PATIENT INFORMATION

PLEASE PRINT

Patient's Legal Name____ Birth Date ______________Age ____ Dr. Lic. No.______________

Patient's Preferred Name ____

(CIRCLE) 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: (CIRCLE) 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 Arsecularatne, Desai, Ferrey, Garcia, Kritz, (PA-C's) Celia Gutierrez and Lauren Rodriguez, (FNP-C's) Joannis Levi and Athena Richardson, to furnish information concerning my medical records and authorize the insurer to pay, without equivocation, directly to the above named provider, all benefits due as a result of this claim. I am also aware that I am personally responsible for charges and/or balances 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 protected 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 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

HIPAA 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**: ___________________**Phone**: _____________________

Name: ___________________________ **Relationship**: ___________________**Phone**: _____________________

Name: ___________________________ **Relationship**: ___________________**Phone**: _____________________

Name: ___________________________ **Relationship**: ___________________**Phone**: _____________________

This authorization is valid (**MUST CHOOSE ONE**):

☐-Indefinitely ☐-1 year ☐-Other (must specify) ____________________________________

Patient Name: ___________________ Signature: __________________________ Date: ________

PAVILION FAMILY PHYSICIANS

AUTHORIZATION FOR COMMUNICATION

Patient Information:

Name – Last, First, MI:		DOB:
Street Address:	APPT/ STE#:	
City:	State:	Zip:

You may choose to limit the type of voicemail or mail communications you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons.

Please indicate below what types of correspondence you consent to receive by:

Confidential Voicemail and (SMS) Text Messages:

☐ I consent to receiving a **Voicemail** regarding **appointments** to the following phone number:
Phone Number: ________________________________

☐ I consent to receiving (SMS) **Text Messages** regarding **appointments** to the following phone number:
Mobile Number: _______________________________

☐ I consent to **all voicemail communications**, about my medical condition and advice from my health care providers, including all results for the exception of any STI (Sexually Transmitted Infection) or any Mental Health Records to the following phone number: ________________________

Mail:

☐ I consent to **all mail communications** about my medical condition, advice from my health care providers, and results to be mailed to the authorized address listed above.

PLEASE NOTE: STI (Sexually Transmitted Infection) and Mental Health Records are exempt from this authorization.

If you choose not to consent to any of these methods of communications, please check box below:

☐ I DO NOT consent to any Voicemail, (SMS) Text Message, or Mail communications.

Signature of Patient/Legal Guardian: ____ **Date:** ___/___/___

Print Name: ____ **Relationship**: ___________________________