South Coast Medical Group
Family Medicine ✚ Urgent Care
Orange County

We are a **Family Practice** that offers **Urgent Care** services.

Offering these services is a convenience to our patients by providing continuity of care and access to medical records. Please note the following;

- **Urgent Visits** that require x-rays, wound repair, casting, splinting, IV therapy, and urgent EKG's are examples of urgent care visits. These visits will be billed out as urgent care, **regardless of the day or time**, and you will be responsible for your **contracted co-pay.**

- All visits after **5pm** and on **Sat/Sun are considered Urgent Care and you will be responsible for your contracted co-pay.**

South Coast Medical Group OC

DBA of OC Family Medicine PC

Patient Registration **TODAY'S Date:**_____

Patient

Last name _____ First name _____ Initial _____

Social Security Number _____ Date of Birth ____/____/____ Sex ☐Male ☐Female

Street Address _____

City _____ State _____ Zip _____

Phone – Home_____ Work_____ Cell _____

Preferred **PRIVATE** Message/Contact Phone _____ ☐Cell ☐Home
(I'm fully aware that a cell phone is not secure or private)

Marital Status Single Married Divorced Widowed

Race Asian Black Hispanic Native American Other Refused Unknown White

Employer_____

Have you been seen at South Coast Medical Group in the past 3 years? YES NO

Email Address: _____

Health Insurance

Primary Insurance _____ Policy Holder Name _____

Relationship to Patient _____ Primary's Date of Birth _____

Employer_____ Subscriber ID Number _____

Group Number _____ Effective Date_____

We only bill secondary if Medicare is your primary

Secondary Insurance _____ Policy Holder Name _____

Relationship to Patient _____ Primary's Date of Birth _____

Employer_____ Subscriber ID Number _____

Group Number _____ Effective Date_____

Responsible Party

Last Name _____ First name_____ Initial _____

Social Security Number _____ Date of Birth _____ Sex _____

Street Address _____

City _____ State _____ Zip _____

Phone – Home_____Work _____ Cell _____

Preferred **PRIVATE** Message/Contact Phone _____ Marital Status _____

Employer_____

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Consent to Treat

I consent to and authorize the medical staff at South Coast Medical Group to furnish me and my dependents with necessary medical care. This medical care may include radiology examinations, laboratory testing and other diagnostic procedures as may be required.

Schedule Appointments

I understand that if I do not cancel my appointment within 24 hours a $25 charge will be applied to my account.

Release of Medical Information

I consent to, and authorize South Coast Medical Group to disclose all or part of my or my dependents, medical record to any mutually agreed upon referring physician.

Financial Responsibility

I understand that I am financially responsible for the payment of medical charges incurred on my behalf at the South Coast Medical Group, regardless of third party coverage.

I have read, understand and agree with all of the above listed consents and disclosures.

_____ _____

Patient / Mother Father Guardian Signature Date

_____

Relationship to patient

Credit Policy

It is our desire to provide quality medical services at an affordable price. In order to continue to provide services, we must avoid unnecessary overhead expenses.

For those patients with insurance coverage, we will properly bill insurance on a timely basis. If you do not have insurance coverage, we are sensitive to your individual financial constraints. In either case, it is critical for you, the patient, to stay in contact with our billing department. If you do not choose to stay in touch with our billing manager and your account does not clear on a timely basis, we want you to understand ahead of time the steps we will take to collect outstanding balances.

Procedure

Initial

_____ 1. We will request payment at time of service. If this is not possible, we would expect you to let our billing manager know so we may arrange an acceptable payment schedule.

_____ 2. You will receive at least two statements subsequent to your visit at our clinic. If your account does not clear, and you have not made payment arrangements, we will refer your account to a professional agency.

_____ 3. The Collection Agency will send you a notification that a payment is due. The letter will arrive at your last known address, and will be printed on credit bureau letterhead. If you respond to this letter, you may avoid damage to your credit record. If you ignore this letter, your account is automatically referred to the credit bureau. If this occurs, your credit will be adversely affected.

It is our experience that the vast majority of our patients understands and cooperates with our credit policy. We are disclosing our policy to you now, so that we may avoid misunderstanding in the future.

I have read and understand this policy.

_____ _____ _____

Printed Name **Signature** **Date**

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Health Care Eligibility Form

The patient or Patient's Legal Representative hereby certifies that he/she is eligible for health plan benefits coverage, and has choose South Coast Medical Group Family and Sports Medicine as the provider of his/her care. Furthermore, the Patients legal Representative understands that if he/she is found ineligible for coverage of plan benefits, he/she is financially responsible for all cost incurred during the delivery of health services, and agrees to pay these charges to the physician accordingly.

_____ _____ _____

Print Name Signature Date

Protected Health Information Release

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operation).

   ☐ None _____ Initial

   Name _____ Phone#_____

   Name _____ Phone#_____

   (I am fully aware that a cell phone is not secure or private)

Please list the email address where you want to receive copies of lab results, referral information and other pertinent office information. Please understand that this email is for your physician to send you notifications only. If you are in any distress, call 911 immediately. **No diagnostic or prescription refills will be made via this e-mail system.** DO NOT REPLY to this e-mail as the portal does not receive in-coming messages.

2. Print email address: _____

Can we leave a message on your cell? ☐ YES ☐ NO Can we leave a message at your work? ☐ YES ☐ NO

Can we leave a message at your home? ☐ YES ☐ NO Can we send a message using email? ☐ YES ☐ NO

Can we leave a message with anyone in your household? ☐ YES ☐ NO

Patient Clinical Communication Preferences

Consent to having his/her medical information shared in the HIE (Local Emergency Room)? ☐ YES ☐ NO

Consents to release of medication history? ☐ YES ☐ NO

_____ _____ _____

Print Name Signature Date

Notice and Acknowledgement

Acknowledgment : I acknowledge that I have received the Notice of Privacy Practices.

_____ _____ _____

Print Name Signature Date

Relationship to patient ☐ Mother ☐ Father ☐ Guardian

Do you have advanced Directives? ☐ YES ☐ NO Copy of Advanced Directives received? ☐ YES ☐ NO

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Patient Partnership Agreement

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect lift-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Print Patient Name	**Patient Signature**	**Date**	**Physician Signature**

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HEALTH QUESTIONNAIRE

Name _____ Birthdate _____ Date _____

Last Date of Physical Exam Month_____ Year _____ Last Pap Smear Month_____ Year _____
Last Date of Colonoscopy Month_____ Year _____ Last Tetanus Shot Month_____ Year _____
Last Date of Mammogram Month_____ Year _____

DRUG ALLERGIES

CURRENT MEDICATIONS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease						
High blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding disorder						
Kidney Disease						
Thyroid disease						
Mental Illness						
Osteoporosis						

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY Pregnant? YES NO Planning Pregnancy? YES NO

PAST MEDICAL HISTORY

Migraines
High blood pressure
Heart Arrhythmia
Heart murmur
Heart Attack
High Cholesterol
Peripheral vascular disease
Allergies/Hay fever
Asthma
Bronchitis
Pneumonia
Ulcer
GI disorder

Lactose Intolerance
Gall bladder disease
Prostate disease
Incontinence
Sexual/Menstrual dysfunction
Sexually Transmitted Disease
Hepatitis
Anemia
Arthritis
Osteoporosis
Gout
Anxiety
Depression

Thyroid disease
Diabetes Type I Type II
Last A1C blood test _____
Chronic rashes
Cancer_____type
Sleep Apnea
A.D.D.
Other _____

HABITS

Smoke: Packs daily _____ *How long?* *When stopped?*
Coffee: Cups daily? _____ *Other caffeines?* Diet: Salt intake
Exercise routine: _____ Fat intake
Alcohol: Type/Amount _____
SLEEP: Difficulty falling asleep Snoring Daytime drowsiness Continuity disturbances Early morning awakening

Sleep Disorder Questionnaire

Patient Name: _____

DOB: _____ Gender: M F Height: _____ Weight: _____ BMI: _____

Please circle answer:

Do you snore: None Soft Moderate Loud Disruptive

Snoring can be heard outside of the bedroom	Yes	No
Snoring is present only when sleeping on back?	Yes	No
Do you have unexplained awakenings from sleep?	Yes	No
Do you awaken from sleep gasping for air or choking?	Yes	No
Do you notice frequent twitching or jerking of legs while asleep?	Yes	No
Do you lack energy upon waking in the morning?	Yes	No
Do you have a headache upon waking in the morning?	Yes	No
Do you often lay in bed unable to fall asleep?	Yes	No
Do you wake up during the night and are unable to fall back asleep?	Yes	No
Do you find it difficult to stay awake during the day?	Yes	No

*****If you have answered YES to any one of the above questions please consult with your doctor*****

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

0 = Would never doze 1 = Slight chance of dozing
2 = Moderate chance of dozing 3 = High chance of dozing

Sitting and reading	_____
Watching T.V.	_____
Sitting inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score	_____

*****If your Epworth score is 10 or greater please consult with your doctor*****

Physician Name: _____

Phone: _____ Fax: _____