PATIENT INFORMATION

PLEASE PRINT

Patient's Legal Name_____ Birth Date _____Age ____ Dr. Lic. No._____

Patient's Preferred Name _____

☐Child ☐Single ☐Married ☐Divorced ☐Widowed ☐Seperated Gender: ☐Male ☐Female ☐ Other_____

Home Address _____ Home Tel _____

City, State & Zip _____ Cell _____

Email address _____ Soc. Sec. No. _____

Employer _____ Occupation _____ How Long _____

Employer's Address _____ Telephone _____

City, State & Zip _____

Name Of Parent/Spouse/Domestic Partner _____ Birth Date _____ Age ____ Dr. Lic. No. _____

Employer _____ Occupation _____ Soc. Sec. No. _____

Employer's Address _____ Cell _____

City, State & Zip _____ Wk. Tel. _____

Emergency Contact _____ Relationship _____

Address _____ Home Tel _____

City, State & Zip _____ Cell _____

Referred to Doctor by _____

GENERAL HISTORY

(To be filled out by patient)

PAST ILLNESSES: (Underline) Asthma, Diabetes, Kidney Disease, Heart Disease, Stomach Trouble, Hepatitis, Arthritis, Epilepsy, Nervous Disorder, Skin Disease, Back Trouble, Infections, Measles, Mumps, Chicken Pox, German Measles

Other: _____

Allergies: _____

Surgical History: (Give year & type) _____

Accident History: (Serious Injuries) _____

Menstrual History: Age at onset _____ Frequency _____ Duration _____ Painful Menses? _____ Last Period _____

No. of Children _____ Miscarriages _____ Name of medicines used now _____

_____

Habits: Weight _____ Recent gain or loss _____ Bowel habits _____ Sleep _____

Appetite _____ Use of tobacco _____ Use of alcohol _____

Family History: (Underline & give relationship to you)

Tuberculosis _____ Diabetes _____ Epilepsy _____

Allergies _____ Heart Disease _____ Cancer _____

Other: _____

_____

Attention Insurance Carrier:
I hereby authorize Dr.'s Bond, Desai, Ferrey, Garcia, Kritz, and PA-C's Melissa Bunn and Celia Gutierrez _____ to furnish information concerning my medical records and authorize the insurer to pay, without equivocation, directly to the above named providerm, all benefits due as a result of this claim. I am also aware that I am personally responsible for charges and/or balance not covered by my insurance.

Signed _____ Patient or Policyholder _____ Date _____

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____ , hereby authorize Pavilion Family Physicians, A Medical Group, Inc. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, the practitioners at Pavilion Family Physicians , A Medical Group, Inc. can refuse to treat me.

I have been informed that Pavilion Family Physicians, A Medical Group, Inc. has prepared a Notice of Privacy Standards ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying my practitioner, in writing, but if I revoke my consent, such revocation will not affect any actions that my practitioner took before receiving my revocation.

I understand that Pavilion Family Physicians, A Medical Group, Inc. has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Pavilion Family Physicians, A Medical Group, Inc. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health care operations.

I understand that Pavilion Family Physicians, A Medical Group, Inc. does not have to agree to such restrictions, but that once such restrictions are agreed to , they must adhere to such restrictions.

_____
Printed Name of Patient or Patient's Representative

_____ _____
Signature of Patient or Patient's Representative Date
(*Form MUST Be Completed Before Signing)*

_____
Relationship to the Patient

Pavilion Family Physicians, Inc.
1140 West La Veta Avenue, Suite 700
(714) 547-5404

I understand that it is my responsibility to follow through with any and all laboratory requests and referrals ordered (e.g., blood tests, Pap smears, mammograms, biopsies, sigmoidoscopies) by the physician. I understand that I cannot assume that lab results are normal or that referrals have been denied unless I have been notified (usually within two weeks). I also understand that if I have not received these results/referrals it is my responsibility to obtain the information. Furthermore, I also understand that it is my responsibility to follow up as per the recommendations of the Specialist (e.g., office visits, labs, and procedures).

I acknowledge receiving a copy of this form

_____

Patient Name

_____

Patient Signature Date

_____

Witness Signature Date

Pavilion Family Physicians

Designated Individuals Authorization Form

For Someone Other Than Yourself

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified prior to the release of any information.

Authorized Designees:

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

Where May We Telephone You?

Home Yes / No #_____

Work Yes / No #_____

Cell Yes / No #_____

Where May We Leave Messages?
Please Circle All That Apply

Home Work Cell

_____
Patient Name

_____ _____
Patient Signature Date