PATIENT REGISTRATION FORM

Dear Patients: As part of the modification of our electronic health records to meet national guidelines, we ask that you provide us with some additional demographic information, including: *preferred language, gender, race, ethnicity, and date of birth.*

Last Name:_______________________________Address:__________________________________

First Name:_______________________________City: _________State:_____Zip Code___________

Home Phone # (___)_____________Cell Phone # (__)______________Work#(___)___________

Race __________ **Language** __________**Hispanic (Yes) (No)** DOB:____/___/___Age:__Sex: ___

Marital Status: ___________________

Employer: ____ **(Full Time)(Part Time)**

E-mail Address:____

Primary Pharmacy: Name/City____

PRIMARY INSURANCE

Insurance Name:_________________________________Address:____________________________

Policy/Group #:__________________________________City:_______________________State:___

Insured's ID#: _____________________________Zip Code:__________Phone#: (_____)__________

SUBSCRIBERS INFORMATION

Last Name:_____________________________ First Name_____________________________________

DOB__________Address:________________________City:_______________________State:______

Insured's ID#: _____________________Zip Code:_________Phone#: (_____)____________________

EMERGENCY CONTACT:

Last Name:_____________________First:__________________MI:_____ Relationship:____________

Address:____

____

Home Phone: (   ) ________________________ **Cell** (   ) ________________________________

Alt Phone (   ) _________________________ **Work** (   )__________________________________

I have read and answered all questions to the best of my knowledge. I understand that the charges incurred are my responsibility regardless of insurance coverage. *Diablo Valley Primary Care, Inc*. has provided me the opportunity to review and/or have a personal copy of their Notice of Privacy Practices. I understand that it is my responsibility to inform this office of any changes in the above information.

____   ____________________________

Signature of Patient/Subscriber   **Date**

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I further expressly agree that this signature will bind me as though I had personally signed the particular claim.

I, ________________________ hereby authorize ________________________
(Subscriber/Patient) (Insurance Carrier)

to pay and hereby assign directly to **Diablo Valley Primary Care** all benefits, if any, otherwise payable to me for services described on the attached form. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Diablo Valley Primary Care** will be credited to my account, in accordance with the above said agreement.

"NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov"

____ ____________
(Authorized Signature of Subscriber/Patient) **(Date)**

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information PHI. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone ___________________________

O.K. to leave message with detailed information
Leave message with call-back number only

Cell Phone _________________________

O.K. to leave message with detailed information
Leave message with call-back number only

Work Telephone _____________________

O.K. to leave message with detailed information
Leave message with call-back number only

Written Communication

O.K. to mail to my home address
O.K. to mail to my work/office address

Please List one: Family/Personal Contact ______________________

____

____ ________________

Patient/Guardian (print and signature) **Date**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for treatment, payment or healthcare operations may be permitted without prior consent in an emergency.

OFFICE USE ONLY

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

1. Check this box if the disclosure is authorized
2. Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
3. Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient's Name: ______________________________________ Date Of Birth: _____/____/______

Telephone # (____)____

INFORMATION TO BE RELEASED FROM:

I hereby authorize Dr./ NP ____

____
ADDRESS CITY STATE ZIP CODE

to release the following medical information contained in the patient's medical record.

INFORMATION TO BE RELEASED TO:

Diablo Valley Primary Care Inc.
Chinnavuth De Monteiro, MD P
Ashley Greer, PA-C
Claire Wilkinson, PA-C
2415 High School Ave. Suite 800
Concord, CA. 94520
925-687-5210 (phone)

TYPE OF INFORMATION TO BE RELEASED (Limited to two (2) years of information unless otherwise stated).PLEASE DO NOT FAX RECORD IF ITS MORE THAN 10 PAGES. THANKS

CHECK ALL BOXES ACCEPTABLE TO RELEASE

1. **GENERAL RELEASE**
   ALL RECORDS From: ___________________ To:_______________________

   Medical Records excluding protected records From: ___________________ To: ______________________

   Test Results (specify) __________________ From: ___________________ To: ______________________

   Records pertaining to specific medical date;
   (i.e. Motor Vehicle Accident, immunizations), Specify: ____

2. **INFORMATION PROTECTED BY STATE/FEDERAL LAW**
   Sexually Transmitted Disease From: __________________ To:
   ____
   Diagnosis/Treatment or counseling (includes HIV/AIDS)
   Drug Abuse/Alcoholism Diagnosis/Treatment From: _________________ To: ______________________
   Mental Health Diagnosis/Treatment From: _________________ To: ______________________

3. **INSURANCE COMPANY REQUESTING A COPY OF YOUR MEDICAL RECORD**
   Please be advised that your Life/Health/Disability insurance company has contacted this office to release your medical record in its entirety. By complying with this request you are forfeiting the confidentiality of your Protected Health Information (PHI). You are allowing the release of personal notes, examination findings, diagnosis, test results and treatment plans. Please understand that by releasing this information you may suffer the loss of coverage entirely. These ramifications are based on subjective interpretation of finding in your medical record and compared to your insurance company's actuarial data. As a result, the insurance company's interpretation of your overall health may not always coincide with my overall opinion of your medical health.

____ ___________/_________/___________
PATIENT SIGNATURE (or Legal Representative) DATE

Limiting your authorized release may lead to minor delay in mailing records. Some records may include both protected and unprotected information, therefore; exclusions may create an incomplete document. This authorization applies ONLY to this request. Future requests will require another signed form. All requests will require 14 days for completion.

PERSONAL MEDICAL INFORMATION

PLEASE COMPLETE BOTH SIDES

NAME: ____ DATE: ____________________

Occupation: ____How Long? _________________

Your living situation? _____ Alone _____ Couple _____ Group

Do you have or live with children? _____ Yes _____ No. If yes please give gender and ages ______________________

Do you have any allergies or reactions to medications? (Please explain) ____
____

Do you have a special diet or health practices? (Please explain) ____
____

Do you do any form of exercise, play sports or have any special interests? _____________________________________
____

When was your last complete physical examination? _____ years _____ months

When was your last dental examination? _____ years _____ months

When was your last eye examination? _____ years _____ months

When was your last cholesterol check? _____ years _____ months

Do you smoke? _____ yes _____ no If yes, For how long and how much per day/week? ___________________________

Do you drink alcohol? _____ yes _____ no. If Yes, How much and how often? ________________________________

Do you drink coffee? _____ yes _____ no. If Yes, How much and how often? _________________________________

Have you ever had a problem with alcohol or drugs? ___ Yes ___ No If Yes please explain: ______________________
____

What is the purpose of this visit? ____
____

TESTS AND IMMUNIZATIONS: (If you have had any of the following, please enter the year.)

Gall Bladder X-ray __________

Chest X-ray __________

GI Series __________

Kidney X-ray __________

Last TB Test __________

Last Tetanus Shot __________

Last Measles Vaccination __________

Electrocardiogram __________

Are you up to date with all your immunizations? ____Yes ____ No ____ Don't know

Please list any other tests or immunizations not mentioned here**:** ____
____
____
____

YOUR HEALTH HISTORY

Has anyone in your family had any of the following? **(Please include yourself)**

High Blood Pressure ____________________
Heart Trouble ____________________
Stroke ____________________
Migraines ____________________
Emotional Problems (Treated) ____________________
Arthritis/Rheumatism ____________________
Tuberculosis ____________________
Anemia ____________________
Diabetes ____________________
Seizures ____________________
Glaucoma ____________________
Alcoholism ____________________
Breast Cancer ____________________
Cancer (What kind) ____________________
Other inherited diseases not listed: ____________________

Please indicate the present health of your family members:

Father ____ Good _____ Poor _____ Deceased (Age and Cause) ____________________
Mother ____ Good _____ Poor _____ Deceased (Age and Cause) ____________________
Brother/Sister ____ Good _____ Poor _____ Deceased (Age and Cause) ____________________
Brother/Sister ____ Good _____ Poor _____ Deceased (Age and Cause) ____________________
Brother/Sister ____ Good _____ Poor _____ Deceased (Age and Cause) ____________________

If there are any other family members not mentioned above and there is any information you think is important about their health, Please add them below: ____________________

____

____

Please check additional illnesses or problems that you have had:

___ Measles
___ Mumps
___ Scarlet fever
___ Polio
___ Rheumatic fever
___ Mononucleosis
___ Syphilis
___ Hepatitis
___ Malaria
___ Rashes/Hives
___ Bronchitis
___ Pneumonia
___ Eczema
___ Liver disease
___ Thyroid
___ Hernia
___ Hemorrhoids
___ Eye problems
___ Stomach problems
___ Gall bladder problems

If you have ever been hospitalized for a serious illness or operation, or if you had a serious illness without being hospitalized please list them below. (Illness, operation, and date) ____________________

____

____

____

____

Please list any medications that you are currently taking. Include all non-prescription drugs, like aspirin, laxatives, antacids and vitamins: ____________________

____

____

____

____

____

____

____

GYNECOLOGY HISTORY

NAME____ DATE ________________

At what age did you have your first period? _____ Years

Are your periods regular? ___ yes ___ no. How many days do you have between periods? ___________

How many day do your periods last? _____. Is the bleeding heavy? ____ yes ____ no

Do you have any problems with pain or cramping during your period? ____ yes ____ no

Do you feel tense or unhappy during your period? ____ yes ____ no

Do you douche? ____ yes ____ no With what? ____

Do you have a discharge from your vagina today? ____ yes ____ no

Please describe it ____

Have you ever been pregnant? Yes ___ no ___ How many children do you have? ___________________

Have you ever had an abortion? yes ___ no ___ How many? ____________________________________

Have you ever had a miscarriage? Yes ___ no ___ How many? __________________________________

Did you have any problems with pregnancy, delivery or abortion? (please describe) ___________________

CONTRACEPTIVE HISTORY: Are you sexually active with men ___ women ___ or both ___?

Do you use birth control? Yes ___ no ___ What type of birth control do you use? ____________________

Have you ever used any other type of birth control? (please describe) ______________________________

Do you ever have pain with intercourse? Yes ___ no ___

Have you ever been treated for:
Problems with your uterus: (fibroids, abnormal pap smear, vaginal bleeding, etc.
Please describe) ____
STD? (please explain) ____

Do you examine your breasts yes ___ no ___

Date of last pap smear __________________

Date of last pelvic exam _________________

Date of last breast exam _________________

<u>THIS INFORMATION WILL REMAIN CONFIDENTIAL</u>