Comprehensive Care Center of Irvine
Patient Centered Healthcare

RESET FORM

PATIENT INFORMATION

Name: ______________________, ______________ ______________ ☐ Male ☐ Female
Last First M. I.

Address: ______________ ______________ ______________ ______________
Street City State Zip

Home Phone: (____) ______________ Business Phone: (____) ______________ Cell Phone: (____) ______________

Date of Birth: ______________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SS #: ______________ E-Mail: ______________

Driver's License Number: ______________ Physician you are here to see ______________

Referred By: ______________ Have you or any family member been seen here before? ☐ Yes ☐ No

Preferred Pharmacy ______________ Address ______________ Phone ______________

GUARANTOR INFORMATION – *Must be completed* (Patient and/or Responsible Party)

Responsible Party Name ______________ ______________ ______________ ☐ Male ☐ Female
Last First M. I.

Date of Birth: ______________ Driver's License #: ______________ Social Sec. #: ______________
Month / Day / Year

Employer Name: ______________ Employer Phone: (____) ______________

Employer Address: ______________ Occupation: ______________

PRIMARY INSURANCE INFORMATION

Insurance Company Name ______________ ☐ HMO ☐ PPO ☐ Private

Name of Insured ______________
Last First M. I.

Address ______________
Street City State Zip

Date of Birth (Insured) ______________ ☐ Male ☐ Female
Month / Day / Year

Social Security Number: ______________ Insurance ID #: ______________

Group Number: ______________ Employer: ______________ Occupation: ______________

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: ______________

SECONDARY INSURANCE INFORMATION

Insurance Company Name ______________ ☐ HMO ☐ PPO ☐ Private

Name of Insured ______________
Last First M. I.

Address ______________
Street City State Zip

Date of Birth (Insured) ______________ ☐ Male ☐ Female
Month / Day / Year

Social Security Number: ______________ Insurance ID #: ______________

Group Number: ______________ Employer: ______________ Occupation: ______________

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: ______________

EMERGENCY CONTACT INFORMATION

Name of Person to Contact: ______________ Relationship ______________

Address ______________
Street City State Zip

Home Phone (____) ______________ Work Phone (____) ______________

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. Co-payment amounts are subject to final adjudication by my health plan and I understand that any initial determination of my co-payment (from my card or online) is subject to final verification by my health plan. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

Patient's Signature: ______________ Date: ______________

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250 East Yale Loop, Suite 204
Irvine, CA 92604
(949)732-3530

Name: ______________________ Date: ______________
Birthdate: __________ Previous Primary Physician: ______________
Current Specialists: ______________

Medications

Please list any medications with strength that you currently take regularly (including non-prescription)

Allergies

Please list any allergies to medications, foods or other

Medication ***Food*** ***Other***

Medical History

Illnesses/Conditions

Do you have or have you ever had any of the following:

	Condition	Year
☐	Anemia	
☐	Anethesia complications	
☐	Anxiety	
☐	Arthritis	
☐	Asthma	
☐	Birth Defects	
☐	Cancer (type: __________)	
☐	Colitis	
☐	Concussion	
☐	Depression/Nervous Breakdown	
☐	Diabetes	
☐	Emphysema	
☐	Heart Attack/Heart Disease	
☐	High Blood Pressure	
☐	High Cholesterol	
☐	Kidney Disease	
☐	Liver Disease/Hepatitis	
☐	Migraine Headaches	
☐	Mitral Valve Prolapse/Murmur	
☐	Osteoporosis	
☐	Pneumonia	
☐	Rheumatic Fever	
☐	Seizure Disorder	
☐	Sexually Transmitted Disease	
☐	Stroke	
☐	Thyroid Disorder	
☐	Tuberculosis	
☐	Ulcer	

Surgical Procedures/Hospitalizations	**Year**

	Childhood Diseases	**Year**
☐	Chickenpox	
☐	Measles	
☐	Mumps	
☐	Polio	
☐	Other: __________	

Gynecological History (women only)

Last menstrual period	
How many pregnancies have you had?	
How many children do you have?	
Have you ever had an abnormal pap?	
Have you had a hysterectomy?	
Have your ovaries been removed?	

Health Maintenance

When, if ever, did you last have any of the following:

______ Cholesterol check
______ Colonoscopy
______ EKG/Cardiogram
______ Mammogram
______ Pap Smear
______ Prostate exam
______ Cardiac stress test
______ Bone Density

List Year of Last Vaccinations:

______ Tetanus (TD)
______ TB Skin Test
______ Pneumonia
______ Hepatitis A
______ Hepatitis B
______ Shingles (Zostavax)

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Health Maintenance continued

Name: ______________________
Birthdate: __________

Family History

Has any blood relative ever had any of the following :

	Relative (mother, father, sister, children)
Alcoholism	
Asthma	
Bleeding problems	
Cancer	
Type:	
Diabetes	
Emphysema	
Glaucoma	
Heart Attack	
Heart Disease	
High Blood Pressure	
Mental Illness / Suicide	
Osteoporosis	
Seizures	
Stroke	
Thyroid	

	Living Age	Deceased Age (at death) & cause
Father		
Mother		
Brother		
Sister		
Son		
Daughter		
Husband/Wife		

Social History

Marital Status? ○ *Single* ○ *Married* ○ *Divorced* ○ *Widow* ○ *Partner*

Do you have children / dependents at home? ○ Yes / No ○ *How many?* ________

Are you employed? ○ Yes / No ○ *Occupation?* ________________

Do you or have you ever smoked or chewed tobbacco? ○ Yes / No ○ *When?* ________ *Quit date?* ________

Packs/cans/bags per day ______/ *yrs* ______ *Type?* ________ *How often?* ________

Do you or have you ever used illegal drugs? ○ Yes / No ○ *Type?* ________ *How often?* ________

Do you drink alcohol? ○ Yes / No ○ *Type?* ________ *How often?* ________

Have you been exposed to toxic substances? ○ Yes / No ○

Do you drink caffeine daily? ○ Yes / No ○ *Type?* ________ *How often?* ________

Do you exercise regularly? ○ Yes / No ○ *Type?* ________ *How often?* ________

Do you wear seat belts? ○ Yes / No ○

Do you have a living will or advance directives? ○ Yes / No ○

What is your highest level of education?

Review of Symptoms

Please check any of the following that you are experiencing:

General: ☐ Fatigue ☐ Fever ☐ Hopelessness ☐ Hot Flashes ☐ Insomnia ☐ Night Sweats ☐ Poor Concentration ☐ Recent Weight Loss / Gain ☐ Loss of Interest in Usual Activities

Skin: ☐ Change in Pigmentation ☐ Eczema ☐ Hives ☐ Jaundice ☐ Rashes

ENT: ☐ Change in Vision / Hearing ☐ Dizziness ☐ Enlarged Glands ☐ Glaucoma ☐ Headaches ☐ Hearing Loss ☐ Neck Stiffness ☐ Nose Bleeds ☐ Chronic Sinus or Ear Problems

Respiratory: ☐ Asthma ☐ Difficulty Breathing ☐ Frequent Colds / Coughing ☐ Shortness of Breath ☐ Spitting up Blood

Cardiac: ☐ Angina ☐ Chest Pain ☐ Difficulty Walking 2 Blocks ☐ Heart Murmur ☐ High Blood Pressure ☐ Palpitations ☐ Swelling of Hands / Feet

Gastrointestinal: ☐ Abdominal Pain / Cramping ☐ Blood or Dark Stool ☐ Change in Bowel Habits ☐ Frequent Diarrhea ☐ Frequent Indigestion / Heartburn / Gas / Bloating ☐ Hepatitis ☐ Hemorrhoids ☐ Vomiting Blood

Genitourinary: ☐ Difficulty Urinating ☐ Frequent Urination ☐ Loss of Bladder Control ☐ Unsatisfactory Sex Life

Musculoskeletal: ☐ Joint Pain or Swelling ☐ Difficulty Walking ☐ Muscle Cramping or Weakness ☐ Varicose Veins

Neuropsychiatric: ☐ Prior Treatment for Depression / Psychiatric Care ☐ Fainting Spells ☐ Paralysis ☐ Convulsions

Hematologic: ☐ Easy Bruising ☐ Excessive Bleeding After Cuts ☐ Slow Healing After Cuts

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and reports. *Note: Information and records regarding minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorizations.*

I hereby authorize:

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________ Fax: ______________________

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To:
[ ] Dr. Kalena Hwang
[ ] Dr. Amanda Binns
[ ] Dr. Kelly Wong

At:
Comprehensive Care Center of Irvine, Inc.
250 East Yale Loop, Suite 204
Irvine, CA 92604
P: (949)732-3530 F: (949)999-8160

This medical information / records will be used for the following purpose:
□ Change of Primary Care Physician □ Consult with Specialist □ Other ______________

This authorization is:
[ ] Unlimited (all records including Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information:
- [ ] Last 2 years of records (progress notes, test results, procedures, immunizations, consults)
- [ ] Test Results
- [ ] Immunizations
- [ ] Other: ______________________________

This authorization shall be effective immediately and remain in effect until ______________. Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

Signature of Patient, Guardian / Legal Representative	Relationship (if other than Patient)
Patient's Name (PRINT)	Date of Request
Patient's Social Security Number	Patient's Date of Birth
Witness	Date Records Sent

Comprehensive
Care Center of Irvine

Communicating with You

To effectively communicate with you about your medical and financial needs, we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information, financial information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email (Secure Patient Portal), and telephone, including text messages, leaving messages on your answering machine's/voice mail.**

Please check all boxes that give Comprehensive Care Center of Irvine permission to use for your communications:

☐ You may contact me by telephone	Phone Number: ______________________	☐ Cell ☐ Home ☐ Work
☐ You may leave a message/voice mail	Phone Number: ______________________	☐ Cell ☐ Home ☐ Work
☐ You may contact me through email (Secure Patient Portal)		
☐ You may contact me through secure texting	Cell Phone Number: ______________________	

Please list any persons you would like to have access to your billing, appointment, or health information, such as your spouse, caretaker, or other family member. We will ask for additional consent prior to releasing information related to psychiatric services and/or HIV test results.

Name/Phone Number	Relationship	Options
1.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of the notice of Privacy Practices for the above medical practice. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended notice of Privacy Practices will be made available at my next appointment.

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Legal Guardian or conservator of an incapacitated patient
- Beneficiary or personal representative of deceased patient

Name of Patient: ______________________________

______________________________ ______________ ______________
Signature of Patient/Responsible Party Patient Date of Birth Todays Date

______________________________ ______________________________
Name of Patient/Responsible Party (Print) Relationship to Patient