SAN CLEMENTE MEDI-CENTER

910 S. EL CAMINO REAL ▪ SAN CLEMENTE, CA 92672
Tel (949) 492-4994 ▪ Fax (949) 492-4995

Thank you for choosing San Clemente Medi-Center. In order to serve you properly, the following information is needed. All information will remain confidential. ***Please fill out all sections that apply to you.*** ****Starred fields must be completed.***

Registration Form - Patient Information

***Name:** _____
First **Middle** **Last**

***Sex**: Male / Female ***Date of Birth:** _____/_____/____ ***Marital Status: M S D W DP**

Social Security Number: _____ **(optional in most cases)**

US Federal Government Requirement

***Ethnicity:** Hispanic / Non-Hispanic / Decline ***Race:** _____ ***Preferred Language:** _____

Whom may we thank for referring you _____

Contact Information

***Home Address:**_____
Street address **City** **State** **Zip**

***Mailing Address (if different):**_____
Street address **City** **State** **Zip**

Work Address: _____
Street address **City** **State** **Zip**

***Phone: Main#:** _____**Cell#:** _____**Work#:** _____

***Email Address:**_____

****Emergency Contact(s)***

(1) Name: _____ **Relationship:** _____ **Phone #:** _____

(2) Name: _____ **Relationship:** _____ **Phone #:** _____

Insurance

***Do you have any Medical Insurance?** Yes / No ***If Yes, is it an HMO Plan?** Yes / No _____

Insurance Company: _____**Name of Primary Care Physician** _____

Please carefully read and sign important office policy forms and financial agreement on the following pages.

***I have read and signed the Arbitration Agreement Form, HIPAA Compliance Form and Financial Agreement Form (included in packet):**

I would also like to be offered an Integrative/Complementary Medicine approach whenever possible to possibly shorten or eliminate need for more medications. I will request more information from the physician if needed. I know that this is an added alternate healing option available to me.

I would like to decline any other form of therapy other than the Traditional / Allopathic Medicine.

X_____ _____/_____/2016
***Signature of Patient or Parent/Guardian if Minor** ***Date**

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DETAILED MEDICAL HISTORY AND PHYSICAL

NAME: _____ **DATE** _____ /_____ /2016
First *Middle* *Last*

AGE: ____ **SEX:** M / F **Height:** ___' ___" **Weight**: _____ **lbs** **OCCUPATION:** _____ **MARITAL:** S/M/D/W/SEP/DP

Concern(s) (Please rank by priority) Example: Headaches	**Onset** Month, Date, or Time	**Frequency** 4 Times/Week	**Severity** Mild/Moderate/Severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

What are your goals for this visit? _____

Are you Allergic to any Medications? Yes / No (Circle) **to food or environments? Yes / No** (Circle)

Medication	Reaction / Intolerance	Food or Environment	Reaction / Intolerance
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____

Please list all the Medications, Vitamins, Supplements, etc. (Prescription and Over the counter) **that you have been taking currently:**

Medication Name	Strength / mg	Frequency/day	Reason taking	Duration

PAST MEDICAL HISTORY

NAME: _____

First *Middle* *Last*

Please **checkmark** and add any other condition(s) that you have been diagnosed with and/or treated for.

CARDIOVASCULAR	GASTROINTESTINAL	ENDOCRINE	MUSCULOSKELETAL
☐ Angina/Chest Pain	☐ Colon Cancer	☐ Addison's Disease	☐ Back Problems/ Back Injury
☐ Angioplasty & Stent Placement	☐ Crohn's Disease	☐ Cushing's Disease	☐ Carpal Tunnel Syndrome
☐ Arrhythmias/ Dysrhythmias	☐ Diverticulitis/Diverticulosis	☐ Diabetes Mellitus- Adult Onset	☐ Degenerative Disk Disease
☐ Arterial Thrombosis	☐ Gall Stones	☐ Diabetes Mellitus- Juvenile	☐ Degenerative Joint Disease
☐ Atrial Fibrillation	☐ Gastrointestinal Bleed	☐ Epilepsy/ Seizures,	☐ Fibromyalgia
☐ Cardiac Catheterization	☐ GERD/Gastro esophageal Reflux	☐ Hyperaldosteronism	☐ Foot Problems
☐ Cardiomyopathy	☐ H. Pylori Infection	☐ Hyperthyroidism	☐ Fractures
☐ Congestive Heart Failure	☐ Hemorrhoids	☐ Hypothyroidism	☐ Gout
☐ Deep Venous Thrombosis	☐ Hepatitis- A B C	☐ Metabolic Syndrome	☐ Muscle Disease
☐ Heart Attack	☐ Hiatal Hernia	☐ Thyroid Cancer	☐ Osteoarthritis
☐ Heart Murmur	☐ Irritable Bowel Syndrome	☐ Thyroid Disorder	☐ Osteoporosis/Osteopenia
☐ High Cholesterol	☐ Jaundice	☐	☐ Polymyalgia Rheumatica
☐ High Triglycerides	☐ Liver Disease	**NEUROLOGIC**	☐ Rheumatoid Arthritis
☐ Low HDL	☐ Other GI Cancer	☐ Alzheimer's Dementia	☐ Sciatica
☐ Hypertension / High BP	☐ Pancreatitis	☐ Chorea	☐ Sjogren's Disease
☐ Mitral valve prolapse	☐ Peptic Ulcer Disease	☐ Headaches	☐ Systemic Lupus Disorder
☐ Peripheral Vascular Disease	☐ Rectal Fistula	☐ Mental Retardation	☐
☐	☐ Ulcerative Colitis	☐ Migraine	☐
☐	☐	☐ Multiple Sclerosis	**OTHER**
RESPIRATORY	**GENITOURINARY**	☐ Neuropathy	☐ Attempt to quit addiction
☐ Allergic Sinusitis/Rhinitis	☐ Atrophic Vaginitis	☐ Parkinson's Disease	☐ Blood Disease
☐ Asthma	☐ Benign Prostatic Hypertrophy	☐ Pituitary Disorder	☐ Blood Transfusion
☐ Bronchiectasis	☐ Chronic Renal Failure	☐ Senile /Other Dementia	☐ Cataracts
☐ Bronchitis - Recurrent	☐ Endometriosis	☐ Stroke/Paralysis/TIA	☐ Counseling to quit addiction
☐ COPD / Chronic Bronchitis	☐ Hematuria	☐ Tremors	☐ Dengue Fever
☐ Emphysema	☐ Hemodialysis	**PSYCHIATRIC**	☐ Exposure to HIV/Hepatitis
☐ Hay Fever	☐ Menstrual Disorders	☐ ADHD/ADD	☐ Glaucoma
☐ Lung Cancer	☐ Ovarian Cancer	☐ Alcoholism-current / past	☐ HIV Related Diseases
☐ Pneumonia	☐ Pelvic Inflammatory Disease	☐ Anorexia/ Bulimia	☐ Leukemia
☐ Pneumothorax	☐ Prostate Cancer	☐ Anxiety	☐ Malaria
☐ Positive PPD	☐ Prostatitis	☐ Bipolar Depression	☐ Multiple Myeloma
☐ Pulmonary Embolism	☐ Pyelonephritis	☐ Depression	☐ Obesity
☐ Pulmonary Fibrosis	☐ Renal Stones	☐ Drug Addiction - current / past	☐ Other Skin Disorders
☐ Silicosis/Asbestosis	☐ Uterine Fibroid	☐ Drug Overdose	☐ Other Tumors
☐ Sleep Apnea	☐ Venereal Disease/STD	☐ Other Mental Illness	☐ Retinal Detachment
☐ Tuberculosis	☐ Recurrent Urinary Tract Infections	☐ Psychosis/ Neurosis	☐ Tropical Disease
☐	☐	☐ Rehab for _____	☐ Work related injury
	☐	☐ Suicide Attempt	☐ Multiple Myeloma

PAST SURGICAL HISTORY

Please **checkmark** and add any other **condition(s)** that you have been treated for and the year of treatment.

Operation/ Trauma/ Procedure	Year	Operation/ Trauma/ Procedure	Year
☐ Appendectomy		☐ Ovarian Cyst Removal	
☐ Back surgery – neck / low back		☐ Pacemaker/Defibrillator Placement	
☐ Breast Surgery		☐ Prostatectomy	
☐ Cholecystectomy		☐ Tonsillectomy & Adenoidectomy	
☐ Coronary Artery Bypass Graft		☐ Transurethral Resection Of Prostate	
☐ Cosmetic Surgery		☐ Vasectomy	
☐ Dilation And Curettage		**Fractures: List Site**	
☐ Gastric Stapling		☐	
☐ Hernia Repair		☐	
☐ Hysterectomy Total/Partial		☐	
☐ Open Reduction & Internal Fixation		☐	

PERSONAL HISTORY

NAME: _____

First *Middle* *Last*

Please describe your current or past history of tobacco, alcohol, substance and caffeine abuse.

			Amount	How Long?	Date Last Used?			
Substances	**Yes**	**Never**	Per day / week	Month/ years		**Have you Quit?**		
Smoking	☐	☐				**Yes**	**No**	**Year**
-Passive/ Second-hand	☐	☐				☐	☐	
-Cigarettes: *Packs/day*	☐	☐				☐	☐	
-Cigars	☐	☐				☐	☐	
-E-Cigarette	☐	☐				☐	☐	
Tobacco Chewing	☐	☐				☐	☐	
Nicotine Use	☐	☐				☐	☐	
Caffeinated Beverages	☐	☐				☐	☐	
Drinking	☐	☐				☐	☐	
-Beer	☐	☐				☐	☐	
-Wine	☐	☐				☐	☐	
-Hard Liquors	☐	☐				☐	☐	
Illicit Drugs – specify:	☐	☐				☐	☐	
-Marijuana	☐	☐				☐	☐	
-Cocaine	☐	☐				☐	☐	
-Meth/Amphetamine	☐	☐				☐	☐	
-PCP	☐	☐				☐	☐	
-Opiates	☐	☐				☐	☐	
-IV	☐	☐				☐	☐	

EDUCATION: No High School / High School / Undergraduate / Graduate / _____

OCCUPATION: _____ **HOBBIES**: _____

FAMILY HISTORY

Please Circle if any of your family members have had any of the following or other medical conditions:

AIDS/HIV Infection	Bleeding/Clotting Disorders	Diabetes	High Blood Pressure	Lung Disease	Seizures
Allergies	Cancer	Dementia	Hyperlipidemia	Mental Disorder	Stroke
Alcoholism	Collagen Vascular Disorder	Heart Attack	Kidney Disease	Neurology Disorder	Thyroid Disease
Asthma	COPD	Hepatitis B / C	Liver Disease	Rheumatoid Arthritis	Tuberculosis
Other:					

Please write the age of your living relatives. If no longer alive, please write the cause of death and age when died.

Relation	Age (if living)	Medical Condition	Deceased	Cause of Death & Age	Comments
Father					
Mother					
Brother 1					
Brother 2					
Sister 1					
Sister 2					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Paternal Uncle					
Paternal Aunt					
Maternal Uncle					
Maternal Aunt					
Spouse					
Son 1					
Son 2					
Daughter 1					
Daughter 2					

NAME: _____
First *Middle* *Last*

Have you been in good general health most of your life? **Yes** / **No** *(please circle)*
Do you have any of the following?
Please check the appropriate boxes if the response is yes; specify details if appropriate.

GENERAL	Current	Past	Never	Comments
1. Fatigue	☐	☐	☐	
2. Weight loss___/gain__	☐	☐	☐	
3. Fever? up to _____°F	☐	☐	☐	
4. Chills	☐	☐	☐	
5. Night Sweats	☐	☐	☐	
EENT				
1. Refractory error	☐	☐	☐	
2. Loss/Blurred Vision	☐	☐	☐	
3. Ear Disease	☐	☐	☐	
4. Hearing loss	☐	☐	☐	
5. Use hearing aid	☐	☐	☐	
6. Nasal Polyps	☐	☐	☐	
7. Nose Bleeds	☐	☐	☐	
8. Rhinitis/postnasal drip	☐	☐	☐	
9. Sinusitis	☐	☐	☐	
10. Sore Throat	☐	☐	☐	
11. Hoarseness of voice	☐	☐	☐	
12. Tooth & gum trouble	☐	☐	☐	
CHEST				
1. Chest Pain	☐	☐	☐	
2. Angina	☐	☐	☐	
3. Pleurisy	☐	☐	☐	
4. Palpitations	☐	☐	☐	
5. Swelling of ankles/feet	☐	☐	☐	
6. Difficulty Breathing	☐	☐	☐	
-with exertion/ at night	☐	☐	☐	
7. Cough	☐	☐	☐	
8. Sputum production	☐	☐	☐	
Sputum Color	☐	☐	☐	
9. Blood in sputum	☐	☐	☐	
10. Wheezing	☐	☐	☐	
11. Excessive Snoring	☐	☐	☐	
12. Stop Breathing	☐	☐	☐	
during sleep	☐	☐	☐	
13. Daytime sleepiness	☐	☐	☐	
GASTROINTESTINAL				
1. Loss of appetite	☐	☐	☐	
2. Difficulty swallowing	☐	☐	☐	
3. Heart burn	☐	☐	☐	
4. Indigestion	☐	☐	☐	
5. Nausea	☐	☐	☐	
6. Vomiting	☐	☐	☐	
7. Diarrhea	☐	☐	☐	
8. Constipation	☐	☐	☐	
9. Dark Stool	☐	☐	☐	
10. Blood in Stool	☐	☐	☐	
11. Hemorrhoids	☐	☐	☐	
12. Abdominal pain	☐	☐	☐	
13. Hepatitis	☐	☐	☐	
14. Gall stones	☐	☐	☐	
15. Other	☐	☐	☐	

NEUROLOGY	Current	Past	Never	Comments
1. Headaches	☐	☐	☐	
2. Seizures --Type_____	☐	☐	☐	
3. Dizziness	☐	☐	☐	
4. Fainting episodes	☐	☐	☐	
5. Numbness/tingling	☐	☐	☐	
6. Paralysis	☐	☐	☐	
PSYCHIATRIC				
1. Anxiety/ Excessive worrying	☐	☐	☐	
2. Depression/ sadness	☐	☐	☐	
ENDOCRINE				
1. Excessive urination	☐	☐	☐	
2. Excessive thirst	☐	☐	☐	
3. Intolerance to cold or heat	☐	☐	☐	
4. Unusual Intolerance to heat/cold	☐	☐	☐	
HEMATOLOGY				
1. Anemia	☐	☐	☐	
2. Bruise easily	☐	☐	☐	
3. Prolonged bleeding	☐	☐	☐	
MUSCULOSKELETAL				
1. Stiff/painful joints	☐	☐	☐	
2. Swollen joints	☐	☐	☐	
3. Back aches	☐	☐	☐	
4. Gout	☐	☐	☐	
5. Other	☐	☐	☐	
GENITOURINARY				
1. Frequent Urination	☐	☐	☐	
2. Blood in urine	☐	☐	☐	
3. Urinary infection	☐	☐	☐	
4. Painful urination	☐	☐	☐	
5. Night time urination	☐	☐	☐	
6. Homo/Bisexuality	☐	☐	☐	
MALE (For Males Only)				
1. Venereal Disease: Type _____	☐	☐	☐	
2. Hernia	☐	☐	☐	
3. Testicular pain	☐	☐	☐	
or swelling	☐	☐	☐	
4. Impotence	☐	☐	☐	
FEMALE (For Females Only)				
1. Menopause	☐	☐	☐	
2. **Last menstrual cycle**				
3. Abnormal /absence of menses	☐	☐	☐	
4. Number of pregnancies	☐	☐	☐	
5. Number of live births	☐	☐	☐	
6. Number of Miscarriages/Abortions	☐	☐	☐	
7. Birth control pills	☐	☐	☐	
8. Breast Lump	☐	☐	☐	
9. Nipple Discharge	☐	☐	☐	
10. **Last Mammogram**	☐	☐	☐	
Findings: Normal/Abnormal				
11. **Last pap smear** Normal/Abnormal	☐	☐	☐	
12. Venereal disease: Type_____	☐	☐	☐	

Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counseling fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nor supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes with this arbitration, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services: **X** _____

PLEASE INITIAL **(**Patient's or Patient Representative's)

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature Date

By: **X** _____ _____
Patient or Representative's Signature **Date**

By: _____
Print Patient's Name

_____ _____
Print or Stamp Name of Physician, Medical Group or Association Name **(If Representative, Print Name and Relationship to Patient)**

A signed copy of this document will be given to the Patient. Original is to be filed in Patient's medical records.

SCMC HIPAA Compliance Form and Financial Agreement

In order to control the cost of billings, we request that your portion of charges incurred be paid at the time service is rendered, unless prior arrangements have been made.

Please remember that insurance is a method for reimbursing the patient for fees paid to the doctor and is not a substitute for payment; all professional services given are charged to, and are the responsibility of, the patient. As a courtesy to you, we file claims with pre-authorized insurance companies, and therefore it is your responsibility to provide us with insurance cards or other necessary information. It is also your responsibility to notify us of any changes in your insurance coverage and/or important contact information such as, but not limited to, your telephone number and address.

I hereby assign to and authorize payment of all benefits payable under the terms of my health insurance policy (policies) to my physician if payment in full is not made at the conclusion of my visit. I also understand that charges are assigned in full upon services rendered.

I also understand that I am financially responsible for all charges whether or not paid by health insurance policy (policies) within 30 days of receipt of bill. In the event that this account becomes delinquent, I will be responsible for any unpaid balances, collection fees, and/or reasonable attorney's fees associated with collection of any unpaid balances for services provided.

I have been informed that San Clemente Medi-Center will, only after prior financial arrangements have been made, carry any unpaid balance for up to three months. All unpaid balances beyond three months will be turned over to a collection agency and are no longer maintained in the SCMC business office.

I authorize the release of any medical information necessary to process all claims. If there is an individual to whom I specifically wish or do not wish to authorize release of my medical records, I will notify the physician in writing.

San Clemente Medi-Center values your trust and does its best to protect your confidentiality. In return, we request that you disclose all symptoms, conditions, and medical history fully and accurately to receive the best possible treatment.

May We: (Mandatory to fill out)	**Yes**	**No**	**Comments (If Any)**
Leave Confidential Messages be left on your telephone voicemail or answering machine?			
Mail correspondence from our office in a sealed envelope marked "CONFIDENTIAL"?			
Inform anyone other than Emergency Contact(s) about your medical condition, diagnosis, treatment or payment?			

Please list any other instructions:

_____

_____

_____

I hereby authorize and consent to examination and treatment at San Clemente Medi-Center:

X_____
Parent/Guardian Signature ***(if under age 18)***

X_____
Patient Signature

X_____

_____
Print Name

_____
Print Name

_____/_____/_____
Date