Rancho Paseo Medical Group ADULT, Health History Form

Last Name: _____
First Name: _____
Date: _____ Phone: _____

PERSONAL HISTORY

Date of Birth _____Birthplace: _____

Marital Status: ☐*Single* ☐*Married* ☐*Separated* ☐*Divorced* ☐*Widowed*

Health of Spouse: _____
Occupations: _____
Religion: _____

Ethnic Background: ☐*American Indian* ☐*Asian* ☐*African American*

☐*Filipino* ☐*Caucasion* ☐*Pacific Islander* ☐*Other:* _____

Recreation / Exercise: _____
Sleep: Avg Hrs: _____

ALLERGIES TO MEDICATIONS ☐ *NO KNOWN ALLERGIES*

Substance / Medication	Reaction

HOSPITALIZATIONS & SURGERIES

Year	Hospital	Reason for Hospitalization

Year	Surgery	Reason for Surgery

(continue on back if you need more room)

Date of Last
PAP Smear: _____ Mammogram: _____
Tetanus Shot: _____ Pneumova : _____
Flu Shot: _____ Gardasil: _____
Zostovax: _____

List Over-the-Counter Medications:

_____ _____
_____ _____
_____ _____

SPIRITUAL ASSESSMENT (optional)

Do you believe in God or a higher power? ☐*YES* ☐*NO*

Would you like to speak with our Chaplain about spiritual matters or grief counseling? ☐*YES* ☐ *NO*

Would you like us to pray for: ☐*You* ☐*Your Family* ☐*Your Health*

Other: _____

☐*YES – during office visit* ☐*YES – while I'm not present.* ☐*NO - Not at this time.*

ADVANCE DIRECTIVE

☐ I have executed an Advanced Healthcare Directive, Living Will, or Durable Power of Attorney: _____

☐ Copy Placed in Chart: _____

☐ I would like to fill out an Advanced Directive.

☐ I do not wish to fill out an Advanced Directive at this time.

MY DESIRES CONCERNING LIFE SUPPORT ARE AS FOLLOWS:

☐ I would never want resuscitation or life support: _____

☐ I would want resuscitation or life support only if something happened that was easily correctable: _____

☐ I want everything possible done to prolong my life, even if I were in a permanent coma: _____

HEALTH HABITS / SOCIAL HISTORY

	Currently		Quit Date
Caffeine:	☐YES	☐NO	_____
Tobbacco:	☐YES	☐NO	_____
Alcohol:	☐YES	☐NO	_____
Illicit Drugs:	☐YES	☐NO	_____

Have you ever felt you should cut down on your drinking?
☐YES ☐NO

Have people annoyed you by criticizing your drinking?
☐YES ☐NO

Have you ever felt bad or guilty about your drinking?
☐YES ☐NO

Have you ever had a drink first thing in the morning to calm your nerves or get rid of a hang-over? ☐YES ☐NO

Are you sexually active? ☐YES ☐NO

FAMILY HEALTH HISTORY

Check (√) if you or your blood relatives have or have had any of the following:

Disease	You	Family	Relation to
Alcohol / Drug dependency			
Asthma/ Chronic Lung Disease			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney disease			
Mental illness or Depression			
Migraines			
Peptic Ulcer			
Seizures			
Stroke			
Thyroid trouble			
Tuberculosis			
Other			

RANCHO PASEO MEDICAL GROUP
Total Family Care

AUTORIZACION DEL PACIENTE PARA PERMITIR EL USO Y DIVULCION DE INFORMACION DE SALUD.

Este documento autoriza la divulgación y/o el uso de información de la salud, sobre usted. La falta de información pedida puede invalidar esta autorización.

Nombre del Paciente: _____ Fecha de Nacimiento _____

Dirección _____ Número de Seguro Social ____-__-____

_____

Autorizo a: _____ _____
Nombre de persona/Organización *Dirección*

_____ _____ _____
Teléfono *Fax* *Ciudad* *Estado, Código Postal*

Divulge información a: Rancho Paseo Medical Group Teléfono: 951-769-0079
264 N. Highland Springs Ave., 5A, Banning, CA 92220 Fax: 951-845-6750

La información siguiente:

a. ☐ Toda la información de la salud referente a mi condición médica del historial, mental o física
o ☐ Solamente los siguientes expedientes o los tipos de información de la salud (incluya la fecha o fechas del tratamiento):_____

b. Autorizo específicamente divulgo de la información siguiente (cheque como apropiado):
☐ Información del tratamiento de la salud mental
☐ Resultados de la prueba del VIH
☐ Información del tratamiento del alcohol/de la droga

Se requiere una autorización separada de autorizar el acceso o el uso de las notas de la sicoterapia. Propósito del uso o del acceso pedido: Petición paciente ☐; O ☐ otro _____

Fecha de vencimiento: _____ (Esta autorización quedará anulada y expirará en 6 meses a menos que se indicare contrariamente).

- Puedo rechazar firmar esta autorización. Mi denegación no afectará a mi capacidad de obtener el tratamiento o pago o elegibilidad para los beneficios.
- Puedo examinar u obtener una copia de la información de la salud que me están pidiendo.
- *Puedo revocar esta autorización pero* debo hacerlo por escrito y presentar mi *revocación* en *este* domicilio
  Rancho Paseo Medical Group, 264 N. Highland Springs Ave. 5A, Banning, CA 92220
- *Mi revocación tomará efecto* en cuanto sea recibida, excepto hasta el punto de otros hayan actuado en confianza sobre esta autorización.
- Tengo una derecha a y recibiré una copia de esta autorización.
- La información divulgada conforme a esta autorización se podía re-divulgar por el recipiente. Tal re-acceso no es protegido por la ley de California y se puede en algunos casos proteger no más por ley de secreto federal (HIPAA).

Si esto esta marcado ☐, el solicitante recibirá la remuneración para el uso o la divulgación de mi información.

Firma: _____ Nombre: _____
(paciente/representante/esposo/partido financieramente responsable)

Si es firmado por alguien con excepción del paciente, indique su relación legal al paciente: _____

Firma del testigo: _____ Fecha: _____

Rancho Paseo Medical Group. 264 N. Highland Springs Ave. 5A. Banning, CA 92220

FINANCIAL DISCLOSURE STATEMENT

The following disclosure is furnished in compliance with Federal Truth-in-Lending Act.

Rancho Paseo Medical Group shall charge a FINANCE CHARGE on any part of the "previous balance" at the periodic rate of 1¼% per month after deducting current payments and/or credits received prior to the closing (billing) date of the statement. The ANNUAL PERCENTAGE RATE is 15% per annum. There shall be in all cases a minimum FINANCE CHARGE of $.50 per month. Said minimum charge may result in an ANNUAL PERCENTAGE RATE in excess of 15% per annum. No FINANCE CHARGE will be charged on any "previous balance" as shown on the periodic statement, which is paid 90 days from the first billing of the "previous balance" or on any current charges listed on the periodic statement. The FINANCE CHARGES are figured on your account by applying the periodic rate to the amount you owe at the beginning of each billing cycle. All payments received shall be first applied to any FINANCE CHARGE assessed to the account, and then to that portion of the "previous balance" which is more than 90 days unpaid and then to that portion of the "previous balance" which is less than 91 days unpaid and then to the current charges listed on the periodic statement, and then finally to credit.

You may pay your entire balance at any time.

Any credit balances of $5.00 or less will be automatically adjusted to $0.00 due to the administrative costs of processing balances.

You are responsible for payment on your account regardless of Insurance. Rancho Paseo Medical Group cannot accept the responsibility for collecting your Insurance claims or negotiation of a settlement on a disputed claim. Notwithstanding Insurance benefits that may have accrued, the FINANCE CHARGES as set out above shall be assessed against all accounts, even if the account will ultimately be paid by Insurance benefits.

Rancho Paseo Medical Group will not acquire or retain any security interest in any property to secure the payment of credit extended for services rendered, except that Rancho Paseo Medical Group reserves the right to obtain assignment of benefits for payment of balances accrued to the group.

I certify that I have read this statement and have had an opportunity to review with the group personnel any questions I may have had regarding the same.

Patient's Signature: _____ Date: _____

CONSENT FOR TREATMENT

1. I hereby do voluntarily consent to such care including routine procedures and other treatment by Rancho Paseo Medical Group professionals and their assistants, appointees, or consultants as is necessary in their judgment.

2. I am aware that the practices of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments of examination by Rancho Paseo Medical Group.

3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Further, if I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.

4. I understand that Rancho Paseo Medical Group shall not be responsible or liable for the loss of/or damage to any personal property.

5. I authorize the release to any party responsible for such information from my records as is required in order for the group and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

I have read the above statement and my questions have been adequately answered and I certify that I understand its contents.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Signature of Patient or Guardian: _____ Relationship: _____

Signature of Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

To The Patients of Rancho Paseo Medical Group: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Rancho Paseo Medical Group, 264 North Highland Springs Ave., Ste. 5, Banning, California 92220 (951) 769-0079. Attention Administrator or Safety Officer.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Rancho Paseo Medical Group, 264 North Highland Springs Avenue, Banning, California 92220 (951) 769-0079. Attention: Administrator or Practice Privacy Officer. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Rancho Paseo Medical Group, 264 North Highland Springs, Banning California 92220 (951) 769-0079. Attention Administrator or Practice Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Rancho Paseo Medical Group, Attention Administrator or Practice Privacy Officer, (951) 769-0079

Name of Patient: _____ Date: _____

Patient's Signature: _____