United Care Family Medical Center

PATIENT REGISTRATION FORM

PR#_____

PATIENT INFORMATION

DATE_____

Name:_____
Last First Middle

Address:_____
Number Street City State Zip

Home Telephone:(____)_____ Cell:(____)_____Social security_____

Date of Birth:_____ Age_____ Sex_____ Drivers Lic.#_____E-mail_____

Place of Birth_____ Race: ☐White ☐ African American ☐ Hispanic ☐Asian ☐Other_____

Preferred Language: ☐ English ☐ Spanish ☐ Hebrew ☐ Farsi ☐ Other_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Spouse Name:_____ Phone#(____)_____

Patient's Employer :_____Occupation_____

Address_____ Tel: (____)_____

INSURACE INFORMATION

Do you have insurance? ☐ Yes ☐ No Name of insurance_____ ID #: _____

Medi-cal? ☐ Yes ☐ No Plan name _____ ID#_____

Responsible Party (person responsible for payment) _____ Date of Birth_____

Address: _____Tel#: (___)_____ Relationship _____

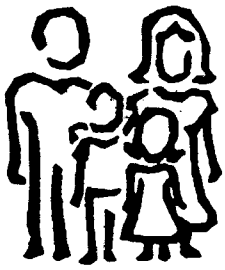
EMERGENCY CONTACT

Name:_____ Tel# (____)_____

Address:_____ Relationship to patient:_____

I hereby authorize my insurance company to pay United Care Family Medical Center directly for all customary charges, I also authorize United Care Family Medical Center to release any information requested by my insurance company or other agency, responsible for my health care bills that may be needed to properly process my claims. I understand that I am personally responsible for any co-pays, deductibles, co-insurances and/or any non-covered services. I further understand that if I do not have medical insurance I will be responsible for the entire balance, and payment is expected at the time services are rendered. I have read, understand and agree with the above statement.

Patient's / Responsible party's Signature:_____



UNITED CARE FAMILY MEDICAL CENTER

ADVANCE DIRECTIVE

Reference: Patient Self Determination Act (OBRA 1990)

An Advance Directive is that written instruction which relates to the provision of health care when the individual is incapacitated, such as a Durable Power of Attorney for Health Care, a Declaration pursuant to the Natural Death Act, or a Living Will.

Please check the box that applies to you:

- ☐ Yes I have a signed Advance Directive and will provide a copy for my records.
- ☐ A copy of my signed Advance Directive is on file with _____
- ☐ I DO NOT have a signed Advance Directive
- ☐ I do not currently have a signed Advance Directive but I am interested in learning more about it and discussing it with my physician and family.

Patient's Signature: _____ **Date:** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I _____ (please print name of patient or personal representative), acknowledge that **United Care Family Medical Center** has provided a written copy of its **Notice of Privacy Practices for Protected Health Information** to ☐ Myself or ☐ Other (specify): _____

_____ _____

Signature of Patient or Personal Representative

Date

*** If signing as a personal representative, documentation of your legal right to do so must be provided)**

1 **We have provided the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but were not successful in obtaining their signature on this acknowledgement because:**

2 **Patient refused to sign**

2 **Patient unable to sign**

Explain: _____

1 **We have made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:**

1 **Patient refused to accept a copy**

2 **Other (Explain)** _____

UNITED CARE FAMILY MEDICAL CENTER

REQUEST/REFUSAL FORM FOR INTERPRETIVE SERVICES

Patient Name: _____

Primary Language: _____

☐ Yes, I am requesting interpretive services

Language(s):_____

☐ I prefer to use my family member or friend as an interpreter, although the clinic staff informed me that interpreter services are available at no cost to me.

☐ No, I do not require interpretive services.

☐ N/A

Comments: _____

_____

_____

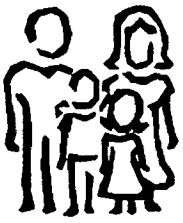
_____

_____ _____

Patient Signature Date

***TO BE KEPT IN PATIENT'S MEDICAL RECORD.**

Original Date: ____/____/____
Dates Revised: ____/____/____
____/____/____
____/____/____



United Care Family Medical Center

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)* ☐ M ☐ F **DOB** ____/____/____

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

Previous or Referring Doctor: **Date of Last Physical Exam:** ___

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates:
☐ Tetanus _____ ☐ Pneumonia _____
☐ Hepatitis _____ ☐ Chickenpox _____
☐ Influenza _____ ☐ MMR _____
Measles, Mumps, Rubella

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? ... ☐ Yes ☐ No

Please turn to next page

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____/_____/_____

Period every _____ days. Heavy periods, irregularity, spotting, pain or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy or cesarean?	☐ Yes	☐ No
Any urinary tract, bladder or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps or nipple discharge?	☐ Yes	☐ No

Date of last pap and rectal exam? _____/_____/_____

MEN ONLY

Do you usually get up to urinate during the night? ☐ Yes ☐ No If yes, # of times _____

Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No

Date of last prostate and rectal exam? _____/_____/_____

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin _____	☐ Back _____	☐ Energy Level _____
☐ Head/Neck _____	☐ Intestinal _____	☐ Ability to Sleep _____
☐ Ears _____	☐ Bladder _____	**Other Pain/Discomfort:**
☐ Nose _____	☐ Bowel _____	_____
☐ Throat _____	☐ Circulation _____	_____
☐ Lungs _____	**Recent Changes In:**	_____
☐ Chest/Heart _____	☐ Weight _____	_____

NAME: DOB:

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Sex:

Are you sexually active? ..... ☐ Yes ☐ No
If yes, are you trying for a pregnancy? ..... ☐ Yes ☐ No
If not trying for a pregnancy list contraceptive or barrier method used? _____
Any discomfort with intercourse? ..... ☐ Yes ☐ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ..... ☐ Yes ☐ No

Personal Safety:

Do you live alone? ..... ☐ Yes ☐ No
Do you have frequent falls? ..... ☐ Yes ☐ No
Do you have vision or hearing loss? ..... ☐ Yes ☐ No
Do you have an Advance Directive and/or Living Will? ..... ☐ Yes ☐ No
Would you like information on the preparation of these? ..... ☐ Yes ☐ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ..... ☐ Yes ☐ No

FAMILY HEALTH HISTORY

		Age	Age at Death	Significant Health Problems or Cause of Death
Father				
Mother				
Brothers and Sisters	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

		Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
Grandparents (Mother's Side)				
Male				
Female				
Grandparents (Father's Side)				
Male				
Female				

Please turn to next page

Name: _____ DOB: _____

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken

Allergies to Medications:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:
Are you dieting? ☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No
# of meals you eat in an average day?_____
Rank Salt Intake ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low

Caffeine:
☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:
Do you drink alcohol? ☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____
Are you concerned about the amount you drink? ☐ Yes ☐ No
Have you considered stopping? ☐ Yes ☐ No
Have you ever experienced blackouts? ☐ Yes ☐ No
Are you prone to "binge" drinking? ☐ Yes ☐ No
Do you drive after drinking? ☐ Yes ☐ No

Tobacco:
Do you use tobacco? ☐ Yes ☐ No
☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____
☐ Cigars - #/day _____ ☐ # of Years _____ ☐ or Year Quit _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs:
Do you currently use recreational or street drugs? ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Name: DOB:

Please turn to next page

United Care Family Medical Center

2324 W. Pico Blvd

Los Angeles CA, 90006

Tel:(213)-383-3600

Fax: (213)383-5300

Acknowledgement / Reconocimiento

Effective January 01, 2014 all of our patients need to provide a copy of his/her immunization record, as mandated in our clinic's procedures and policies regarding medical records. An immunization and record history sheet will be maintained in your chart.

Name: _____ DOB:_____

○ Yes, I will provide a copy of my Immunization record as soon as possible.

○ No, I'm unable to provide a copy of my Immunization record and would like to be exempt, with This exemption I accept complete responsibility of my health including any case of emergencies.

Empezando Enero 01,2014 a todos nuestros pacientes se les pedira una copia de su cartilla de vacunas, como requisito mandatorio de procedimientos y polizas de la clinica; que se necesita incorporar en su expediente medico. Un historial de vacunaciones se mantendra en su expediente.

Nombre:_____ Fecha de Nacimiento :_____

○ Si, lo mas pronto posible voy a proveer una copia de mi cartilla de vacunas.

○ No podre proveer una copia de mi cartilla de vacunas y me gustaria tener una exepcion. Con esta excepcion yo accepto completa resposabilidad hacia mi salud, incluyendo cualquier caso de emergencia.

United Care Family Medical Center

1835 S La Cienega Blvd #205 Los Angeles, CA 90035
(310)-836-2273

Are you interested in participating in our new online patient portal?
Patient Portal is a new online system, which allows patients an easy, safe, and secure way to access their medical records. With patient portal you can create an online account to access the following:

- Diagnoses
- Medications
- Lab results
- Immunization records

Yes, I would like to participate.

No, I would not like to participate.

Please provide us with an email address if you would like to participate in patient portal.

_____
Email address

I understand I have the ability to view online, download, and transmit my health information within 4 business days of the information being available to my provider.

I have been given information to view, download, or transmit their information including how to access my health information, website and information to access my health information on the patient portal.

I understand that if I "opt out" of participation I may, at any time during business hours, optback-in by calling the clinic at the number above I will be given information to access to view, download, or transmit their information.

_____ _____ _____
Patient Name Patient Signature Date of Service