Comprehensive Care Center of Irvine
Patient Centered Healthcare

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: ________________

Comprehensive Care Center of Irvine
Patient Centered Healthcare

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. We will not ask why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. ***Some method of contact must be provided****, and as appropriate, information as to how payment will be handled.*

I, ___________________________________, give my permission for Comprehensive Care Center of Irvine
(Print Name of Patient)
Physicians and employees to communicate information related to my personal health, as indicated below. This request supersedes any prior request for communication of information I may have made.

Phone

Contact me regarding my test results by telephone. YES ☐ NO ☐

Leave messages on my answering machine/voice mail. YES ☐ NO ☐

You may use the following telephone numbers:

Work____

Home____

Cell Phone____

You may leave messages regarding my medical information with the following people (Print Names):

1.______________________________________ 2. ______________________________________

3.______________________________________ 4. ______________________________________

E-Mail
Send e-mail messages by secured e-mail (Relay Health / NextMD) YES ☐ NO ☐

Mail
Send mail regarding appointments, test results, my condition and treatment YES ☐ NO ☐

Address: ____

____

Signature: ________________________________ Date: _________________ Date of Birth: ____________
(Patient signature, if Patient is a minor then Parent or Legal Guardian must sign.)

Name: ___________________________________ Relationship: __________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

250 East Yale Loop, Suite 204, Irvine, CA 92604

Privacy Officer: Kristina Leatherman, Manager **(949)732-3530** **Effective Date: April 18, 2011**

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above physicians. 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.

Signed: ________________________________ Date: ____________________________

Print Name: ____________________________ Telephone: ______________________

If not signed by the patient, please indicate:

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: ____

Notice of Privacy Practices Acknowledgment Tracking Information

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain: ____

Reasons for refusal: ____

____

Employee Name: ____

Comprehensive Care Center of Irvine
Patient Centered Healthcare

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:

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

List Year of Last Vaccinations:

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

Comprehensive Care Center of Irvine
Patient Centered Healthcare

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

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

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
[ ] Sarah Campbell FNP-C

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