

Patient Registration Form-Adult

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Gender (Circle One): **M** **F** Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Contact Preference (Circle One): **Home** **Cell** **Work**

Employer Name: _____ Marital Status (Circle One): **Single** **Married** **Other**

Preferred Pharmacy: _____

Email Address: _____

How did you hear about our office (If friend, family, or Dr. please state name):

Emergency Contact Information:

Name: _____ Relationship: _____

Primary Number: _____ Secondary Number: _____

Interpretive Service Needs:

Primary Language: _____ Interpreter Services Required (Circle One): **YES** **NO**

Advance Directives:

Do you have an Advance Directive? (Circle One) **YES** **NO** If yes, please provide a copy.

Would you like information regarding Advance Directives? (Circle One) **YES** **NO**

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plan to the physician/facility on record. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Authorization of Treatment: I hereby authorize the physician of record, and associates, to treat the above patient.

Patient's Signature: _____ Date: _____

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <p><input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats</p> <p>MUSCLE/JOINT/BONE Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders</p> <p>GENITO-URINARY</p> <p><input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination</p>	<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins</p>	<p>EYE, EAR, NOSE, THROAT</p> <p><input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision – Flashes <input type="checkbox"/> Vision – Halos</p> <p>SKIN</p> <p><input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal</p>	<p>MEN only</p> <p><input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other</p> <p>WOMEN only</p> <p><input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other</p> <p>Date of last menstrual period _____ Date of last Pap Smear _____ Have you had a mammogram? _____ Are you pregnant? _____ Number of children _____</p>
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CONDITIONS Check (✓) conditions you have or have had in the past.

<p><input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts</p>	<p><input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease</p>
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MEDICATIONS List medications you are currently taking.

ALLERGIES To medications or substances

_____ _____ _____	_____ _____ _____
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Pharmacy Name _____ Phone _____

Staying Healthy Assessment Adult

Patient's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date
Person Completing Form <i>(if patient needs help)</i> <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Other (Specify)			Need help with form? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	Alcohol, Tobacco, Drug Use

19	In the past year, have you had: <input type="checkbox"/> (men) 5 or more alcohol drinks in one day? <input type="checkbox"/> (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:

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined the SHA
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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:



10835 New St.
Downey, CA 90241

English

I hereby acknowledge that I received a copy of this medical practices Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signature: _____

Date: _____

Printed Name: _____

Telephone #: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of an underage minor patient
- Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

Español

Por este medio reconozco que recibí una copia de este Aviso de práctica médica de Prácticas de Intimidad. Adelante reconozco que una copia del aviso corriente será fijada en el área de la recepción, y que una copia de cualquier Aviso enmendado de Prácticas de Intimidad estará disponible en cada cita.

Firma: _____

Fecha: _____

Nombre en Letra de Molde: _____

de Teléfono: _____

Si no está firmado por el paciente, por favor indique la relación:

- Padre o guardián de un paciente menor de edad
- Guardián o conservador de un paciente incompetente

Nombre y Dirección del Paciente: _____

PRIVACY POLICY STATEMENT



10835 New St
Downey, CA 90241
Patient Care Manager 562)923-9100

Purpose: The following privacy policy is adopted to ensure that this Physician Practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.

Effective Date: This policy is in effect as of 09/01/2014.

It is the policy of this Physician Practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

Notice of Privacy Practices

It is the policy of this Physician Practice that a notice of privacy practices must be published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this Physician Practice to post the most current notice of privacy practices in our "waiting room" area, and to have copies available for distribution at our reception desk.

Assigning Privacy and Security Responsibilities

It is the policy of this Physician Practice that specific individuals within our workforce are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rules' requirements. Furthermore, it is the policy of this Physician Practice that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum it is the policy of this Physician Practice that there will be one individual or job description designated as the Privacy Official.

Deceased Individuals

It is the policy of this Physician Practice that privacy protections extend to information concerning deceased individuals.

Minimum Necessary Use and Disclosure of Protected Health Information

It is the policy of this Physician Practice that for all routine and recurring uses and disclosures of protected health information (PHI) (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPAA compliance) such uses and disclosures of PHI must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also the policy of this Physician Practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for PHI (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request, and where practicable, to the limited data set.

Marketing Activities

It is the policy of this Physician Practice that any uses or disclosures of protected health information for marketing activities will be done only after a valid authorization is in effect except as permitted by law. It is the policy of this organization to consider any communication intended to induce the purchase or use of a product or service where an arrangement exists with a third party for such inducement in exchange for direct or indirect remuneration, or where this organization encourages purchase or use of a product or service directly to patients to constitute "marketing". This organization does not consider the communication of alternate forms of treatment, or the use of products and services in treatment, or a face-to-face communication made by us to the patient, or a promotional gift of nominal value given to the patient to be marketing, unless direct or indirect remuneration is received from a third party. Similarly, this organization does not consider communication to our patients who are health plan enrollees in conjunction with our provision, coordination, or management of their health care and related services, including our coordination or management of their health care with a third party, our consultation with other health care providers relating to their care, or if we refer them for health care to be marketing, but only to the extent these communications describe: 1) a provider's participation in the health plan's network, 2) the extent of their covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. This organization may make remunerated communications tailored to individual patients with chronic and seriously debilitating or life-threatening conditions provided we are making the communication in conjunction with our provision, coordination, or management of their health care and related services, including our coordination or management of their health care with a third party, our consultation with other health care providers relating to their care, or if we refer them for health care. If we makes these types of communications to patients who have a chronic and seriously debilitating or life-threatening condition, we will disclose in at least 14-point type the fact that the communication is remunerated, the name of the party remunerating us, and the fact the patient may opt out of future remunerated communications by calling a toll-free number. This organization will stop any further remunerated communications within 30 days of receiving an opt-out request.

Mental Health Records

It is the policy of this Physician Practice to require an authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows:

- A. Use by originator for treatment;
- B. Use for training physicians or other mental health professionals as authorized by the regulations;
- C. Use or disclosure in defense of a legal action brought by the individual whose records are at issue; and
- D. Use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes.

Complaints

It is the policy of this Physician Practice that all complaints relating to the protection of health information be investigated and resolved in a timely fashion. Furthermore, it is the policy of this Physician Practice that all complaints will be addressed to Patient Care Manager (i.e. Privacy Official) who is duly authorized to investigate complaints and implement resolutions if the complaint stems from a valid area of non-compliance with the HIPAA Privacy or Security Rule.

Prohibited Activities-No Retaliation or Intimidation

It is the policy of this Physician Practice that no employee or contractor may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. It

is also the policy of this organization that no employee or contractor may condition treatment, payment, enrollment or eligibility for benefits on the provision of an authorization to disclose protected health information except as expressly authorized under the regulations.

Responsibility

It is the policy of this Physician Practice that the responsibility for designing and implementing procedures to implement this policy lies with the Privacy Official.

Verification of Identity

It is the policy of this Physician Practice that the identity of all persons who request access to protected health information be verified before such access is granted.

Mitigation

It is the policy of this Physician Practice that the effects of any unauthorized use or disclosure of protected health information be mitigated to the extent possible.

Safeguards

It is the policy of this Physician Practice that appropriate safeguards will be in place to reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards will include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection of PHI. These safeguards will extend to the oral communication of PHI. These safeguards will extend to PHI that is removed from this organization.

Business Associates

It is the policy of this Physician Practice that business associates must comply with the HIPAA Privacy and Security Rules to the same extent as this Physician Practice, and that they be contractually bound to protect health information to the same degree as set forth in this policy pursuant to a written business associate agreement. It is also the policy of this organization that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate, or if that is not feasible, by notification of the HHS Secretary. Finally, it is the policy of this organization that organizations that transmit PHI to this Physician Practice or any of its business associates and require access on a routine basis to such PHI, including a Health Information Exchange Organization, a Regional Health Information Organization, or an E-prescribing Gateway, and Personal Health Record vendors, shall be business associates of this Physician Practice.

Training and Awareness

It is the policy of this Physician Practice that all members of our workforce have been trained by the compliance date on the policies and procedures governing protected health information and how this Physician Practice complies with the HIPAA Privacy and Security Rules. It is also the policy of this Physician Practice that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is the policy of this Physician Practice to provide training should any policy or procedure related to the HIPAA Privacy and Security Rule materially change. This training will be provided within a reasonable time after the policy or

procedure materially changes. Furthermore, it is the policy of this Physician Practice that training will be documented indicating participants, date and subject matter.

Material Change

It is the policy of this Physician Practice that the term "material change" for the purposes of these policies is any change in our HIPAA compliance activities.

Sanctions

It is the policy of this Physician Practice that sanctions will be in effect for any member of the workforce who intentionally or unintentionally violates any of these policies or any procedures related to the fulfillment of these policies. Such sanctions will be recorded in the individual's personnel file.

Retention of Records

It is the policy of this Physician Practice that the HIPAA Privacy and Security Rules' records retention requirement of six years will be strictly adhered to. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended at this organization's discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

Regulatory Currency

It is the policy of this Physician Practice to remain current in our compliance program with HIPAA regulations.

Cooperation with Privacy Oversight Authorities

It is the policy of this Physician Practice that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy and security compliance reviews and investigations.

Investigation and Enforcement

It is the policy of this Physician Practice that in addition to cooperation with Privacy Oversight Authorities, this Physician Practice will follow procedures to ensure that investigations are supported internally and that members of our workforce will not be retaliated against for cooperation with any authority. It is our policy to attempt to resolve all investigations and avoid any penalty phase if at all possible.