REGISTRATION RECORD

Member Information

Patient Name: Last Name	First Name	Middle Initial	
Address: Street	City	State	Zip
Phone: Social Security #:	Date of Birth:	[ ] Male	[ ] Female

Responsible Party Information

Responsible Party Name: Last Name	First Name	Middle Initial	
Relationship to Patient: [ ] Mother [ ] Father [ ] Legal Guardian [ ] Self			
Address: Street **Phone:**	City	State	Zip

Employer Information:

Employer Name:			
Employer Address: Street	City	State	Zip
Employer Phone Number:	**Occupation:**		

Linguistic Service Needs

Primary Language:	**Secondary Language:**
Interpreter Services Offered: [ ]Yes [ ]No	**Interpreter Services Accepted:** [ ]Yes [ ]No (if No – indicate who will interpret for patient)
Interpreter Services Provided By: [ ] PCP [ ] Other (if Other explain here)	**Is Patient Hearing Impaired:** [ ]Yes [ ]No (if Yes, indicate services offered)

Emergency Contact Information

Name:	**Relationship:**
Phone Number:	**Message Phone:**

Authorization

I hereby authorize the doctor's of _____________ Medical Clinic to be attending physicians and to administer to me any examination, treatment, and medications he/she deems therapeutic to my presenting complaint. I hereby authorize _____________ Medical Clinic to furnish information to my insurance carriers concerning this illness and I hereby irrevocably assign to the doctors all payments for medical services.

Signature of Patient/Parent/Guardian: ______________________________ **Date:** __________

ADULT HEALTH HISTORY

Name/Nombre	Age/Edad	D.O.B./Cuando Nació	Date/Fecha

HISTORY OF PAST ILLNESS Have you had?/ENFERMEADES PASADAS:(Ha tenido)

Measles/Sarampión	No	Yes/Si	Rheumatic fever/Fiebre Reumática	No	Yes/Si
Mumps/Paperas	No	Yes/Si	Heart Disease/Enfermedad del Corazón	No	Yes/Si
Chickenpox/Viruela	No	Yes/Si	Tuberculosis	No	Yes/Si
Diabetes	No	Yes/Si	Venereal Disease/Enfermedad Veneria	No	Yes/Si
Stroke/Embolio	No	Yes/Si	Serious Disease/Enfermedad Graves	No	Yes/Si

Ever hospitalized/Has sido hospitalizado No Yes/Si Explain/Explicación ____________

Ever had surgery/Ha tenido operaciones No Yes/Si Explain/Explicación ____________

Had broken bones/Ha tenido fracturas No Yes/Si Explain/Explicación ____________

Head concussions or injuries/
Glopes o heridas de cabeza No Yes/Si Explain/Explicación ____________

>Date of last Tetanus/La fecha de su ultima inmunización de Tétano ____________

>Date of last Pap Smear/La Fecha de papanicolou de cáncer ____________

>Date of last Mammogram/Mammographia ____________

FAMILY HISTORY/HISTORI FAMILIAR:
Has anyone in your family ever had?/Ha habido en su familia?

Cancer	No	Yes/Si	Who/Quien? ____________
Diabetes	No	Yes/Si	Who/Quien? ____________
Tuberculosis	No	Yes/Si	Who/Quien? ____________
Heart trouble/Enfermedad del Corazón	No	Yes/Si	Who/Quien? ____________
High blood pressure/Presión alta	No	Yes/Si	Who/Quien? ____________
Stroke/Embolio	No	Yes/Si	Who/Quien? ____________
Convulsions/Epilepcia	No	Yes/Si	Who/Quien? ____________
Suicide/Suicidio	No	Yes/Si	Who/Quien? ____________

SOCIAL HISTORY/HISTORIA SOCIAL

Single/Soltero ☐ Married/Casado ☐ Separated/Separado ☐ Divorced/Divorciado ☐ Widowed/Viudo ☐

Alcoholic Beverages/Bebidas Alcohólicas: Never/Numca______________ How much/Cuanto______________

Tobacco or Cigarettes/Tobacco o Cigarrillos: Never/Numca______________ How much/Cuanto______________

Are you sexually active?/Esta sexualmente active? Yes ☐ No ☐

What is your job?/Cuál es su trabajo?______________

Education Level/Nivel de Educación:1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐10☐11☐12 College/Colegio Superior:1☐ 2☐ 3☐ 4☐

Ethnic Background/Nacionalidad: ☐ American Indian ☐ Asian ☐ Filipino ☐ Pacific Islander ☐ Black ☐ Hispanic ☐ White

SYSTEMIC REVIEW GENERAL/REVISION DE SYSTEMAS:

Recent weight change/Reciente cambio de peso? No Yes/Si

Have you been in good health most of your life?/Ha tenido Buena salud la mayor parte su vida? No Yes/Si

HAVE YOU EVER HAD PROBLEMS WITH?/ALGUNA VEZ HA TENIDO PROBLEMAS CON?

Skin/Piel	No	Yes/Si	Explain/Explicación ____________
Head-Eyes-Ears-Nose-Throat/ Cabeza-Ojos-Oidos-Nanz-Garganta	No	Yes/Si	Explain/Explicación ____________
Neck/Cuello	No	Yes/Si	Explain/Explicación ____________
Lungs/Pulmones	No	Yes/Si	Explain/Explicación ____________
Heart Circulation/Corazón o Circulación	No	Yes/Si	Explain/Explicación ____________
Blood/Sangre	No	Yes/Si	Explain/Explicación ____________
Emotions/Emociones	No	Yes/Si	Explain/Explicación ____________
Nerves/Nervios	No	Yes/Si	Explain/Explicación ____________
Muscles and bones/Músculos o Huesos	No	Yes/Si	Explain/Explicación ____________
Stomach and Bowels/Estomago o Intestinos	No	Yes/Si	Explain/Explicación ____________
Sex Organs/Órganos Sexuales	No	Yes/Si	Explain/Explicación ____________
Urinary/Únannos	No	Yes/Si	Explain/Explicación ____________
Any other/Cualquiera otro	No	Yes/Si	Explain/Explicación ____________

ALLERGIES OR REACTIONS TO FOOD OR MEDICATION/
ALERGIAS O REACCIONES A ALIMENTOS O MEDICINAS______________

Patient Signature/Firma______________ Date/Fecha______________

Provider Signatura______________ Date/Fecha______________

CONSENT OF MEDICAL SERVICE

I hereby consent and authorize the attending physician and/or medical personnel of Clinica Medica General the administration of all routine or emergency therapeutic and diagnostic treatments for me or my minor child.
No Guarantees: I understand that the practice of medicine and the rendering of health care is not an exact science and that there are no guarantees as to the results of my treatment, examination or other health services rendered by this medical office.
In this same matter I accept full financial responsibility of the payment for these services. I am aware that I will receive an appropriate receipt of payment for my personal use only. I understand that neither Dr. Hernandez nor his staff will complete any billing form provided by any health insurance company sent to me or physician regarding these medical services.
NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

______________________________ ______________________________
Printed Name Date of Birth

______________________ ______________________________
Date Patient's Signature or Parent/ Guardian

ADVANCED DIRECTIVES

This acknowledgment that the physician, or one of his/her staff members, has provided me information concerning Advanced Directives.

1. I am 18 or older Yes No
2. I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.
3. I am aware that Advacned Directives may be any one of the following:
   A. A Durable Power of Attorney for Health Care.
   B. The Declaration in the A natural Death Act- Ex. A Living Will
   C. I may write down my wishes on a piece of paper so that my family may use the document, in deciding my medical treatment, in the event I am unable to do so.

Patient Signature________________________________**Date**______________________

ACKNOWLEDGEMENT OR RECIEPT FOR NOTICE OF PRIVACY PRACTICES

Patient's Name: ________________________________ Date of Birth: _________________

YOU ARE ENTITLED TO A COPY OF THE CONSENT AFTER YOU SIGN IT.

Signature of Patient or Parent/ Guardian: ____________________________Date:__________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information. A copy of our Privacy Practices Notice is available upon your request. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes mat apply to any of your protected health information that we maintain. You may obtain the revised copy upon request.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to this office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE OF CONSENT

I have had the full opportunity to read and consider of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature: ____ Date: _______________

Relationship to Patient: ____

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: ____ Date: _______________

Relationship to Patient: ____

NOTICE OF REFERRAL PROCESS

Patient's Name: ______________________________ Date of Birth: ____________

Patients with specialist referrals please be advised:

- All routine referral will have a turnaround time of 10 to 14 days
- Urgent referrals have a turnaround time of 72 hours, however, any life threatening matter will be automatically referred to the Emergency Room.

Please note that once your referral has been submitted you will receive a letter in the mail from the medical group informing you of their decision. Please note it is the patient's responsibility to ensure that your insurance plan has your correct mailing address and phone number.

If your referral has been approved you will need to make an appointment at your convenience.

Appointment scheduling, transportation arrangements, and keeping appointments will be the patient's responsibility.

If your referral has been denied, you will be given instructions on appealing the decision. Please keep in mind that referral authorizations do expire and if for any reason you will not be able to obtain an appointment before such expiration date it is the patient's responsibility to contact the ordering physician's office within 3 days prior to expiring, to ensure authorized referral extension from the medical group.

It is the patient's responsibility to follow the specialist's treatment plan and follow up care.

URGENT REFERRALS: Please contact the office within 3-5 days to check the status of your referral.

ROUTINE REFERRALS: If you have not received a notice by mail from the medical group within 10 business days, please contact our office.

By signing below you are acknowledging that you have been informed of the referral process at Clinica Medica General the office of David Hernandez-Rodriguez MD and that you, as the patient, take responsibility of the indications mentioned about.

Signature of Patient or Parent/Guardian: ________________________________

Date: ________________

Adult TB (Tuberculosis) Risk Assessment

*** You may be at increased risk for TB if you answer YES to any of the following questions:**	Date / /		Date / /		Date / /		Date / /	
1. Do you have a family member or close contact with history of confirmed or suspected TB?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
2. Are you from Asia, Africa, Central America or South America? (These areas have a higher prevalence of TB.)	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
3. Do you live in an "out of home" placement facility?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
4. Do you have a history of confirmed or suspected HIV infection?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
5. Do you live with any individual who is HIV positive?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
6. Have you been, or do you live with any individual who has been incarcerated in the last 5 years?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
7. Do you live among, or are you frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or resident in a nursing home.	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

* A person who is at increased risk for TB should have a yearly TB test.

Name:______________________________ Date:__________________

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *Please specify:*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

#	Question				***Clinic Use Only:***
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date: