

Patient Information

 Name: _____ Date of Birth: _____
 First *MI* *Last*

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Pharmacy: _____ City: _____ Phone#: _____

 Sex: Male Female SS#: _____

 Marital Status: Single Divorced Married Widowed Legally Separated

 Ethnicity: Caucasian Hispanic African-American Asian/Pacific-Islander Other _____

Employer: _____ Occupation: _____

Home Phone	Cell Phone	Work Phone
(____) _____ - _____ <input type="checkbox"/> This is my preferred number <i>May we leave personal/medical information on your voicemail?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	(____) _____ - _____ <input type="checkbox"/> This is my preferred number <i>May we leave personal/medical information on your voicemail?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*I understand that a cellular phone is not a secure and private line.</i>	(____) _____ - _____ <input type="checkbox"/> This is my preferred number

 Email: _____

Primary Emergency Contact	Secondary Emergency Contact
Please check box below indicating whether or not you would like to have this Primary Emergency Contact added as an authorized HIPAA contact. <input type="checkbox"/> I authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact. <input type="checkbox"/> I do NOT authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact. Name: _____ Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Sibling <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Other _____	Please check box below indicating whether or not you would like to have this Primary Emergency Contact added as an authorized HIPAA contact. <input type="checkbox"/> I authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact. <input type="checkbox"/> I do NOT authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact. Name: _____ Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Sibling <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Other _____
Primary Care Provider Name: _____	Referring Provider Name: _____

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Insurance Coverage

You must bring a photo I.D. and insurance card(s) on the day of your appointment.

Primary Insurance	Secondary Insurance
Carrier: _____ Policy #: _____ Group #: _____ Policy Holder's Name: _____ Policy Holder's date of birth: _____ Relationship to policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	<input type="checkbox"/> I do not have a secondary insurance Carrier: _____ Policy #: _____ Group #: _____ Policy Holder's Name: _____ Policy Holder's date of birth: _____ Relationship to policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____

By signing this form I authorize:

1. The release of any medical and/or other information necessary to process my claims.
2. Payment of medical benefits to my treating physician or supplier for services rendered by Guadalupe Regional Medical Group.
3. I am financially responsible for all charges not covered by my insurance.

 Patient/Guardian Printed Name

 Date

 Patient/Guardian Signature

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 Please describe the reason for your visit with us today: _____

Past Medical History

<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Anemia	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lupus	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/>
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures	<input type="checkbox"/>

Surgical History

<input type="checkbox"/> Abdominal surgery	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Cataract	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Coronary Bypass	<input type="checkbox"/> Gallbladder removal	<input type="checkbox"/> Knee Surgery
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Coronary Stent	<input type="checkbox"/> Heart Surgery (other than coronary bypass)	<input type="checkbox"/> Neck Surgery
<input type="checkbox"/> Biopsy	<input type="checkbox"/> Stomach Endoscopy	<input type="checkbox"/> Hip surgery	<input type="checkbox"/> Other

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Have you recently been experiencing any of the following symptoms recently?

Constitutional symptoms:

- Fever
- Weight loss
- Extreme fatigue

Eyes:

- Double vision
- Sudden loss of vision

Ears, nose, mouth, and throat:

- Sore throat
- Runny nose
- Ear pain

Cardiovascular:

- Chest pain
- Palpitations
- Swelling of your feet

Respiratory:

- Cough
- Wheezing
- Shortness of breath

Gastrointestinal:

- Nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Blood in stools

Genitourinary:

- Irregular menses
- Vaginal bleeding after menopause
- Frequent or painful urination
- Bloody urine
- Testicular pain of pass

Skin:

- Rash
- Changing mole

Neurological:

- Headache
- Persistent weakness
- Falling

Musculoskeletal:

- Joint pain
- Muscle pain

Psychiatric:

- Depression
- Anxiety
- Suicidal thoughts

Endocrine:

- Excessive thirst
- Cold or heat tolerance
- Breast mass

Hematologic:

- Unusual bruising or bleeding
- Enlarged lymph nodes

Allergic:

- Hay fever

OFFICE & FINANCIAL POLICIES

Please initial by each number:

____ 1. **PAYMENTS.** We require payment in full for any amounts designated to be the patient’s responsibility at the time services are rendered. This may include co-pays, co-insurance, and/or deductible amounts. For returned checks, there will be a \$25 charge and future payments will be required to be paid with cash, a money order, or a credit card.

____ 2. **APPOINTMENT CANCELLATION.** All appointments must be rescheduled or cancelled 24 hours before your scheduled appointment. You will be charged a \$25 fee for missed appointments, cancellations or rescheduled appointments less than 24 hours, unless you had an emergency.

____ 3. **HMO & PPO REFERRALS.** If your insurance policy requires written authorization (referrals or precertification) from your referring physician, we require this authorization be on file at the time of your appointment. It is your responsibility to make sure that your visit is pre-approved so that your insurance company will pay for your visit. Otherwise you will be responsible for the payment in full.

____ 4. **MEDICATION REFILL REQUEST.** Please allow 24 to 48 hours to refill your medication(s). If your medication refill has expired you will need to schedule an appointment.

____ 5. **TEST RESULTS.** Test results will not be given over the phone and an appointment will be made to review results.

____ 6. **15 MINUTE LATE POLICY.** Please arrive 10 minutes before your scheduled appointment in order to be processed. If you are not here at the requested time before your appointment, we may have to delay or reschedule your visit.

____ 7. **CHRONIC CARE MANAGEMENT.** (For patients 65+) I understand Chronic Care Management services are subject to the usual Medicare deductible and coinsurance. I hereby indicate by signature that Dr. Sangha is designated as my primary care physician for purposes of providing Medicare chronic care management. This designation is effective as of the date below and remains in effect until revoked in writing by me. If revoked, this will result in limited services outside of a clinic visit.

____ 8. **NON-COVERED SERVICES.** I understand some services may *not* be a covered benefit under my medical policy (weight loss, obesity, mental health {depression, anxiety, Insomnia, post-traumatic stress disorder}, and erectile dysfunction) and that my health insurance coverage has certain restrictions and limitations. If non-covered services are provided, I understand and agree to be financially responsible for any and all charges related to these services. I also understand that my account balance must be current to receive refills for medications prescribed by my Health-Care Provider.

“I, the guarantor of payment and responsible party, agree to the above policies and agree to the terms.”

Signature of Patient: _____ **Date:** _____

Printed Name: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, have read the Guadalupe Regional Medical Group Notice of Privacy Practices. By signing, I acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices and HIPAA Consent and agree to all provisions outlined herein and I give permission to GRMG to obtain my Medication History from my pharmacy, my health plan, or other healthcare provider.

Signature of Patient: _____ **Date:** _____

I give permission to GRMG to release my private information to the following person(s). Please print below:
