



PATIENT REGISTRATION FORM

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#: () _____

SECONDARY 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

COMMUNICATION PREFERENCES

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 address

Written Communication

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

Cell Phone _____

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

Please List one: Family/Personal

Contact _____

Work Telephone _____

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

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.

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
Mintra Saefong, PA-C
Claire Reiton, PA-C
2415 High School Ave. Suite
800 Concord, CA. 94520
925-687-5210 (phone)**

TYPE OF INFORMATION TO BE RELEASED

PLEASE DO NOT FAX RECORD IF ITS MORE THAN 10 PAGES, PLEASE MAIL TO THE ADDRESS ABOVE

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 NOT TO BE DISCLOSED

- Sexually Transmitted Disease From: _____ To: _____
- Diagnosis/Treatment or counseling (includes HIV/AIDS) From: _____ To: _____
- Drug Abuse/Alcoholism Diagnosis/Treatment From: _____ To: _____
- Mental Health Diagnosis/Treatment From: _____ To: _____

1. 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

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 _____

Chest X-ray _____

GI Series _____

Kidney X-ray _____

Last TB Test _____

Last Tetanus Shot _____

Last Measles Vaccination _____

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: _____

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:

<input type="checkbox"/> Measles	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hernia
<input type="checkbox"/> Mumps	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Eye problems
<input type="checkbox"/> Polio	<input type="checkbox"/> Malaria	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Stomach problems
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Rashes/Hives	<input type="checkbox"/> Thyroid	<input type="checkbox"/> 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: _____

GYNECOLOGY HISTORY

NAME _____ DATE _____

At what age did you have your first period? _____ Years

Are your periods regular? ____yes____no. How many days do you have between periods? _____

How many day do your periods last? _____. Is the bleeding heavy? ____yes____no

Do you have any problems with pain or cramping during your period? ____yes____no

Do you feel tense or unhappy during your period? ____yes____no

Do you douche? ____yes____no With what? _____

Do you have a discharge from your vagina today? ____yes____no

Please describe it _____

Have you ever been pregnant? Yes____no____ How many children do you have? _____

Have you ever had an abortion? yes____no____ How many? _____

Have you ever had a miscarriage? Yes____no____ How many? _____

Did you have any problems with pregnancy, delivery or abortion? (please describe) _____

CONTRACEPTIVE HISTORY: Are you sexually active with men____women____or both____?

Do you use birth control? Yes____no____ What type of birth control do you use? _____

Have you ever used any other type of birth control? (please describe) _____

Do you ever have pain with intercourse? Yes____no____

Have you ever been treated for:

Problems with your uterus: (fibroids, abnormal pap smear, vaginal bleeding, etc.

Please describe) _____

STD? (please explain) _____

Do you examine your breasts yes____no____

Date of last pap smear _____

Date of last pelvic exam _____

Date of last breast exam _____

THIS INFORMATION WILL REMAIN CONFIDENTIAL

Authorization to Disclose and Release Information

In this office we feel as though all aspects of healthcare is confidential between the patient, their Doctor and the office.

We understand some patients would like their family, friends, caretaker's etc. to be involved in their healthcare management. In an effort to protect your personal information we ask that all patients over the age of 18, that would like their healthcare information shared to please sign and check what information you authorize us to release on your behalf.

We thank you in advance as this helps us to provide the best quality healthcare possible.

I _____ give authorization to _____,
Patient Name **Appointed Person(s) Name**

_____, _____,
_____ to do the following on behalf of my medical care:

- Schedule, cancel and verify appointments.
- Inquire about lab and x-ray results
- Request prescription refills
- Speak to the doctor about my healthcare
- Other _____

If this authorization is temporary please indicated the date in which this authorization is no longer valid.

_____.
Date

Signature of Patient

Date