VISTA MEDICAL GROUP
"We Care For You"

☐ **CORONA** 2071 Compton Avenue, Suite 102 Corona, CA 92881 **(951) 549-0900 Fax (951) 278-8552**
☐ **CHINO** 12488 Central Avenue, Suite B Chino, CA 91710 **(909) 613-0100 Fax (909) 613-0600**

PATIENT REGISTRATION FORM

Date: / / NEW PATIENT ☐ CHANGE ☐

Patients: *Please fill out completely and return to the receptionist desk. Thank You!*

I. PATIENT INFORMATION

Patient Name (Last, First) Sex: ☐ Male ☐ Female DOB: / /

Address City State Zip

Home Phone #: ( ) Cell Phone #: ( )

Driver's Lic **#**: SS #: -- --

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated Ethnicity/Race: Language:

Email: Referred by:

Patient's Employer: Work Phone #: ( )

Employer's Address: City State Zip

Emergency Contact Name: Emergency Contact #: ( )

II. RESPONSIBLE PARTY INFORMATION ☐ Self ☐Parent ☐ Spouse ☐ Other

Name: DOB: / / Phone #: ( )

Employer: Work Phone #: ( )

Employer's Address: City State Zip

Relationship to Patient: Drivers Lic #: SS # -- --

III. HEALTH INSURANCE INFORMATION

Primary Insurance Co.: Phone #: ( )

Name of Insured: DOB: / / SS #: -- --

Group #: Policy #: Co-Pay Amount $: Relationship to Patient:

Secondary Insurance Co: Phone #: ( )

Name of Insured: DOB: / / SS #: -- --

Group #: Policy #: Co-Pay Amount $: Relationship to Patient:

IV. PHARMACY INFORMATION

Name of Pharmacy: Phone #: ( ) Fax #: ( )

Pharmacy Address: City State Zip

V. REASON FOR VISIT

Is this visit due to?: ☐ Vehicle Accident ☐ Work Injury ☐ Other

Description of Accident or Injury:

How will your service be paid today? ☐ Cash ☐ Check ☐ Credit Card ☐ Bill Insurance

How would you like us to communicate with you and/or send your appointment reminder?
☐ Voice Message ☐ Text message ☐ Email ☐ Postal Mail

CONSENT: I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I hereby authorize the physician to release any information acquired in the course of my examination or treatment.
Initial: _____

GUARANTEE: I, (the patient or guardian) am an eligible member as of this date of service of a health plan and a copy of the benefits card is attached to this document. Signature of responsible party below acknowledges full financial responsibility for services rendered to me if it is determined I am I am "Not Eligible" on the date of service in question, or if service rendered is determined to be a non-covered benefit under the plan provisions.
Initial: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby irrevocably authorize payment directly to the above named corporation/physician, benefits otherwise payable to me but not to exceed the corporation's/physician's regular charge due as a result of this claim. I understand I am financially responsible to the corporation/physician for charges not covered.
Initial: _____

Signature: _____ **Date:** ____/____/_____ **Relationship to Patient:** _____

Staff Initial:

HEALTH QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____/_____/_____

ADDRESS: _____ PHONE: _(____)_____

REASON FOR THIS VISIT: ☐ ROUTINE ☐ WORK INJURY ☐ ILLNESS ☐ OTHER _____

HISTORY OF PAST ILLNESS:

Have you had childhood:

Measles	No	Yes	Rheumatic fever or heart disease	No	Yes
Mumps	No	Yes	Tuberculosis	No	Yes
Chickenpox	No	Yes	Venereal disease	No	Yes
Diabetes	No	Yes	Congenital Abnormalities	No	Yes
Strokes	No	Yes	Other serious diseases	No	Yes
Cancer	No	Yes	_____	No	Yes

Adult

Have you had any serious illness? No Yes

Have you ever been hospitalized or been under medical care for very long? No Yes

If "Yes", for what reason? _____

Operations

Have you had any surgery? Please list below No Yes

_____ _____

_____ _____

Injuries

Have you had any broken bones? No Yes

Have you had any head concussions or injuries? No Yes

Have you ever been knocked unconscious? No Yes

FAMILY HISTORY	IF LIVING Age	Health	IF DECEASED Age (at death)	Cause	HAS ANY BLOOD RELATIVES EVER HAD		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother / Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High Blood Pressure	No	Yes
Husband / Wife					Stroke	No	Yes
Son / Daughter					Convulsions	No	Yes
					Suicide	No	Yes
					Insanity	No	Yes
					Bleeding Tendency	No	Yes
					Gout or other Arthritis	No	Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed

Are you living with your spouse? No Yes

Is your sex life satisfactory? No Yes

Do you have more than one sexual partner? No Yes

Do you have dependants at home? No Yes

Alcoholic Beverages: Never: ___ Rarely: __ Moderate: __ Daily: __ Ever? _____

Tobacco/Cigarettes: Packs a Day: ___ Don't Smoke: __ Ever Smoke? _____

Use of Recreational Drugs: Never: __ Rarely: __ Moderate: __ Daily: __ Ever? _____

Are you employed? Full Time: __ Part Time: __

What is your job? _____

Are you exposed to fumes, dusts or solvents? _____

How much time have you lost from work because of your health during the past:

Six Months: _____

One Year: _____

Five Years: _____

SYSTEMIC REVIEW: Do you have any of the following:

General:			Head-Eyes-Ears-etc. (cont'd):		
Recent weight change	No	Yes	Sneezing/runny nose	No	Yes
Have you been in good health most of your life	No	Yes	Nosebleeds	No	Yes
Skin:			Chronic sinus trouble	No	Yes
Skin Disease	No	Yes	Ear disease	No	Yes
Jaundice	No	Yes	Impaired hearing	No	Yes
Hives, eczema or rash	No	Yes	Dizziness or episodes of unconsciousness	No	Yes
Frequent infection or boils	No	Yes	Neck:		
Abnormal pigmentation	No	Yes	Stiffness	No	Yes
Head-Eyes-Ears-Nose-Throat			Thyroid trouble	No	Yes
Eye disease or injury	No	Yes	Enlarged glands	No	Yes
Do you wear glasses	No	Yes	Respiratory:		
Double vision	No	Yes	URI (Cold) now	No	Yes
Headaches	No	Yes	Spitting up blood	No	Yes
Glaucoma	No	Yes	Chronic or frequent cough	No	Yes
Itching eyes or nose	No	Yes			

SYSTEMIC REVIEW: (continued)

Respiratory: (continued) :

Asthma	No	Yes
Difficulty breathing	No	Yes
Any trouble with lungs	No	Yes
Pleurisy or Pneumonia	No	Yes

Cardio vascular:

Chest pain or angina pectoris	No	Yes
Shortness of breath walking or lying down	No	Yes
Difficulty walking two blocks	No	Yes
Heart trouble or heart attacks	No	Yes
High blood pressure	No	Yes
Swelling of hands, feet or ankles	No	Yes
Awakening in the night smothering	No	Yes
Heart murmur	No	Yes

Gastrointestinal:

Peptic ulcer (stomach or duodenal)	No	Yes
Vomiting blood or food	No	Yes
Gallbladder disease	No	Yes
Liver trouble	No	Yes
Hepatitis	No	Yes
Painful bowel movements	No	Yes
Bleeding with bowel movements	No	Yes
Black stools	No	Yes
Hemorrhoids or piles	No	Yes
Recent change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Heartburn or indigestion	No	Yes
Does food stick in throat	No	Yes

Genitourinary:

Loss of urine	No	Yes
Frequent urination	No	Yes
Night time urinating	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Kidney trouble	No	Yes
Kidney stones	No	Yes
Brights disease	No	Yes

Gynecological: No Yes

Age periods started _____

How long do periods last _____ Days

Gynecological (continued):

Number of pregnancies _____

Nosebleeds _____

Date of last cancer smear & results _____

_____

Frequency of periods _____ Days

Any pain with periods No Yes

Date of first day of last period _____

Number of children & ages _____

_____

Locomotor-Musculoskeletal :

Varicose veins	No	Yes
Muscle or joint weakness	No	Yes
Difficulty walking	No	Yes
Pain in calves or buttocks while walking (relieved by rest)	No	Yes

Neuro-Psychiatric

Have you had psychiatric care	No	Yes
Been advised to see a psychiatrist	No	Yes
Have or had fainting spells	No	Yes
Convulsions	No	Yes
Paralysis	No	Yes

Hematological

Are you slow to heal after cuts	No	Yes
Blood disease	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery	No	Yes

Allergic:

Any allergies including medication	No	Yes
Endocrine	No	Yes
Thyroid disease	No	Yes
Hormone therapy	No	Yes
Any change in hat or glove size	No	Yes
Any change in hair growth	No	Yes
Have you become colder than before or skin become dryer	No	Yes

HEIGHT _____

WEIGHT _____

ALLERGIES & SENSITIVITIES

1. Date of last tetanus: _____

2. Is there a history of skin reaction or other reaction/sickness following injection or oral administration of:

Circle One				**Please list your present medications**
Penicillin or other antibiotics	No	Yes	Don't Know	
Morphine, Codeine, Demerol, other narcotics	No	Yes	Don't Know	
Novocain or other anesthetics	No	Yes	Don't Know	
Aspirin, empirin or other pain remedies	No	Yes	Don't Know	
Sulfa drugs	No	Yes	Don't Know	
Tetanus antitoxin or other serums	No	Yes	Don't Know	
Adhesive tape	No	Yes	Don't Know	
Iodine or merthiolate	No	Yes	Don't Know	
Any foods, such as egg, milk or chocolate	No	Yes	Don't Know	

3. Drugs taken within the past six months:

Aspirin	No	Yes	Don't Know	
Cortisone	No	Yes	Don't Know	
ACTH	No	Yes	Don't Know	
Anticoagulants	No	Yes	Don't Know	
Tranquilizers	No	Yes	Don't Know	
Hypotensives	No	Yes	Don't Know	

4. Has the patient received treatment for:

Asthma, rheumatism or rheumatic fever	No	Yes	Don't Know	

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

_____/_____/_____

Doctor Date Signature of patient

CONSENT FOR PURPOSES OF TREATMENT,
PAYMENT & HEALTHCARE OPERATIONS

Patient's Name _____
(Please Print)
VISTA Medical Group Provider _____

In connection with the medical services that I am receiving from the above-named physician or physician group, I hereby authorize the above-named physician and/or group to disclose any/or all Protected Health Information (PHI) concerning my medical condition and treatment, including copies of applicable hospital and medical records tl:

A. Any third party payor covering the medical services of the patient
B. Other health care professionals and institutions involved in the delivery of health care to the patient
C. The proponent of any legally sufficient subpoena, or in response to a court order
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services
E. Pharmacies
F. Other parties as otherwise required by law

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

Special Restrictions:

_____
_____
_____
_____

This consent is valid from the date executed for Six (6) years or until revoked in writing by the patient.

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Witness Date

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ACKNOWLEDGEMENT / *RECONOCIMIENTO*

_____ _____/_____/_____
Patient's Name / *Nombre del Paciente* **Date of Birth** / *Fecha de Nacimiento*

_____ (_____)_____-_____
Address / *Dirección* **Phone** / *Teléfono*

_____ _____
City/State/Zip – *Ciudad/Estado/Código Postal* **Email** / *Correo Electronico*

_____ (_____)_____-_____
Physician / *Medico* **Phone** / *Teléfono*

_____ _____
Address / *Dirección* **Email** / *Correo Electronico*

_____
City/State/Zip – *Ciudad/Estado/Código Postal*

Advanced Directives / *Los Directivos Avanzados*

This acknowledges that the physician, or one of his/her staff members, has provided me information concerning Advanced Directives. / *Este document es un reconocimiento que el medico o los miembros de su oficina me han dado información sobre los directives avanzados.*

1) **I am age 18 years or older.** ☐ Yes ☐ No / *Tengo 18 aňos o mas.* ☐ *Si* ☐ *No*

2) **I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives**. / *Entiendo que tengo la opción de formar mis propios directives avanzados sobre mi tratamiento medico. Mi medico me ha dado información sobre estos directives avanzados. Entiendo que es mi responsabilidad de presenter a mi medico, cualquier document necesario para llevar a cabo mis directives avanzados.*

3) **I am aware that Advanced Directives may be any one of the following:**
Entiendo que un directive avanzado puede ser cualquirra de los documentos que siguen:
   a. **A Durable Power of Attorney for Health Care. / *Poder Notarial Duradero Para la atención de la Salud.***
   b. **The Declaration in the A Natural Death Act – Ex. A Living Will. / *La Declaración en la Ley de la Murete natural, por ejemplo, Testamento en Vida.***
   c. **I may write down my wishes on a piece of paper so that my family may use the document in deciding my medical treatment in the event I am unable to do so.** / *Puedo escriber mis deseos en un papel para que mi familia use este document en tomar decisions necesarias sobre mi tratamiento medico,en el evento que no puedo hacerlo yo mismo.*

This document will become part of my medical record. / *Este document se pone un parte del exediente medico.*
Patient's Signature/*Firma del Paciente:*_____
Date/*Fecha*:_____/_____/_____