# 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.

**GENERAL**
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

**MUSCLE/JOINT/BONE**

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

**GENITO-URINARY**
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

**GASTROINTESTINAL**
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

**CARDIOVASCULAR**
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

**EYE, EAR, NOSE, THROAT**
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

**SKIN**
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

**MEN only**
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

**WOMEN only**
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

**CONDITIONS** Check (✓) conditions you have or have had in the past.
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

| **MEDICATIONS** List medications you are currently taking. | **ALLERGIES** To medications or substances |
|---|---|
| | |
| | |
| | |
| Pharmacy Name Phone | |

**All information is strictly confidential**

## FAMILY HISTORY Fill in health information about your immediate family.

| Relation | Age | State of Health | Age at Death | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |
| | | | | |

| Check (✓) if, your blood relatives had any of the following: Disease | Relationship to you |
|---|---|
| Arthritis, Gout | |
| Asthma, Hay Fever | |
| Cancer | |
| Chemical Dependency | |
| Diabetes | |
| Heart Disease, Strokes | |
| High Blood Pressure | |
| Kidney Disease | |
| Tuberculosis | |
| Other | |

## HOSPITALIZATIONS

| Year | Hospital | Reason for Hospitalization and Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Have you ever had a blood transfusion?** ☐ Yes ☐ No

If yes, please give approximate dates._____

| SERIOUS ILLNESS/INJURIES | DATE | OUTCOME |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## PREGNANCY HISTORY

| Year of Birth | Sex of Birth | Complications if any |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## HEALTH HABITS Check (✓) which substances you use and describe how much you use.

| | | |
|---|---|---|
| | Caffeine | |
| | Tobacco | |
| | Street Drugs | |
| | Other | |
| | | |
| | | |

## OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

| | |
|---|---|
| | Stress |
| | Hazardous Substances |
| | Heavy Lifting |
| | Other |

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

# Staying Healthy Assessment

## Senior

| 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 | Do you have difficulty chewing or swallowing? | No | Yes | Skip | |
| 8 | Are you concerned about your weight? | No | Yes | Skip | |
| 9 | Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day? | Yes | No | Skip | Physical Activity |
| 10 | Do you feel safe where you live? | Yes | No | Skip | Safety |
| 11 | Do you often have trouble keeping track of your medicines? | No | Yes | Skip | |
| 12 | Are family members or friends worried about your driving? | No | Yes | Skip | |
| 13 | Have you had any car accidents lately? | No | Yes | Skip | |
| 14 | Do you sometimes fall and hurt yourself, or is it hard to get up? | No | Yes | Skip | |
| 15 | Have you been hit, slapped, kicked, or physically hurt by someone in the past year? | No | Yes | Skip | |
| 16 | Do you keep a gun in your house or place where you live? | No | Yes | Skip | |
| 17 | Do you brush and floss your teeth daily? | Yes | No | Skip | Dental Health |
| 18 | Do you often feel sad, hopeless, angry, or worried? | No | Yes | Skip | Mental Health |
| 19 | Do you often have trouble sleeping? | No | Yes | Skip | |
| 20 | Do you or others think that you are having trouble remembering things? | No | Yes | Skip | |

| | | | | | |
|---|---|---|---|---|---|
| 21 | Do you smoke or chew tobacco? | No | Yes | Skip | Alcohol, Tobacco, Drug Use |
| 22 | Do friends or family members smoke in your house or where you live? | No | Yes | Skip | |
| 23 | In the past year, have you had 4 or more alcohol drinks in one day? | No | Yes | Skip | |
| 24 | Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight? | No | Yes | Skip | |
| 25 | Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.? | No | Yes | Skip | Sexual Issues |
| 26 | Have you or your partner(s) had sex with other people in the past year? | No | Yes | Skip | |
| 27 | Have you or your partner(s) had sex without a condom in the past year? | No | Yes | Skip | |
| 28 | Have you ever been forced or pressured to have sex? | No | Yes | Skip | |
| 29 | Do you have someone to help you make decisions about your health and medical care? | Yes | No | Skip | Independent Living |
| 30 | Do you need help bathing, eating, walking, dressing, or using the bathroom? | No | Yes | Skip | |
| 31 | Do you have someone to call when you need help in an emergency? | Yes | No | Skip | |
| 32 | 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 |
|---|---|---|---|---|
| ☐ Nutrition | ☐ | ☐ | ☐ | ☐ |
| ☐ Physical activity | ☐ | ☐ | ☐ | ☐ |
| ☐ Safety | ☐ | ☐ | ☐ | ☐ |
| ☐ Dental Health | ☐ | ☐ | ☐ | ☐ |
| ☐ Mental Health | ☐ | ☐ | ☐ | ☐ |
| ☐ Alcohol, Tobacco, Drug Use | ☐ | ☐ | ☐ | ☐ |
| ☐ Sexual Issues | ☐ | ☐ | ☐ | ☐ |
| ☐ Independent Living | ☐ | ☐ | ☐ | ☐ |

Comments:

☐ **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: |


**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: _____

_____

_____

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## 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.