PATIENT REGISTRATION FORM

Dear Patients: As part of the modification of our electronic health records to meet national guidelines, we ask that you provide us with some additional demographic information, including: *preferred language, gender, race, ethnicity, and date of birth.*

Last Name:_____Address:_____
First Name:_____City: _____State:____Zip Code_____
Home Phone # (___)_____Cell Phone # (__)_____Work#(___)_____
Race _____ **Language** _____**Hispanic (Yes) (No)** DOB:___/___/___Age:__Sex: ___
Marital Status: _____
Employer: _____ **(Full Time)(Part Time)**
E-mail Address:_____

Primary Pharmacy: Name/City_____

PRIMARY INSURANCE

Insurance Name:_____Address:_____
Policy/Group #:_____City:_____State:___
Insured's ID#: _____Zip Code:_____Phone#:_(____)_____

SUBSCRIBERS INFORMATION

Last Name:_____ First Name_____
DOB_____Address:_____City:_____State:_____
Insured's ID#: _____Zip Code:_____Phone#:_(____)_____

EMERGENCY CONTACT:

Last Name:_____First:_____MI:_____ Relationship:_____
Address:_____
_____

Home Phone: ( ) _____ **Cell** ( ) _____

Alt Phone ( ) _____ Work ( )_____

I have read and answered all questions to the best of my knowledge. I understand that the charges incurred are my responsibility regardless of insurance coverage. *Diablo Valley Primary Care, Inc.* has provided me the opportunity to review and/or have a personal copy of their Notice of Privacy Practices. I understand that it is my responsibility to inform this office of any changes in the above information.

_____ _____
Signature of Patient/Subscriber **Date**

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I further expressly agree that this signature will bind me as though I had personally signed the particular claim.

I, _____hereby authorize_____
(Subscriber/Patient) (Insurance Carrier)

to pay and hereby assign directly to **Diablo Valley Primary Care** all benefits, if any, otherwise payable to me for services described on the attached form. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Diablo Valley Primary Care** will be credited to my account, in accordance with the above said agreement.

"NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov"

_____ _____
(Authorized Signature of Subscriber/Patient) **(Date)**

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information PHI. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone _____
- O.K. to leave message with detailed information
- Leave message with call-back number only

Cell Phone _____
- O.K. to leave message with detailed information
- Leave message with call-back number only

Work Telephone _____
- O.K. to leave message with detailed information
- Leave message with call-back number only

Written Communication
- O.K. to mail to my home address
- O.K. to mail to my work/office address

Please List one: Family/Personal
Contact _____
_____

_____ _____
Patient/Guardian (print and signature) **Date**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for treatment, payment or healthcare operations may be permitted without prior consent in an emergency.

OFFICE USE ONLY

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

1. Check this box if the disclosure is authorized
2. Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
3. Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient's Name: _____ Date Of Birth: _____/____/_____

Telephone # (____)_____

INFORMATION TO BE RELEASED FROM:

I hereby authorize Dr./ NP _____

_____

ADDRESS **CITY** **STATE** **ZIP CODE**

to release the following medical information contained in the patient's medical record.

INFORMATION TO BE RELEASED TO:

Diablo Valley Primary Care Inc.
Chinnavuth De Monteiro, MD
Rocio Flores Neale, PA-C
Claire Reiton, PA-C
2415 High School Ave. Suite 800
Concord, CA. 94520
925-687-5210 (phone)
925-687-5091 (fax)

TYPE OF INFORMATION TO BE RELEASED (Limited to two (2) years of information unless otherwise stated).PLEASE DO NOT FAX RECORD IF ITS MORE THAN 10 PAGES. THANKS

CHECK ALL BOXES ACCEPTABLE TO RELEASE

1. **GENERAL RELEASE**
   - ALL RECORDS From: _____ To:_____
   - Medical Records excluding protected records From: _____ To: _____
   - Test Results (specify) _____ From: _____ To: _____
   - Records pertaining to specific medical date; (i.e. Motor Vehicle Accident, immunizations), Specify: _____

2. **INFORMATION PROTECTED BY STATE/FEDERAL LAW**
   - Sexually Transmitted Disease From: _____ To: _____
   - Diagnosis/Treatment or counseling (includes HIV/AIDS)
   - Drug Abuse/Alcoholism Diagnosis/Treatment From: _____ To: _____
   - Mental Health Diagnosis/Treatment From: _____ To: _____

3. **INSURANCE COMPANY REQUESTING A COPY OF YOUR MEDICAL RECORD**
   Please be advised that your Life/Health/Disability insurance company has contacted this office to release your medical record in its entirety. By complying with this request you are forfeiting the confidentiality of your Protected Health Information (PHI). You are allowing the release of personal notes, examination findings, diagnosis, test results and treatment plans. Please understand that by releasing this information you may suffer the loss of coverage entirely. These ramifications are based on subjective interpretation of finding in your medical record and compared to your insurance company's actuarial data. As a result, the insurance company's interpretation of your overall health may not always coincide with my overall opinion of your medical health.

_____ _____/_____/_____

PATIENT SIGNATURE (or Legal Representative) **DATE**

Limiting your authorized release may lead to minor delay in mailing records. Some records may include both protected and unprotected information, therefore; exclusions may create an incomplete document. This authorization applies ONLY to this request. Future requests will require another signed form. All requests will require 14 days for completion.

PERSONAL MEDICAL INFORMATION

PLEASE COMPLETE BOTH SIDES

NAME: _____ DATE: _____

Occupation: _____How Long? _____

Your living situation? _____ Alone _____ Couple _____ Group

Do you have or live with children? _____ Yes _____ No. If yes please give gender and ages _____

Do you have any allergies or reactions to medications? (Please explain) _____
_____

Do you have a special diet or health practices? (Please explain) _____
_____

Do you do any form of exercise, play sports or have any special interests? _____
_____

When was your last complete physical examination? _____ years _____ months

When was your last dental examination? _____ years _____ months

When was your last eye examination? _____ years _____ months

When was your last cholesterol check? _____ years _____ months

Do you smoke? _____ yes _____ no If yes, For how long and how much per day/week? _____

Do you drink alcohol? _____ yes _____ no. If Yes, How much and how often? _____

Do you drink coffee? _____ yes _____ no. If Yes, How much and how often? _____

Have you ever had a problem with alcohol or drugs? ___ Yes ___ No If Yes please explain: _____
_____
What is the purpose of this visit? _____
_____

TESTS AND IMMUNIZATIONS: (If you have had any of the following, please enter the year.)

Gall Bladder X-ray	_____	Last TB Test	_____
Chest X-ray	_____	Last Tetanus Shot	_____
GI Series	_____	Last Measles Vaccination	_____
Kidney X-ray	_____	Electrocardiogram	_____

Are you up to date with all your immunizations? ____Yes ____ No ____ Don't know

Please list any other tests or immunizations not mentioned here**:** _____
_____
_____
_____

YOUR HEALTH HISTORY

Has anyone in your family had any of the following? **(Please include yourself)**

High Blood Pressure _____
Heart Trouble _____
Stroke _____
Migraines _____
Emotional Problems (Treated) _____
Arthritis/Rheumatism _____
Tuberculosis _____
Anemia _____
Diabetes _____
Seizures _____
Glaucoma _____
Alcoholism _____
Breast Cancer _____
Cancer (What kind) _____
Other inherited diseases not listed: _____

Please indicate the present health of your family members:

Father ____ Good _____ Poor _____ Deceased (Age and Cause) _____
Mother ____ Good _____ Poor _____ Deceased (Age and Cause) _____
Brother/Sister ____ Good _____ Poor _____ Deceased (Age and Cause) _____
Brother/Sister ____ Good _____ Poor _____ Deceased (Age and Cause) _____
Brother/Sister ____ Good _____ Poor _____ Deceased (Age and Cause) _____

If there are any other family members not mentioned above and there is any information you think is important about their health, Please add them below: _____
_____
_____

Please check additional illnesses or problems that you have had:

___ Measles	___ Mononucleosis	___ Bronchitis	___ Hernia
___ Mumps	___ Syphilis	___ Pneumonia	___ Hemorrhoids
___ Scarlet fever	___ Hepatitis	___ Eczema	___ Eye problems
___ Polio	___ Malaria	___ Liver disease	___ Stomach problems
___ Rheumatic fever	___ Rashes/Hives	___ Thyroid	___ Gall bladder problems

If you have ever been hospitalized for a serious illness or operation, or if you had a serious illness without being hospitalized please list them below. (Illness, operation, and date) _____
_____
_____
_____
_____

Please list any medications that you are currently taking. Include all non-prescription drugs, like aspirin, laxatives, antacids and vitamins: _____
_____
_____
_____
_____
_____
_____
_____