New Patient Registration Form

Please Print

Patient's First Name_____Last Name_____Middle Name_____

Patient's social Security #_____Date of Birth_____Gender_____

Marital Status (circle one) Minor Single Married Widowed Divorced Separated

Home Address:_____
Street Apt# City State Zip code

Cell Phone: _____Home Phone:_____

Email Address: _____ (We occasionally send email to our patients for our new services, vaccines, and health promotions, would you like to receive this occasional email? Yes No)

Patient's Occupation_____Patient's Employer_____

Name of Patient's Spouse_____Spouse's Employer_____

Spouse's Phone Number_____

If patient has a guardian, please fill in guardian's info:

Guardian's First Name_____Last Name_____ Middle Name_____

Guardian's Date of Birth_____Social Security#_____Cell Phone_____

Guardian's Address_____

Emergency Contact:

First Name_____Last Name_____Relationship to patient_____

Cell Phone_____Other Phone_____

Address_____

INSURANCE CARRIER INFORMATION (Please allow us to make copy of your insurance cards)

Insurance carrier #1_____Policy#_____

Group#_____ Effective Date_____Expiration Date_____

Subscriber's First Name_____Last Name_____Social security #_____

Subscriber's birthdate_____Patient's relationship to subscriber_____

Insurance carrier #2_____Policy#_____

Group#_____ Effective Date_____Expiration Date_____

Subscriber's First Name_____Last Name_____social security #_____

Subscriber's birthdate_____Patient's relationship to subscriber_____

New Patient Registration From Continued

FIANCIAL RESPONSIBILTY

Payment for services rendered is to be made as follows:

I request that payment of authorized insurance benefits be made to Yan Zhang, MD for any services or items furnished to me by the physician or supplier. I authorize the practice to release to the Health Care Financing Administration, my Insurance Carrier, and/or its agents appropriate information needed to determine these benefits or the benefits payable for related services in accordance with HIPAA guidelines. Release of other information requires specific release authorization.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered as well as any late, collection, or monthly billing fees as stated. I have read all the information above and understand and agree to make an estimated co-payment or payment in full after services are rendered. I further agree to notify Yan Zhang's Clinic of any changes to my insurance coverage so that filing of my claim is expedited.

Signature of Beneficiary or Guardian_____Date Signed_____

Beneficiary or Guardian Address_____

RELEASE OF MEDICAL INFORMATION:

To whom may we, as your health care providers, release information about your medical conditions?

Name_____ Relationship_____

Name_____Relationship_____

Patient or Guardian signature_____ Date signed_____

AUTHORIZATION AND CONSENT FOR TREATMENT

I, the undersigned, or as the legal guardian of the undersigned authorize Dr. Yan Zhang to render medical treatment to myself or the patient above for whom I am responsible.

Signature_____Date signed_____

ACKNOWLEDGEMENT

I, the undersigned, or as the legal guardian of the undersigned confirm that I have read and understand the privacy policy. The information that I provided to the office is accurate and true. I agree to be bound by the terms and agreements.

Signatue_____Date Signed_____

HOW DID YOU HEAR ABOUT US? (Please fill in names)

TV_____Radio_____Web Search_____

Friends_____Colleges_____ Family Member_____

Bulletion_____ Newspaper_____Church_____

Walk By_____Yellow Page_____Health Care Personnel_____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Uses and Disclosures

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medial record to all health professional who may provide treatment or who may be consulted by staff members. During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist to obtain his/her input. Another example would be that the staff members obtain treatment information about you and records it in a health record.

Payment: Your health information may be used to seek payment from your health plan, employer, from other sources of coverage such as your automobile insurer or employer's workers compensation carrier, from credit card companies that you may use to pay for \services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. If medical care information if requested by your health insurance carrier or carrier responsible for payment, i.e. employer, workers compensation carrier etc. We will provide information to them about you and the care given.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of our medical office. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. We obtain services from our insures or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandates reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Newsletter: Unless you request us not to, we will use your name and address to send a flyer or newsletter when available. If you do not wish to receive this information, please check off the box on the authorization form.

Communication with Family: in non-emergent situation, we will only disclosed your medical information to the person that you choose to. In emergent situation, we will use our best judgment in assisting your medical care. That might involve disclose your information to close relatives or friends.

Disaster Relief: We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations: Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or to the entities engaged in the procurement, banking, or transplantations of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls,
repairs, or replacements.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health: As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reaction to medications or problems with products to notify people of recalls; to notify a person with may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse and Neglect: We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers: We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provider either to conduct and evaluation relation to medical surveillance of the workplace or the evaluate whether you have a work-related illness or injury. In such circumstance, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for release of that information to your employer.

Corrections Institutions: If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected

health information necessary for your health and the health and safety of other individuals.
Law Enforcement: We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.
Health Oversight: Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.
Judicial/Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceedings as allowed or required by law, with your authorization, or as directed by a proper court order.
Serious Threat: To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person of the public.

For Specialized Governmental Functions: We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
Coroners. Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of Covered Entities to funeral directors as necessary for them to carry out their duties.
Other Uses: Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights and Requests to Inspect Protected Health Information."
Website: If we maintain a website that provides information about our entity, this Notice will be on the website.

Your Health Information Rights and Requests to Inspect Protected Health Information

The health and billing records we maintain are the physical property of our medical office. The information in it, however, belongs to you. You have certain rights under the federal privacy standards. You have a right to:
a. Request a restriction on certain uses and disclosures of your health information be delivering the request to our office - we are not required to grant the request, but will comply with any request granted
b.Obtain a paper copy of the current Notice of Privacy for Protected Health Information ("Notice") by making a request at our office
c.Request that you be allowed to inspect and copy your health record and billing record - you may exercise this right by delivering the request to our office
d.Appeal a denial of access to your protected health information, except in certain circumstances
e.Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to office in writing.
f. We may deny your request if you ask us to amend information that:
1. Was not created by us
2. Is not part of the information that you would be permitted to inspect and copy, or
3.Is accurate and complete

Our Responsibility

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy polices and practices that are outlined in this notice. We are required to:
a.Maintain the privacy of your health information as required by law
b.Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you
c.Abide by the terms of this Notice
d.Notify you if we cannot accommodate a requested restriction or request, and
e.Accommodate your reasonable requests regarding methods to communicate health information with you.

Right to Revise Privacy Practices

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. These changes in our polices and practices may be required by changes in federal and state laws and regulations. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy. The revised polices and practices will be applies to all protected health information we maintain.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact: Yan Zhang, MD, 3665 bilberry road, San Bernardino, CA 92407. Tel:909-270-1830. Fax: 888-523-5237.

I, _____ have reviewed and understand this HIPPA policy.

Signature_____ Date_____

Yan Zhang, MD.

Internal Medicine Center

3665 Bilberry Road, San Bernardino, CA 92407

Tel: 909-270-1830 Fax: 888-523-5237

www.yanzhangclinic.com

Agreement to communicate less sensitive patient information via unsecured email or text.

I understand that my email and cell phone text message is unsecured. I request to communicate with the doctor this way for the convenience. This agreement is limited to less sensitive information ie: my appointment information and billing information. Please send this info to: email:_____ and cell phone:_____.

Patient's Name:_____

Signature: _____

Date:_____

Agreement to communicate more sensitive patient information via unsecured email or text.

I understand that my email and cell phone text message is unsecured. I request to communicate with the doctor this way for the convenience. This agreement applied to all my medical record information. Please send this info to: email: _____ and cell phone:_____.

Please note, even you agree with this, we might not comply with your request on some medical information that we deemed too sensitive to transmit via unsecured route.

Patient's Name:_____

Signature: _____

Date:_____

Yan Zhang, MD.

Internal Medicine Center

3665 Bilberry Road, San Bernardino, CA 92407

Tel: 909-270-1830 Fax: 888-523-5237

www.yanzhangclinic.com

Acknowledgment of Cancellation fee

I understand that Yan Zhang, MD, Medical Center charge a $30.00 cancellation fee. This fee will incur if I don't cancel 48 hours prior to the appointment time. This applied to both online and calling in appointment. No show or showing up more than 30 minutes late is considered canceled.

Patient Name: _____

Signature: _____

Date:_____

Yan Zhang, MD
Internal Medicine Center
3665 Bilberry Road
San Bernardino, CA 92407
Tel: 909-270-1830
Fax: 888-523-5237

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Yan Zhang, MD to charge my credit card above for my account balance. For any balance larger than $100, it will be spitted automatically to $100 a month until it is paid off. Any larger one-time payment needs my separate writing approval. I understand that my information will be saved to file for future transaction.

_____ _____

Customer Signature Date

YOUR OTHER DOCTORS

(Please list other doctors, clinics, and hospital that you are visiting, and we would like to obtain medical record if possible)

1.Name_____Speciality_____

How long_____Phone_____ Fax:_____

Address_____

2. Name_____Speciality_____

How long_____Phone_____ Fax:_____

Address_____

3. Name_____Speciality_____

How long_____Phone_____ Fax:_____

Address_____

4. Name_____Speciality_____

How long_____Phone_____ Fax:_____

Address_____

5. Name_____Speciality_____

How long_____Phone_____ Fax:_____

Address_____

6. Name_____Speciality_____

How long_____Phone_____ Fax:_____

Address_____

Yan Zhang, MD
Internal Medicine Medicine & Mobile Centers
Tel: 909-270-1830 Fax:1-888-523-5237
www.yanzhangclinic.com

REQUEST FOR MEDICAL RECORD

Patient Name:_____

DOB:_____

Social Security Number_____

Medical Record Number_____

Dear Colleagues:

The above patient is requesting her/his medical record from_____ to _____ be released to our office. Please fax her/his medical record to 888-523-5237 or mail the record to: 3665 bilberry road, san Bernardino, ca 92407. Thank you!

Patient Print Name:_____

Patient Signature:_____

Date_____

Patient's Health History

1.Chief Complaint: (**DOCTOR's USE ONLY):**

2. HPI: **(DOCTOR's USE ONLY)**

3. Please list all the prescribed medicine, over the counter medicine and herbal supplement that you are taking. **Please note, it is absolutely essential that you bring the list and dose your medicine every time you visit. If you don't know the dose, please bring all your medicine bottles. For you safety, it is extremely important that we know what you are taking!**

Medicine_____ Dose_____Times/day_____

Medicine_____ Dose_____Times/day_____

Medicine_____ Dose_____Times/day_____

Medicine_____ Dose_____Times/day_____

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Medicine_____ Dose_____Times/day_____

Medicine_____ Dose_____Times/day_____

Medicine_____ Dose_____Times/day_____

Medicine_____ Dose_____Times/day_____

Are you using any blood thinner ? (Coumadin? Asprin? Plavix?)

4. Allergic To:

a. _____reaction_____

b._____ reaction_____

c._____ reaction_____

d._____ reaction_____

e._____ reaction_____

5. Past & Current Medical Problem:

Eye:

Ear, Nose, Throat

Lung:

Cadiovascular:

GI:

GU:

Endocrine:

Neuro:

Dermatology:

Muscle/Skelatal:

Psychiatric:

Tumor/Hemo:

Others:

6. Any implants in your body? Pacemaker? Defibrillator? Breast Implant?

7. Past Surgeries History:

Surgery performed_____When_____Any complication _____

Surgery performed_____When_____Any complication _____

Surgery performed_____When_____Any complication _____

Surgery performed_____When_____Any complication _____

Surgery performed_____When_____Any complication _____

8. What diseases do your blood related family have? (family history)

Grandparents on mother's side:

Grandparents on father's side:

Mother:

Father:

Sibling:

Children:

9. Preventive care history:

Did you receive all your shots as kid?

Last Tetanus shot?

Last MMR?

Last Shringle Shot?

Last Peumovax?

Have your received Hepatitis B series?

Have your received Hepatitis A series?

When was your last flu shot?

Last Colonoscopy?

10. SOCIAL HISTORY:

Work Situation:

Living Situation:

Smoke:

Alcohol:

Recreational drugs, IV drugs?

Have unprotected sex?

11. OB & GYN History (Male patient, Please skip this section)

How many times you have been pregnant? How many children? Are they healthy?

How many abortions you have ever had? When did your last menstrual period started?

Do you use any contraceptive method?

Are you pregnant? Yes. No. Not Sure.

Are you nursing a child? When is your last Pap smear?

When is your last your mammogram? Do you do self breast exam? How often?

12. Men's History (Female Patient, Please skip)

Prostate Problem?

Abnormal PSA? Sexual dysfunction?

Review of Systems

Please circle the symptoms that you have, thank you!

General: Weight loss, fatigue, fever, chills, trouble sleeping.

Skin: rash, lumps, itching, dryness, color change, change in hair or nail.

Head: headache, head injury.

Eyes: Vision loss, eye pain, eye redness, double vision, blurred vision, glaucoma, cataracts.

Ear: decreased hearing, tinnitus, ear pain, ear discharge.

Nose & Sinuses: stuffiness, discharge, itching, hay fever, nosebleeds, sinus pain.

Throat & Mouth: condition of teeth, bleeding gums, dentures, sore tongue, dry mouth, sore throat, hoarseness.

Neck: lumps, swollen glands, goiter, pain, stiffness.

Breast :lumps, pain, discharge, warmth, nursing a child.

Respiratory: cough, cough up blood, shortness of breath, wheezing, painful breath, exposure to tuberculosis.

Cardiovascular: chest pain or tightness, racing heart, need to sit up to breathe, edema, Leg pain after walking, varicose veins, blood clots.

GI: trouble swallowing, heartburn, loss of appetite, nausea, change in bowel habit, blood in stool, black stool, constipation, diarrhea, abdominal pain, jaundice.

GU: urine frequency, urine pain, urine a lot in the night, blood in the urine, frequent UTI, kidney stone, incontinence, difficulty when urinate.

Male Genital: hernia, penile discharge, sores, testicular mass or pain, erectile dysfunction, condom use, history of sexually transmitted disease.

Female Genital: vaginal discharge, itching, rashes, sexually transmitted diseases, birth control.

Musculoskeletal: muscle pain, joint pain, stiffness, gout, back pain, swelling of joint, trauma.

Neurologic: dizziness, lightheadedness, fainting, seizures, weakness, paralysis, numbness, tingling, tremor.

Hematologic: easy bruising, easy bleeding, anemia, blood clots, blood transfusion history.

Endocrine: heat or cold intolerance, excessive sweating, urine excessively, eat excessively, change in shoe size, change in glove size.

Psychiatric: nervousness, depressed mood, and memory loss, stress, disturbing thoughts.

PHYSICAL EXAM FORM
(Physician Use Only, Patient please stop here)

HEIGHT: **WEIGHT:** **BP:** **TEMP:** **HR:** **RR:** **POX:**

GENERAL:

HEENT:

LUNG:

HEART:

ABDOMEN:

NEURO:

SKIN:

EXTREMIITY:

RECTAL:

BREAST/FEMALE GENITAL (MALE GENITAL/PROSTATE):

Office Test Result Today:

1. Office EKG:

2. Office Dip UA today: leukocytes ( ) , nitrite ( ), urobillinogen ( ) , protein ( ), PH____, gravity___, ketone ( ), Billirubin ( ), glucose ( ).

3. HCG: ( )

4. Strep Throat: ( )

5. Flu A &B: ( )

6. H. pylori: ( )

7.Glucose:

8. HA1C: ( )

9. Human blood stool: (-)

10.HIV1 & HIV2: ( )

11. TB:

Vaccines Administered In Office Today:

1. Flu vaccine is given in office per protocol without any complications.
2. Pneumovax vaccine given in office per protocol without any complications
3. Tetanus vaccine given in office per protocol without any complications
4. MMR vaccine is given in office per protocol without any complications
5. HPV vaccine is given in office per protocol without any complications
6. HBV vaccine is given in office per protocol without any complications

Therapy Administered In Office Today:

1. Ceftriaxone 1g, IM, times one is given in office per protocol without any complications.
2. Albuterol nebulizing is administered in office for 15 minutes. Patient feels better afterwards.
3. Oxygen therapy at 2L/min is administered in office for 15 min. Patient feels better afterwards.
4. The following Oral Medications is administered in office:
5. Trigger Point Injection is performed today. The medication used is 1% lidocaine. The areas are first sterilized by iodine and alcohol. The medication is sprayed to the area, and then injected into the muscles. The procedure is performed successfully without any complications. Patient feels less pain after treatment.

Locations: Muscles:

Locations: Muscles:

6. The following Physical Therapy is performed by me without any complications. Patient feels better afterwards.

Electrical stimulation: location_____ Min_____

Ultrasound therapy: location_____ Min_____

7. Diagnostic Ultrasound:

Area 1:_____ Area 2:_____ Area 3:_____