the results? \_\_\_\_\_

Where/When were they done? \_\_\_\_\_

Are the conditions: the same    improving    getting worse (circle one)

Social History:

1. Name of school: \_\_\_\_\_

2. Grade in school: \_\_\_\_\_

3. How are you doing in school: Excellent    Good    Fair    Poor (please circle one)

4. Have you ever skipped a grade? Yes No

5. Have you ever been held back a grade for any reason? Yes No

6. Are your parents: Married    Separated    Divorced

7. Who do you live with: Parents    Father    Mother    Other: \_\_\_\_\_

8. Do you have any brothers/sisters? Yes No

How Many? \_\_\_\_\_

Older? \_\_\_\_\_

Younger? \_\_\_\_\_

9. Do You Drink Alcohol? Yes No  
 # of drinks per day \_\_\_\_\_ week \_\_\_\_\_ month \_\_\_\_\_ year \_\_\_\_\_
10. Do you smoke cigarettes? Yes No  
 When did you start? \_\_\_\_\_  
 # of cigarettes per day \_\_\_\_\_
11. Illicit Drug Use: Yes No  
 Date of Last Use: \_\_\_\_\_  
 How often: \_\_\_\_\_  
 Type: \_\_\_\_\_  
 Mode of Ingestion: \_\_\_\_\_
12. Are you sexually active? Yes No
13. How would you rate your diet? Good Fair Poor
14. How many glasses of soda do you drink per day? \_\_\_\_\_  
 Do you drink Regular or Diet Soda? \_\_\_\_\_
15. Are you satisfied with your weight? Yes No

Family History:

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

Has any blood relative ever had any of the following?

- Asthma: Yes No Who: \_\_\_\_\_
- Epilepsy: Yes No Who: \_\_\_\_\_
- High Blood Pressure: Yes No Who: \_\_\_\_\_
- Kidney Disease: Yes No Who: \_\_\_\_\_
- Diabetes: Yes No Who: \_\_\_\_\_
- Tuberculosis: Yes No Who: \_\_\_\_\_
- Psychiatric Disorder: Yes No Who: \_\_\_\_\_
- Heart Disease: Yes No Who: \_\_\_\_\_
- Stroke: Yes No Who: \_\_\_\_\_
- Breast Cancer: Yes No Who: \_\_\_\_\_
- Ovarian Cancer: Yes No Who: \_\_\_\_\_
- uterine Cancer: Yes No Who: \_\_\_\_\_
- Colon Cancer: Yes No Who: \_\_\_\_\_
- Prostate Cancer: Yes No Who: \_\_\_\_\_
- Other Cancer: Yes No Who: \_\_\_\_\_

Gynecological History: (females only)

Menstrual: Age of Onset (menarche): \_\_\_\_\_

Duration: \_\_\_\_\_

Are they Regular: Yes No

Are they: Light Moderate Heavy

Pain Associated: Yes No

Last Menstrual Period: \_\_\_\_\_

Birth Control:

Yes No

Type: \_\_\_\_\_

Pregnancies: Number: \_\_\_\_\_ Dates: \_\_\_\_\_

Vaginal Delivery or C-Section (specify): \_\_\_\_\_

Miscarriages: \_\_\_\_\_

Abortions: \_\_\_\_\_

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

	1.	2.	3.	4.	5.
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.