Sunset Road Medical Associates

Patient Information

Patients Name: ______________________________

Date of Birth:______________ Gender:_______ Preferred Language:______________

Street Address:______________________________

City: ____________________ State: __________ Zip:______________

Social Security #:__________________ Email Address:____________________

Home Phone #: __________________ Cell Phone #: ____________________

Work Phone#: __________________ Occupation: ____________________

Employer's
Address:______________________________

City: ____________________ State: __________ Zip Code:______________

Marital Status: Single Married Civil Unionized Divorced Widow

Spouses Name: ______________________________

Primary Care Provider: ______________________________

Primary Pharmacy: ____________________ Phone #:______________

Pharmacy Location: __________________ Mail Order Pharmacy:______________

Parent/Guardian (if applicable): ____________________ Phone #: __________

Emergency Contact Information

Emergency Contact: ____________________ Phone #: ______________

Street Address:______________________________

City: ____________________ State: __________ Zip Code:______________

Guarantor's Information

Please fill out the following information for the person who holds the policy for the patient's primary insurance. (i.e. Father's information for the dependent child who is the patient. Wife's information if the husband is the patient and his coverage is through her insurance from her employer.)

Policy Holder's Name: ______________________ Date of Birth: ______________

Social Security Number: ______________________________

Street Address: ____

City: ______________________ State: __________ Zip: ______________

Home Phone #: ________________ Cell Phone #: ______________________

Employer's Name: ____

Employer's Address: ____

City: ______________________ State: __________ Zip Code: ____________

Financial Policy

As a courtesy to you, we will bill your insurance carrier if you provide us with the appropriate insurance information, however, you must recognize that you are ultimately responsible for payment of the bill. As an additional courtesy, we will bill your secondary insurance carrier one time. If payment is not made by the secondary carrier, you will be responsible for payment of the bill.

In the event that your visit or specific procedures are deemed non-covered, full contracted payment is not received, deductible has not been satisfied, or for any reason whatsoever the insurance company does not make full and prompt payment, full payment will be expected from you within 30 days of notification.

A $40.00 fee will be imposed for all returned checks. Patient balances not satisfied within 90 days of initial notice will be turned over to a National Credit Bureau and charged an additional 25% collection fee.

I authorize my insurance carrier(s) to send any payments made on my behalf directly to the physician's office.

Print Name: ____

Authorized Signature: ______________________________ Date: ____________

Medical History *Date:* / /

Name ______________________ Age ______ Birthdate __ / __ / __
Address ______________________ Sex: ☐ M ☐ F
______________________ Home phone ______________________
______________________ Work phone ______________________
Occupation ______________________ Emergency contact ______________________
Phone ______________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name ______________________

Children's names and ages ______________________

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction):

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

Past Medical History and Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. ______________
50. ______________

Gynecologic and Obstetric History

Age at onset of periods: ______________ Frequency: ______________ Length of period: ______________

Pregnancies: ______________ Births: ______________ Miscarriages: ______________

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please describe): ______________

Leakage of urine: ☐ No ☐ Yes (Please describe): ______________

Pelvic pain: ☐ No ☐ Yes (Please describe): ______________

Abnormal discharge: ☐ No ☐ Yes (Please describe): ______________

History of abnormal Pap smear: ☐ No ☐ Yes (Type of treatment): ______________

Patient Name: *Date:* / /

Please List and Supply the Dates of:

Operations: ______ ______ ______ ______ ______ ______

Hospitalizations other than for surgery: ______ ______ ______

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? ______

Other? ______ ☐ No ☐ Yes When? ______

Pneumovax immunization? ☐ No ☐ Yes When? ______

Flu immunization? ☐ No ☐ Yes When? ______

Tetanus immunization? ☐ No ☐ Yes When? ______

When was your last:

Pap smear? ______ Breast exam? ______ Stool check for blood? ______

Mammogram? ______ Cholesterol check? ______ Prostate exam? ______

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other:		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug name	Dose	Drug name	Dose

Prevention

Do you wear seat belts? ☐ Yes ☐ No If no, why not? ______

Do you wear a bike helmet? ☐ Yes ☐ No ☐ N/A

Do you smoke? ☐ No ☐ Yes If yes, how many packs per day? ______

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how much per week? ______

Do you drink coffee? ☐ No ☐ Yes If yes, how many cups per day? ______

Do you drink tea? ☐ No ☐ Yes If yes, how many cups per day? ______

If there is a gun in your home, do you keep it unloaded and out of children's reach? ☐ Yes ☐ No ☐ N/A

Do you use drugs? (marijuana, cocaine, crack, etc.) ☐ No ☐ Yes If yes, explain: ______

Have you ever engaged in any activity which has put you at risk of getting AIDS? ☐ No ☐ Yes If yes, explain: ______

Do you wish to be tested for AIDS? ☐ No ☐ Yes

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? ☐ No ☐ Yes If yes, explain: ______

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ No ☐ Yes

Do you ever feel afraid of your partner? ☐ No ☐ Yes ☐ N/A

Do you have a "living will"? ☐ Yes ☐ No

Do you have a donor card? ☐ Yes ☐ No

Method of birth control? ______

This information is for use by your physician as part of your confidential medical record

Sunset Road Medical Associates

Releasing Personal Health Information – In Person and Over the Telephone

A vast amount of health information is exchanged to our patients over the telephone, including lab/radiology results and other personal data. Numerous forms and documents are also picked up at our facility, such as referrals and medical forms. In order to comply with HIPAA guidelines, Sunset Road Medical Associates has created safeguards to make sure that the person who calls for or picks up personal health information is who they say they are.

While there is no foolproof way to identify patients over the telephone or in person, our goal is to increase as substantially possible the degree of certainty.

If you would like to receive personal health information in person or over the telephone in the future, you must provide us with a 4-digit personal identification number.

Personal Identification Number: ___ ___ ___ ___

Each time you call for or come into the facility to pick-up test results, billing/referral information, or any other request for personal health information, you will be required to provide us with your 4 – digit identification number.

Many times we also receive telephone calls from our patient's spouses or other family members requesting personal health information. Sunset Road Medical Associates employees will only release personal health information to the individuals you list below. You must also provide us with the person's date of birth and what their relationship is to you.

Name:	Date of Birth	Relationship to you:

The above listed individuals must also know your social security number before we will release any of your personal information to them.

______________________________ (Signature) ______________ (Date)

______________________________ (Print Name) ______________ (Date of Birth)

Sunset Road Medical Associates

Consent to Use/Disclose Health Information

Prior to using or disclosing your protected health information to carry out treatment, payment, or health care operations, Sunset Road Medical Associates is required under federal law to obtain your consent.

Please review this consent. If you understand and agree with its terms, please sign and date this consent below.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

You may request the Notice from a Patient Support Representative. Please note that we have reserved the right to change the privacy practices described in the Notice; should you wish to obtain a revised Notice, please contact a Patient Support Representative.

By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment, or health care operations.

You have a right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. However, Sunset Road Medical Associates is not required to agree to such restrictions. If we do agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that Sunset Road Medical Associates have taken action in reliance on your consent.

I, ____, hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this contract.

_______________________________________ (Signature)   ____________________ (Date)

_______________________________________ (Print Name)   ____________________ (Date of Birth)

Sunset Road Medical Associates

Voicemail Authorization

Patient's Name: ____
(Please Print)

Patient's Date of Birth: _______/_______/______

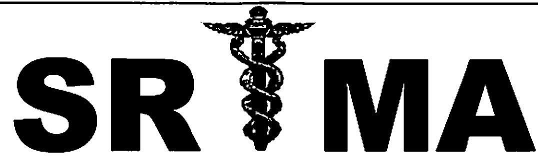
I authorize Sunset Road Medical Associates to leave all general office messages, including results for all lab, radiology and diagnostic testing on the following telephone numbers voice mail system:

Cell Phone Number: ____ **or**

Home Phone Number: ____

Patient's Signature: ____

Date: _________________________________



Sunset Road Medical Associates

Race Demographics

Patient's Name: ______________________________
(Please Print)

Patient's Date of Birth: ______/______/______

Please circle the appropriate selection:

Race:
- Asian
- Black or African American
- Hispanic
- White
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander

Language:
- English
- Other
- Sign Language
- Spanish

Ethnicity:
- Latino
- Non-Latino

Patient's Signature: ______________________________

Date: ______________________________

Sunset Road Medical Associates

Patient Portal Registration Form

Name: ____

Date of Birth:__________________

Email Address: ____

Signature:____

Date: __________________