

**PATIENT INFORMATION (please print)**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

If minor, name of responsible party/parties: \_\_\_\_\_

Name you would like to appear on your health records: \_\_\_\_\_

What are your pronouns:  He/Him  She/Her  They/Them  Other: \_\_\_\_\_

Drivers License # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Billing Address (if different) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Preferred Contact # \_\_\_\_\_ Email Address \_\_\_\_\_

Preferred Contact Method for Communications will be via the Patient Portal if registered.

Sex:  M  F  Transgender man  Transgender woman  Genderqueer/gender nonconforming, not exclusive

A category not listed here, please specify: \_\_\_\_\_  Decline to answer

Do you think of yourself as:

Straight or Heterosexual  Lesbian or gay  Bisexual Queer, pansexual and /or questioning  Don't know

An orientation not listed here, please specify: \_\_\_\_\_  Decline to answer

Marital Status:  S  M  D  W  Other \_\_\_\_\_

Education, Language & Demographics:

Primary Language \_\_\_\_\_ Interpreter Required?  Yes  No

Race \_\_\_\_\_ Ethnicity (circle one) \_\_\_\_\_ Hispanic or Latino \_\_\_\_\_ Not Hispanic or Latino \_\_\_\_\_

Highest level of education:  High School  College  Trade School  Other: \_\_\_\_\_

**GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:**

Guardian Last Name (if applicable) \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

Guarantor Address \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

## INSURANCE INFORMATION

### Have you recently changed or added to your health insurance?

No, please verify your current information on file.

**YES - Give receptionist a copy of your NEW card.**

### **Primary Insurance Carrier**

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

Billing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Group or Policy #\_\_\_\_\_ Cert. or Member #\_\_\_\_\_ Local Union #\_\_\_\_\_

Co-pay Amount \_\_\_\_\_ Policy Effective Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

**Patient Relation to Policy Holder:**  **Self**     **Spouse**     **Child**     **Other:** \_\_\_\_\_

### **Secondary Insurance Carrier**

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

Group or Policy #\_\_\_\_\_ Cert. or Member #\_\_\_\_\_ Local Union #\_\_\_\_\_

Co-pay Amount \_\_\_\_\_ Policy Effective Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

**Patient Relation to Policy Holder:**  **Self**     **Spouse**     **Child**     **Other:** \_\_\_\_\_

## PATIENT REFERRAL INFORMATION

<b>Patient referred by</b>	<b>Phone #</b>		
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>

## PREFERRED PHARMACY INFORMATION

In Person Pharmacy Name \_\_\_\_\_ Address \_\_\_\_\_

Phone : (\_\_\_\_) \_\_\_\_\_ Fax : (\_\_\_\_) \_\_\_\_\_

Mail Order Pharmacy Name: \_\_\_\_\_

Phone : (\_\_\_\_) \_\_\_\_\_ Fax : (\_\_\_\_) \_\_\_\_\_

**Note: It is our office policy that no prescription refills will be given after hours or on weekends.**

## EMERGENCY CONTACT INFORMATION

Please list two people who do not live with you that we may call in case we are unable to reach you and we have an urgent matter to discuss with you.

**NOTE:**

**NO CONFIDENTIAL INFORMATION SHALL BE DISCLOSED TO THESE CONTACTS, SIMPLY A REQUEST TO CONTACT YOU AND HAVE YOU CALL US.**

Emergency Contact Name	Relationship	Phone Number

Signature (Patient or Parent of Minor): \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization to Communicate Patient's Medical Information

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name of Person Authorized To receive information	Relationship to Patient	Type of Information			
		All	Medical	Appt Only	Billing Only

Validation Code Word: \_\_\_\_\_ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

### Other Required Information

Advance Directive Given:  Yes  No Initials: \_\_\_\_\_ Adv. Directive Completed & On File:  Yes  No

Signature (Patient or Parent of Minor) \_\_\_\_\_ Date: \_\_\_\_\_

Patient representative/parent name: \_\_\_\_\_

For patients requiring translation or verbal reading of the document, the reader or translator may document and sign below:

Reader/translator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reader/translator Printed Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_



## **GENERAL PRACTICE INFORMATION & CONSENT AND OFFICE POLICIES**

Welcome to Pacific Coast Care! Thank you for choosing us to be your primary care provider and trusting us with your medical care. Below is some general information regarding our practice as well as some consent forms for providing you with medical care.

We are conveniently located across the street from UCI/Los Alamitos Medical Center and both major laboratories (Labcorp and Quest Diagnostics) are located on the second floor.

### **Appointments**

Appointments are generally scheduled for 20 minutes (40 minutes for senior wellness exams) during regular business hours. Bring your ID and insurance cards to every appointment.

### **Refills**

Medication refills will only be completed during normal business hours, so we encourage you to have your provider refill your medications during your office visits to ensure that you do not run out.

### **Fees**

Patients who fail to show for their appointment, cancel or reschedule within 24 hours of their scheduled appointment time shall be subject to a fee of \$50. As a small practice, we appreciate your understanding. Forms not completed at the time of your appointment will be subject to a fee of \$25 per page.

### **CONSENT TO LEAVE VOICEMAIL OR TEXT MESSAGES**

I hereby authorize Pacific Coast Care to call or text the following telephone numbers:

Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Home: \_\_\_\_\_

and leave detailed voice or text messages with the following information (check all that apply):

- Details about my next appointment (provider name, date/time, and number)
- Test and other exam results
- Account payments, balances, or cost estimates

I DECLINE. Please do NOT leave any voice or text messages.

I may refuse to sign this authorization, and it will not affect my ability to obtain treatment or payment or eligibility for benefits.

***Please initial for consent to leave voicemails/texts*** \_\_\_\_\_

### **TELEHEALTH CONSENT**

I understand that telehealth appointments involve sharing my medical information electronically and I need to check with my health insurance plan to see if telehealth visits are covered. I understand that I will be asked to confirm my identity and current location to the provider (or staff) at the start of my appointment.

I understand that telehealth visits carry some level of risk including but not limited to:

- My computer, tablet, or phone may not be private and secure.
- My healthcare provider cannot examine me as closely during a telehealth visit, and this may make it harder to diagnose and effectively treat me.

By initialing below, I agree to use telehealth visits with my Pacific Coast Care provider and assume all associated costs if not covered by my insurance.

***Please initial for telehealth consent*** \_\_\_\_\_

### **GENERAL CONSENT TO TREAT**

I consent to receive diagnosis, medical care, and treatment that is considered necessary or recommended by my provider(s) at Pacific Coast Care, including services through the use of telehealth technologies, such as telephonic and interactive audio-visual communications and other virtual care through the patient portal. Providers include physicians, Nurse Practitioners, Physician Assistants, and staff. I acknowledge that no guarantee can be made concerning the results of treatments. I understand that if specific procedures are recommended, I may be asked to read and sign additional consent forms prior to the procedure.

I have the right to discontinue services at any time and the right to discuss treatment plans with my physician about the purpose, potential risks and benefits of any test ordered, and ask questions.

I consent to the use of the electronic prescription system, which allows prescription history and related information to be electronically shared between my providers and my pharmacies. I also give permission to send or fax immunization records, completed forms, or notes to my school or employer upon my request. I understand that certain circumstances require mandatory disclosure to organizations such as the state health department and that this entity participates in the statewide immunization registry, which complies with federal health information privacy laws.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. By signing below, I acknowledge that this consent will remain effective until it is revoked in writing.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **PRIVACY POLICY (CAREQUALITY)**

We may make your protected health information available electronically through an electronic health information exchange to other health care providers that request your information for their treatment purposes. In all cases the requesting provider must have or have had a treating relationship with you. Participation in an electronic health information exchange also lets us see other provider's information about you for our treatment purposes. These records include but are not limited to hospital and emergency room records, consultation notes from other providers, imaging reports, vaccination records, and records from your previous primary care physician(s).

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## **GENERAL CONSENT TO TREAT A MINOR (FOR PATIENTS UNDER 18)**

I, the undersigned parent/legal guardian of the minor named below, hereby give my informed consent for Pacific Coast Care and its physicians, nurse practitioners, physicians assistants, nurses, or other healthcare staff to examine, diagnose, and provide medical treatment to my minor child as deemed medically appropriate. This includes, but is not limited to, routine medical care and evaluations, preventive care and immunizations (as discussed with me), diagnostic testing and procedures, and treatment of acute and chronic medical conditions.

In the event of an emergency where I cannot be reached, I authorize the provider to administer such emergency medical treatment as is necessary to protect the health or life of my child. I understand that I will be solely responsible for any charges, fees, or expenses incurred as a result of the treatment provided to the minor.

I also authorize and consent to medical care provided for the minor in my absence when he/she is accompanied by a designated adult chaperone or coming to the office by himself/herself.

Agree  Disagree  **Initial here**

This authorization shall remain effective until revocation in writing by the undersigned.

Parent/Legal Guardian Name (print): \_\_\_\_\_

Relationship to Minor: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

**AGREEMENT TO PAYMENT POLICY** I acknowledge that I received a copy of PROHEALTH PARTNERS, INC./Pacific Coast Care, financial policy and agree to the terms of payment due.

**AUTHORIZATION TO RELEASE INFORMATION** I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to PROHEALTH PARTNERS, INC./Pacific Coast Care, any and all of my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

**ASSIGNMENT OF BENEFITS** I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to PROHEALTH PARTNERS, INC. (dba Pacific Coast Care), for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

**GUARANTEE OF PAYMENT** I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to PROHEALTH PARTNERS, INC. (dba Pacific Coast Care),, are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

**MEDICAL DEBT - A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.**

Patient's Signature\_\_\_\_\_ Date\_\_\_\_\_

Responsible Party Relationship to Patient \_\_\_\_\_

**Form PF-2000**  
**Acknowledgement of Receipt of Notice of Privacy Practices**

**The Practice reserves the right to modify the privacy practices outlined in this notice.**

I have received a copy of the Notice of Privacy Practices which is also posted in the reception area of this office. I may receive a copy of an amended notice upon request at subsequent visits. This notice can also be found and downloaded from [www.prohealthpartners.com](http://www.prohealthpartners.com)

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Name of Patient (print or type)

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Signature of Patient

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Date

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Signature of Patient Representative

*(Required if patient is a minor or an adult who is unable to sign this form)*

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Relationship of Representative

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**Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices**

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on \_\_\_\_\_ (date). The acknowledgement was not obtained because:

- The patient was undergoing emergency treatment
- The patient declined to sign the acknowledgement
- Other \_\_\_\_\_

Signature: \_\_\_\_\_

Name of the patient: \_\_\_\_\_

Name of Staff Member: \_\_\_\_\_

Date: \_\_\_\_\_

## NEW PATIENT HEALTH HISTORY FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Past Medical History:** *Check any conditions that you have or have had.*

<input type="checkbox"/> Hypertension (high blood pressure) <input type="checkbox"/> Hyperlipidemia (high cholesterol) <input type="checkbox"/> Diabetes (type I or II) <input type="checkbox"/> Heart disease <input type="checkbox"/> Lung disease (e.g. asthma or COPD) <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Gastrointestinal disease <input type="checkbox"/> Endocrine disease (including thyroid)	<input type="checkbox"/> Urinary problems (bladder or prostate) <input type="checkbox"/> Arthritis or chronic joint or back pain <input type="checkbox"/> Allergies <input type="checkbox"/> Anxiety or Depression <input type="checkbox"/> Skin disorders (e.g. eczema, psoriasis) <input type="checkbox"/> Autoimmune disorders <input type="checkbox"/> Cancer (specify type): _____ <input type="checkbox"/> Other: _____
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**Past Surgical History/Previous Hospitalizations:** *Include the year of surgery/hospitalization.*

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**Medications:** *List all medications (including over-the-counter), dosages, and how often taken.*

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**Allergies:** *List all allergies to medications, foods, etc. or indicate none.*

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**Family History:**

	Father	Mother	Brother	Sister	Other (specify)
High blood pressure					
High cholesterol					
Diabetes					
Heart disease					
Anxiety or Depression					
Cancer (specify type):					
Other: _____					

**Social History and Habits:**

Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Occupation (current and past): \_\_\_\_\_

Smoking status: Never \_\_\_\_\_ Current \_\_\_\_\_ Former \_\_\_\_\_

If so, how much (cigarettes/day)? \_\_\_\_\_ How long? \_\_\_\_\_ Quit date? \_\_\_\_\_

Alcohol Use: How many drinks/wk? \_\_\_\_\_

Caffeine Use: Type and how many drinks/wk? \_\_\_\_\_

Recreational Drug Use (type and frequency): \_\_\_\_\_

Exercise (type and minutes/week): \_\_\_\_\_

**List any other providers/medical specialists you see:**

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**Screening/Immunizations:** Please list approximate date completed.**Vaccinations:**

Colon Cancer Screening \_\_\_\_\_ Tetanus (Tdap/Td) \_\_\_\_\_

Mammogram/Breast Cancer Screening \_\_\_\_\_ Pneumococcal \_\_\_\_\_

Bone Density/Osteoporosis Screening \_\_\_\_\_ Shingles \_\_\_\_\_

Pap Smear/Cervical Cancer Screening \_\_\_\_\_ Other \_\_\_\_\_

**Women's Health History (if applicable):**

First Day of Last Menstrual Period \_\_\_\_\_ Age of First Menstrual Period \_\_\_\_\_

Total # of Pregnancies \_\_\_\_\_ Total # of Live Births \_\_\_\_\_ Age of Menopause \_\_\_\_\_

**Anything else you would like us to know?:**

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Email Address \_\_\_\_\_ Purpose of Release (e.g. Patient request) \_\_\_\_\_

I hereby authorize and direct the health care provider named below to release my health records to:

**Pacific Coast Care  
10861 Cherry St, Suite 105  
Los Alamitos, CA 90720  
Phone (562) 259-8881 / Fax (562) 259-8887**

Name of Physician/Health Care Provider/Other \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

This request and authorization applies to:

All Healthcare Information  
 Healthcare information rendered to me during the period: From \_\_\_\_\_ to \_\_\_\_\_  
 Other: \_\_\_\_\_

I expressly authorize and consent to the disclosure of my health information related to (check all that apply):

Alcohol/Substance Abuse  Mental Health  STIs (including HIV/AIDS)  Genetic Testing/Counseling  
 Communicable Diseases  Reproductive Health

\_\_\_\_\_  
Patient or Authorized Representative Signature (for specific disclosures)

\_\_\_\_\_  
Date

### **CONFIDENTIALITY POLICY (PLEASE READ BEFORE SIGNING)**

Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. All patient care information shall be regarded as confidential and available only to authorized users. Medical records include any protected health information (PHI).

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. This authorization shall expire one year from the date signed. I understand this authorization is voluntary and I may refuse to sign it. My health care treatment will not be affected if I refuse to sign. I have a right to receive a copy of this authorization.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

\_\_\_\_\_  
Patient or Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Authorized Representative Name