40285 Winchester Rd., Ste 103
Temecula, CA 92591
Ph: 951-296-5844
Fax: 951-296-5840
www.temeculaprimarycare.com

PATIENT DEMOGRAPHICS

Last Name____________________________ **First Name**_____________________________ **MI** _________

Date of Birth _____/_____/_____ **Sex**: M / F **Social Security** __________________ **Marital Status** ______

Race (check all that apply)

- American Indian or Native Alaskan
- Asian
- Native Hawaiian or Other Pacific Islander
- African American
- White
- Hispanic
- Other
- Refuse to Report

Ethnicity (please select one)

- Hispanic or Latino
- Not Hispanic or Latino
- Refuse to Report

Primary Language _____________________

If your primary language is NOT English: Do you require an interpreter? (please circle) YES NO

Address __________________________________ **City**______________________ **State**_______ **Zip**__________

Email Address ________________________________ **Preferred Telephone #** (____) ____________________

Secondary Telephone # (____) __________________ **Please circle your cell phone preference:** Voice Text

How did you hear about our office? ____

EMERGENCY CONTACT / FAMILY INFORMATION

Emergency Contact Name __________________________ **Relationship to patient**_______________________

Emergency Contact Telephone # (____) ____________________

May we Release Medical Information to your Emergency Contact? (please circle one) YES NO

Spouse's Name _____________________________ **Spouse's Telephone #** (____) ____________________

May we Release Medical Information to your Spouse? (please circle one) YES NO

Parent or Legal Guardian Name (Minors only) _______________________ **Telephone #** (___) _______________

PATIENT PHARMACY INFORMATION

Primary Pharmacy Name________________________________ **Telephone #** (____) ____________________

Address __________________________________ **City**______________________ **State**_______ **Zip**__________

Secondary Pharmacy Name______________________________ **Telephone #** (____) ____________________

Address __________________________________ **City**______________________ **State**_______ **Zip**__________

REASON FOR VISIT

What is the reason for your visit today? ____

____

____

-Paper work continued on page 2-

TEMECULA VALLEY
PRIMARY CARE PHYSICIANS

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-Patient Information page 2-

EMPLOYMENT / INSURANCE INFORMATION

Type of Employment___________________________________ **Work Telephone #** (____) ____________________

Is it ok to contact you at work? (please circle one) YES NO FOR EMERGENIES ONLY

Current Insurance Company _______________________________ **Relationship to the Policy Holder**__________

-PLEASE PRESENT YOUR INSURANCE CARD TO THE FRONT OFFICE AT THE TIME OF YOUR VISIT-

ALLERGIES

Please list all medications you are allergic:

____

____

____

____

____

Please list all other allergies you have:

____

____

____

____

____

CURRENT MEDICATIONS

Please list all medications you are currently taking (both prescribed and over the counter)

____

____

____

____

____

____

____

____

____

____

-Paper work continued on page 3-

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PAST MEDICAL HISTORY

Please circle all that apply:

Diabetes	Current	Past	N/A
Hypertension	Current	Past	N/A

Other (please explain below)

____

____

When was your last Dental Exam? ____________________ **When was your last Eye Exam?** _______________

When was your last Tetanus Shot? ___________________

For Children under 6 years of age:
Does the child live in or spend time in a building that was built prior to 1960 or that has peeling paint? YES NO
Is the child in a state funded program? YES NO

SURGICAL HISTORY

Please list all surgeries and their dates:

____

____

____

FAMILY MEDICAL HISTORY

Please list any family members with the following:

Diabetes ____

Hypertension ____

Cancer (please list type as well) ____

Other (please list condition and relation)____

SOCIAL HISTORY

Do you use Alcohol? YES NO **If yes, please indicate the type, amount & frequency of use.**

____

Do you use Tobacco? YES NO **If yes, please indicate the type, amount & frequency of use.**

____

Do you use any illegal drugs? YES NO **If yes, please indicate the type, amount & frequency of use.**

____

TUBERCULOSIS (TB) RISK SCREENING

Are you a health care provider? YES NO **Do you have contact with a person known to have TB?** YES NO

Do you have contact with a homeless, illegal drug user or migrant worker? YES NO

Do you live in or visit a group home or prison? YES NO

Have you spend extended time in Asia, Africa or South America? YES NO

-Paper work continued on page 4-

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ADVANCED DIRECTIVE STATUS

An Advanced Directive is a document that allows you to give instructions about your health care or name another person to make health care decisions for you.

This practice respects your right to make your own health care decisions. We comply with state and federal laws regarding advanced health care directives. We do not discriminate against anyone based on the status of their Advanced Directive.

Patient Last Name________________________ **First Name**_________________________ **MI** _________

Date of Birth ______/______/______

Do you have an Advanced Directive? YES NO **If yes, please list who has a copy below.**

____

Would you like to receive information about Advanced Directives? YES NO

FOR OFFICE USE ONLY:

Patient was given information on Advanced Directives? YES NO

Patient provided an Advanced Directive for their medical record? YES NO

Staff signature______________________________________ Date ______/______/______

CONSENT FOR USING AND PROCTECTING HEALTH CARE INFORMATION

-Privacy practices are posted in the patient waiting area. You may request a printed copy. –

May this office call the telephone numbers listed on page 1 and leave a voice message regarding your appointments and medical care? (please circle one) YES NO

May this office send mail to the address listed on page 1 regarding your appointments and medical care? (please circle one) YES NO

My protected health information will be used strictly to carry out my treatment, health care operations and receive payment for medical services provided.

Patient Name____

Patient Signature ____

OR

Parent/Legal Guardian Name____

Parent/Legal Guardian Signature____

I have the right to refuse to sign above and not allow this practice to use my protected health information to carry out my treatment, healthcare operations and receive payment for medical services provided. My healthcare provider may consider this request but is not required to agree. If the provider does not agree with your request, you will be given 30 days to secure a new medical provider. Medical records will be copied upon request.

-Paper work continued on page 5-

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IMMUNIZATIONS

Immunization records are needed for all patients. Please provide your immunization record or request a copy from your previous provider. Records requests are available in the front office.

FINANCIAL AGREEMENT

Please provide your insurance card, co-pay and valid state ID at the time of your visit. A photo ID will be taken and attached to your medical record. All unpaid insurance claims and balances will be billed to the patient.

AUTHORIZATION TO BILL INSURANCE

I authorize the practice to send medical claims, medical information and collect payment from my insurance carrier. I will provide a copy of proof of insurance for both office visits and pharmacy benefits if under a separate plan.

CONSENT TO TREAT

I give my consent for a medical examination, evaluation, treatment and review of my prescriptions. I have the right to understand and agree to my plan of care. I have the right to refuse care. I have the right to request language interpretation.

Patient Name____

Patient Signature ____

OR

Parent/Legal Guardian Name____

Parent/Legal Guardian Signature____

-Please complete the attached Staying Healthy assessment for your age group-