Redding Family Medical Group
JORGE PENA M.D.,F.A.C.O.G.

2510 AIRPARK DRIVE, STE 203, REDDING, CA 96001
Phone(530) 768-5300 Fax (530) 768-5301
dr.penaoffice@yahoo.com

PATIENT REGISTRATION INFORMATION

Patient Name: ___________________________________ Date of Birth: ____/___/_____ S.S.#_____-____-_____

Mailing Address: ______________________________________ City, State, Zip Code: _______________________

Cell Phone (_____)______-________ Home Phone (_____)______-________ Work Phone(_____)_____-_______

Email Address: ____

Marital Status: _____Married, _____Single, _____Divorced, _____Separated, _____Widowed, _____Other

Employer/Occupation: ____

Preferred Local Pharmacy:______________________________________ Location:__________________________

Mail Order Pharmacy:____________________________________

Preferred Laboratory:____ Location:__________________________

REASON FOR VISIT: ____

______ By initialing here, you give Dr. Pena's Office permission to leave messages on your cell/home phone voicemail, including test results, appointments or clinical information

______ By initialing here, I agree to receive automated calls or emails.

______ By initialing here, I acknowledge that I have received a copy of Redding Family Medical Group's Office Policies.

EMERGENCY CONTACT INFORMATION

Emergency contact name(s) and number(s) you provide may be used in the event of an emergency situation on and/or off campus that renders you unable to communicate with appropriate staff members. Please complete the following and include these persons in the HIPPA form that follows.

Primary Contact Name: ____ Relationship:______________________
Cell Phone (______)______-_______ Home Phone (______)______-________
Address: ____

Secondary Contact Name: _______________________________________ Relationship:______________________
Cell Phone (______)______-_______ Home Phone (______)______-________
Address: ____

____

Print Patient/Guardian Name   Patient/Guardian **Signature**   **Date**

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OFFICE POLICIES

I understand that if I miss or cancel 3 appointments in a row within a year I risk discharge from the practice.

I understand that if I have not been seen by a provider in the office in over 3 years I will be released from the practice as a current patient and will need to reestablish care.

As with all life interactions we appreciate respectful interactions with all staff and providers in our office. I understand that any behavior deemed inappropriate will not be tolerated and I may be discharged.

I understand if my account becomes delinquent for over 90 days, I am at risk for being sent to collections and discharged.

I, ___________________________________, fully understand what I am signing and
(**print** patient name)
agree with the above policies.

_______________________________________ **DOB:**______________________
(Patient or Guardian's **signature**)

Date: _______________________________________

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NOTICE OF DISCLOSURE

Dear Patient,

We are asking you to acknowledge that we did not direct or refer you to a particular laboratory or pathology group for your services. **Shasta Pathology Associates** is our preferred laboratory and is the only anatomic pathology lab in the Redding area. However, you are free to request your pathology be sent to any lab of your choice.

In addition we encourage you to check with your Insurance carrier to determine which laboratory is in network with your carrier. There are a multitude of plans and each one is different. In order to not incur additional charges, you are responsible for determining which laboratory provider is in network.

I, ______________________________, fully understand what I am signing and
(**print** patient name)
have let my provider/and or office staff know my laboratory of choice.

__________________________________ **DOB**:____________________
(Patient or Guardian's **signature**)

Date: ______________________________

INSURANCE AND BILLING INFORMATION

Primary Insurance Company: ________________________________ ID#: ______________________________________

Secondary Insurance Company: _____________________________ ID#: ______________________________________

ASSIGNMENT OF INSURANCE INFORMATION

* I hereby authorize direct payment of medical/surgical benefits to Redding Family Medical Group for services rendered.
* I understand that I am financially responsible for all charges incurred whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees.

AUTHORIZATION TO RELEASE INFORMATION

* I hereby authorize Redding Family Medical Group, Dr. Pena's Office, to release any medical or incidental information that may be necessary to secure the payment of benefits. If your insurance requires prior authorization, you are responsible for making sure our office gets a copy of that from your primary care doctor.

CONTACT INFORMATION AND INSURANCE CERTIFICATION

* I certify that the information given by me in applying for payment is correct.
* I authorize release of all records upon request.
* I request that payment of authorized benefits be made on my behalf.
* I further agree that a photocopy of these assignments shall be as valid as the original.
* I agree to be responsible for any costs associated with collection of funds owed to the practice, including but not limited to, collection agency fees, attorney's fees and court costs.

____

Print Patient/Guardian Name Patient/Guardian **Signature** **Date**

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Acknowledgement of Receipt of Notice of Privacy Practices and Release of Protected Health Information

Under the Patient Privacy Act, otherwise known as **HIPPA**, our office cannot release or discuss patient information with anyone other than the patient, custodial parent or legal guardian, unless we have written authorization from the patient.

If you would like us to be able to speak to **family members, caregivers or other entities** regarding your healthcare, please complete the following indicating the person(s), **BY FULL NAME**, to whom we may speak.

I, ______________________________ authorize Redding Family Medical Group and/or Dr. Pena's Office to release or discuss my Private Health Information with the following person(s):

Name: ____ Relationship: ____________________________________

Name: ____ Relationship: _____________________________________

Name: ____ Relationship: _____________________________________

_______ Entire Record _______ Emergency Only _______ Specific Info Only: _______________________________

_______ I **do not** want any information released to anyone by Redding Family Medical Group and/or Dr. Pena's Office, with the exception of the physician who referred me to this practice.

This authorization shall remain in effect until which time I have revoked this authorization in writing. My written revocation must be submitted in writing to: Redding Family Medical Group, Dr. Pena's office, 2510 Airpark Drive, Suite 203, Redding, CA 96001.

Print Patient Name: __________________________________ **Patient Signature:** ________________________________

Date: ____________________________ Relationship if other than patient: ______________________________________

PATIENT HEALTH ASSESSMENT

GYN HISTORY:

What was the first day of your last menstrual period? ________________ HEAVY MODERATE LIGHT

Do you have a period every month? YES NO How many days between, before starting next period? ______

How long do your periods last? __________ Current Birth Control Method: ____________________________

Post- Menopausal? YES NO Age of menopause? __________ SURGICAL NATURAL

Are you taking Hormones? YES NO If so what? ____

Date of last Pap Smear? ___________ NORMAL ABNORMAL Result: ______________________________

Date of last Mammogram? __________ NORMAL ABNORMAL Result: ______________________________

Have you had any of the following pelvic infections? (please circle any that apply)

CHLAMYDIA GONORRHEA SYPHILIS HERPES TRICHOMONAS HPV PID

Any personal or direct family history of Breast Cancer or Gynecologic Cancer YES NO

Type of Cancer: __________________________________ Relationship: _________________________

OBSTETRICAL HISTORY:

Number of Pregnancies: _____ Live Births: _____ Miscarriage: _____ Abortions: _____

Stillbirths: _____ Ectopics: _____

Past Pregnancies:

Date of Birth	Birth Weight	Delivery Type	Complications
___________	__________	VAGINAL C-SECTION	____
___________	__________	VAGINAL C-SECTION	____
___________	__________	VAGINAL C-SECTION	____
___________	__________	VAGINAL C-SECTION	____

GYNECOLOGICAL SURGERIES or PROCEDURES:

Date	Procedure
________	____
________	____
________	____

ALLERGIES/ADVERSE REACTIONS:

☐ **NKDA** (No Known Drug Allergies)

Drug Name: ___________________________ What happens? ____

Drug Name: ___________________________ What happens? ____

Drug Name: ___________________________ What happens? ____

MEDICATIONS: (Including hormones, vitamins, herbs, and over-the counter medications)

DRUG NAME	DOSAGE	DRUG NAME	DOSAGE
_______________________________	__________	_______________________________	__________
_______________________________	__________	_______________________________	__________
_______________________________	__________	_______________________________	__________
_______________________________	__________	_______________________________	__________
_______________________________	__________	_______________________________	__________
_______________________________	__________	_______________________________	__________
_______________________________	__________	_______________________________	__________

SOCIAL HISTORY:

Do you exercise? YES NO How often? ____________________ How long? ______________________________

Do you currently smoke Cigarettes? YES NO How much do you smoke? _____________________________

Have you EVER smoked Cigarettes? YES NO How long did you smoke? ______________________________

Do you drink alcohol? YES NO How many per day? ______ per week? ______ per month? ______

Illicit Drugs (street/illegal drugs) YES NO If yes, what type? ____________________ How often?__________

Deaf or serious difficulty hearing? YES NO Blind or serious difficulty seeing? YES NO

Difficulty concentrating, remembering or making decisions? YES NO

Difficulty walking or climbing stairs? YES NO Difficulty dressing or bathing? YES NO

Difficulty doing errands alone? YES NO

OTHER PROVIDERS YOU SEE:

- **Primary Care Provider:** ____
- **Cardiologist:** ____
- **Other Providers:** ____

PERSONAL MEDICAL HISTORY:

If you have a problem now or if you have had a problem with any of the following body systems in the past, please check and explain at the bottom. If you never have, please write N/A.

_______ Anemia
_______ Anxiety Disorder
_______ Arthritis
_______ Asthma
_______ Birth Defects or Inherited Disease
_______ Breast Cancer
_______ Breast Problem
_______ Cancer
_______ Deep Vein Thrombosis
_______ Depression
_______ Diabetes
_______ Endometriosis
_______ Fibromyalgia
_______ GI Problems
_______ Headaches or Migraines
_______ Heart Conditions
_______ Heart Disease
_______ Hepatitis
_______ Hyperlipidemia (high cholesterol)
_______ Hypertension (high blood pressure)
_______ Infertility
_______ Kidney or Bladder Problems
_______ Lung Disease
_______ Obesity
_______ Osteoporosis
_______ Ovarian Cancer
_______ Psychiatric Illness
_______ Thyroid Problems
_______ Frequent Urinary Tract Infections

FAMILY HISTORY: (Relatives who have had any of the above illnesses listed at the top of this page)

Relationship: _____________ Type: ____ mother's side/father's side

Relationship: _____________ Type: ____ mother's side/father's side

Relationship: _____________ Type: ____ mother's side/father's side

Relationship: _____________ Type: ____ mother's side/father's side

SPACE FOR ADDITIONAL INFORMATION:

____

____

____

Print Patient Name: ___________________________________ Patient **Signature**: _________________________________

Date: ____________________________ Relationship if other than patient: _______________________________________