THE PRACTICE
Family Medicine With a Difference ™

Intake Form

Name: _____ _____

Last **First** **Middle** **Birth Date**

_____ _____ _____

Address **City** **State** **Zip**

Phone # _____ _____ _____

Home **Work** **Cell**

_____

Employer Employer Phone & Extension Occupation/ Position

_____

Email address (Will be used for medical records and updates)

Preferred Pharmacy: _____

Name of Pharmacy and Location

Emergency Contacts (At Least 2)

_____ _____ _____

Name Relationship Telephone#

_____

Address

_____ _____ _____

Name Relationship Telephone#

_____

Address

Please take a brief moment to tell us how you heard of us. Check all that apply

Referred by someone? Please provide Name and phone # so we may give them a special thank you.

_____

Name **Phone #**

□ TV – Which program(s) _____
□ Radio – Which programs _____
□ Show or festival booth – which show or festival? _____
□ Went on Internet and searched
□ Facebook, Email, or YouTube
□ Budget Medical Clinic
□ Sales Representative
□ Kern county Fair
□ Newspaper
□ Flyer:
□ Other -Please Describe: _____

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

Physician's Copy

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, California 95814. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below.
Earlier effective date:_____ Patient's Initials:_____

ARTICLE 7: I have read and understood all of the information in this pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT

_____ Dated:_____, _____
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship:_____

PHYSICIAN'S AGREEMENT TO ARBITRATE: In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

_____ Dated:_____, _____
(Physician or Duly-Authorized Representative)

_____ _____
Title—e.g., Partner, President, etc. Print name of Physician, Medical Group, Partnership or Association

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices and I have been provided an opportunity to review it and a copy to take with me if requested.

Please Print Name

_____

Signature **Date:**

_____

Please Print Full Name and Relationship to Patient If Applicable:

_____

**********************For Office Use Only **********************

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____.

ATTENTION:

Urine Drug Testing

Dear Patients:

At The Practice we strive to be at the forefront of the Healthcare industry. We put our patients care first and hope to build strong Doctor/Patient relationships. One important way that we achieve this is by following current laws as well as complying with current recommendations.

The CDC and other State and Federal agencies are calling the abuse and misuse of prescription drugs an epidemic. They estimate that each day around 44 people are dying of an overdose of prescription painkillers with thousands more being rushed to emergency rooms. One of the ways they recommend that we, as health care providers, can help to stem this epidemic and therefore save more patient's lives, is to more closely monitor use of prescription painkillers and other highly addictive controlled substances.

In order to best do this, and in accordance with recommendations from the CDC, the American Academy of Pain Management (AAPM), as well as other State and Federal agencies, we will now be utilizing routine urine drug testing (UDT) on all our patients that are prescribed narcotics and/or other schedule 4 or higher medications.

This is the optimal way to ensure compliance with physicians dosing instructions for each prescription and will help to build a stronger bond of trust between you and your doctor. It will also help to mitigate any negative drug-to-drug interactions between what the doctors is prescribing and what is already in your system.

If you have any questions about our policy, please feel free to ask your health care providers.

Sincerely,

Your Medical Staff at The Practice

Name: _____

Sign: _____ Date: _____

THE PRACTICE
Family Medicine With a Difference ™

Authorization to Disclose Health Information to Family Members and Friends

Patient Name: _____ Date of Birth_____.

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without patient's consent. If you wish to authorize someone to have access to your medical or billing information, you must sign this form.

I hereby authorize The Practice to release my patient health information as described below:

		Type of Information Allowed to Disclose (Check one or both)		Method of Disclosure (Check one or both)	
Name	Relationship	Medical	Billing	By Phone	In Person

Patient Information

HIPPA regulations authorize the release of PHI for the purposes of treatment, obtaining payment from third party payers, and the day-to-day health care operations of The Practice. Other then those releases authorized by HIPPA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends for disclosure of PHI, The Practice will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

- I understand that I am not required to sign this authorization and I have the right to revoke this authorization at any time in writing.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the Recipient listed above and in that case,will no longer be protected by HIPPA.
- I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.
- This Authorization expires when I am no longer a patient in this practice or have revoked this authorization.

_____ _____

(Signature of Patient or Personal Representative (i.e. Guardian) Date

HEALTH QUESTIONNAIRE

THIS FORM IS TO HELP YOUR DOCTOR PROVIDE YOU BETTER HEALTH CARE.
IT IS COMPLETELY CONFIDENTIAL AND WILL BE A PART OF YOUR MEDICAL RECORD.

Name_____**Age**_____ **Date** _____

Address _____**Phone** _____

Please answer all questions. Circle YES or NO. Write in answers where indicated. Thank You.

PAST HISTORY

Did you ever have an operation? YES NO

If yes, list operation and year performed.

_____
_____
_____
_____

Did you ever have a serious medical illness, which was not a surgical operation? YES NO

If yes, list illness and year of illness.

_____
_____
_____
_____

Have you ever had a serious injury? YES NO

If yes, list injury and date.

_____
_____
_____
_____

Are you allergic to any medications? YES NO

If yes, list the medication and your reaction.

_____
_____
_____
_____
_____

Please list all current medications you are taking.

_____
_____
_____
_____
_____

FAMILY HISTORY

	LIVING		DECEASED	
	Age	Health	Age	Cause
Father				
Mother				
Brothers				
Sisters				

Have any relatives ever had the following?
If so, whom? Yes No

	YES	NO	WHOM
Diabetes			
Heart Trouble			
High Blood Pressure			
Arthritis			
Migraine			
Kidney Disorder			
Goiter			
Cancer			
Tuberculosis			
Stroke			
Epilepsy			
Insanity			

SOCIAL HISTORY- HISTORICAL SOCIAL

What is your occupation?

_____

Occupation History _____

_____

_____

Circle if you are: Single Married Widowed
Separated Divorced

How many children do you have? _____

SOCIAL HISTORY CONT.

How much alcohol do you drink? _____

How much do you smoke? _____

Hobbies _____

_____

_____

Pets _____

_____

_____

Do you have frequent or bad headaches? YES NO

Are headaches common in your family? YES NO

Have you ever seen double? YES NO

Has your eyesight blacked out completely? YES NO

Are you bothered by dizzy spells? YES NO

Have you ever had a convulsion? YES NO

Do you have ringing in your ears? YES NO

Are you hard of hearing? YES NO

Do you have nosebleeds? YES NO

Is you nose frequently stopped up? YES NO

Have you had difficulty swallowing or speaking? YES NO

Do you have persistent hoarseness? YES NO

Do you have a feeling of a lump in your throat? YES NO

Do you have hay fever or asthma? YES NO

Do you cough frequently? YES NO

Have you ever coughed up blood? YES NO

Did you ever live with anyone who had tuberculosis? YES NO

Do you have chest pain? YES NO

Does vigorous exertion cause chest discomfort or pressure? YES NO

Are you short of breath? YES NO

Do you become winded walking up one flight of stairs? YES NO

Do you sleep on more than one pillow? YES NO

Have you ever awakened short of breath? YES NO

Does your heart thump or skip? YES NO

Do your ankles swell? YES NO

Have you ever been told you had high blood pressure? YES NO

Have you ever been told you had heart trouble? YES NO

Have you ever had rheumatic fever, growing pains, or heart trouble? YES NO

Have you ever been told you had emphysema? YES NO

Have you lost or gained more than five pounds in the past year? YES NO

Is your appetite poor? YES NO

Do you consider yourself overweight? YES NO

Do you consider yourself underweight? YES NO

Do you suffer from indigestion, heartburn or gas? YES NO

Do you take antacids such as Tums, Rolaids or baking soda? YES NO

Are you often sick to your stomach? YES NO

Do you have frequent vomiting spells? YES NO

Have you ever-vomited blood? YES NO

Have you ever had an ulcer, gallbladder disease, hepatitis, colitis or jaundice? YES NO

Have you ever had severe abdominal pain? YES NO

Have you had any recent change in your bowel movements? YES NO

Do you have loose bowel movements or constipation? YES NO

Do you have hemorrhoids (piles) YES NO

Have you ever had blood in your bowel movements? YES NO

Have you ever had black bowel movements? YES NO

Were you ever treated for “bad blood” (venereal disease)? YES NO

Has a doctor ever said you had a hernia rupture? YES NO

Have you ever passed blood while urinating? YES NO

Do you have trouble starting your stream? YES NO

Do you get up at night to urinate? YES NO

Do you urinate frequently during the daytime? YES NO

Have you had severe burning when you urinate? YES NO

Do you lose control of your bladder? YES NO

Have you ever had a kidney stone or kidney infection? YES NO

Do you have loss of sexual interest? YES NO

Do you have loss of sexual ability? YES NO

Have you ever had arthritis or rheumatism? YES NO

Are your joints ever swollen or painful? YES NO
Have you ever had sugar in your urine or a high blood sugar? YES NO
Do you have diabetes in your family? YES NO
Do you feel thirsty? YES NO
Have you ever had boils or other skin infections? YES NO
Do you become weak if you do not eat? YES NO
If yes, will it occur between ordinarily paced meals? YES NO
Do you frequently have weak, shaky spells, which are relieved by eating? YES NO
If yes, will this occur only if a regular meal is missed? YES NO
Have you ever taken thyroid hormones? YES NO
Have you ever had a goiter (thyroid enlargement)? YES NO
Do you have bleeding gums? YES NO
Do you bruise easily? YES NO
Have you ever been anemic? YES NO
Have you ever had a blood transfusion? YES NO
Do you have lumps in your neck, under your arms, or in your groin? YES NO
Are you considered a sickly person? YES NO
Do you have difficulty falling asleep or staying asleep? YES NO
Do you awaken tired in the morning? YES NO
Do you often have spells of complete exhaustion? YES NO
Does work tire you out completely? YES NO
Do you push or drive yourself most of the time? YES NO
Does worrying get you down? YES NO
Are you considered a nervous person? YES NO
Did you ever have nervous breakdown? YES NO
Did anyone in your family ever have a nervous breakdown? YES NO
Are your feelings easily hurt? YES NO
Do people misunderstand you? YES NO
Are you easily upset or irritated? YES NO
Do you often get into a violent rage? YES NO
Do you often shake or tremble? YES NO
Are you constantly keyed up or jittery? YES NO
Do frightening thoughts keep coming back in your mind? YES NO
Do you often cry? YES NO
Do you feel unhappy and depressed? YES NO
Are you always miserable and blue? YES NO
Does life look entirely hopeless? YES NO
Do you often wish you were dead and away form it all? YES NO

Please list dates you have had the following…

Rectal Exam _____

Pelvic Exam _____

Pap Smear _____

Mammogram _____

Cardiac Lipid Profile _____

Immunizations _____

THIS SECTION FOR WOMEN PATIENTS ONLY

Are your menses irregular? YES NO
Do you have severe cramps with your menses? YES NO
Do you have hot flashes? YES NO
Are you bothered by an irritating vaginal discharge? YES NO
Do you have discharge from your breasts? YES NO
Have you ever been pregnant? YES NO
Have any of your babies weighed 8 lbs. or more at birth? YES NO