PATIENT INFORMATION (CONFIDENTIAL)

Name: _____ Date: _____

Physical Address:_____City:_____State:____Zip:_____-____

Mailing Address:_____City: _____ State:____ Zip:_____-____

E-Mail: _____ Cell Phone: _____ Home Phone: _____

SS#/Sin _____ Birth date: _____ Sex: MALE / FEMALE

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T./P.T., Name of school: _____ City: _____ State:____

Patient's/Parent's/Guardian's Employer:_____ Work #:_____

Business Address: _____City: _____State:___ Zip:_____

Spouse/Parent's/Guardian's Name: _____Employer: _____Work #: _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency: _____ Phone: _____

RESPONSIBLE PARTY

Name of person responsible for the account: _____Relation to patient: _____

Address: _____ Home Phone: _____

Driver's License #: _____ Birth Date: _____ SS#/SIN:_____

Employer: _____ Work Phone: _____

Is this person currently a patient in our office? ☐ YES ☐ NO

INSURANCE INFORMATION

Name of insured: _____ Relationship to Patient: _____

Birth Date: _____ SS#/SIN: _____ Date Employed: _____

Name of Employer: _____ City: _____ State: _____ Zip: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Co._____ ID#: _____ GRP#: _____ Tel#_____

Ins. Address: _____ City: _____ State: _____ Zip:_____

How much is your deductible? _____ How much have you used: _____ Max annual benefit? _____

Signature of Patient or Parent/Guardian If Minor: _____

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name: _____ Birth Date: _____ Date: _____

Chief Complaint: _____

History or Present Illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: Normal versus abnormal color, activity, etc.)

Severity: _____
(How sever is the pain/problem on a scale of 1-10)

Duration: _____
(How long have you had this pain/problem? Or when did it start?)

Timing:_____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms: _____
(What other associated problems have you been having?)

Modifying Factors: _____
(What makes the pain/problem worse or better? Or have you had previous episodes?)

Past Medical History:

Have you ever had the following: (Mark the boxes that apply, leave blank if uncertain)

- € Allergies
- € Arrhythmia
- € Asthma
- € Breast Cancer
- € Carotid Artery Stenosis
- € Cerebrovascular Accident
- € Cholelithiasis
- € Colon Cancer
- € Congestive Heart Failure
- € COPD
- € Coronary Artery Disease
- € Diabetes, Type 1
- € Diabetes, Type 2
- € Fracture(s)
- € GERD
- € Headaches, Migraine
- € Headaches, tension
- € Hyperlipidemia
- € Iron Deficiency Anemia
- € Lung Cancer
- € Myocardial Infarction
- € Obesity
- € Osteoarthritis
- € Osteoporosis
- € Peptic Ulcer Disease
- € Skin Cancer
- € Recurring Urinary Tract Infections
- € Chronic Pain
- € Fibromyalgia
- € Rheumatoid Arthritis
- € Dementia
- € Meningitis
- € Hemolytic Anemia
- € Chicken Pox
- € Eczema
- € Melanoma
- € Bronchitis
- € Pneumonia
- € Sleep Apnea
- € Hepatitis
- € Irritable Bowel Syndrome

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription)

Name of Medications:	Strength:	How Often Is Medication Taken:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies:_____

Have you ever taken Phen-Fen/Redux? ……. No Yes

Patient Social History:

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

Occupation: ☐ Disabled ☐ Unemployed ☐ Other: _____

Exercise: ☐ None ☐ Type: _____ ☐ Days a week:_____

Hobbies/What you enjoy: _____

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Previously, but quit: _____ ☐ Current Packs/day:_____

Coffee: ☐ Never ☐ Servings A day: _____ ☐ Servings Per Week: _____

Tea: ☐ Never ☐ Servings A Day: _____ ☐ Servings Per Week: _____

Soda: ☐ Never ☐ Servings A Day: _____ ☐ Servings Per Week: _____

Chocolate: ☐ Never ☐ Servings A Day: _____ ☐ Servings Per Week: _____

Supplements: ☐ No ☐ Yes: _____

Specialized Diets: ☐ No ☐ Yes: _____

Substance Abuse: ☐ Never ☐ Type/Frequency: _____

Mental Health History ☐ Never ☐ Diagnosed With: _____

Communicable Disease ☐ Never ☐ Diagnosed With: _____

Family Medical History:

	Age	Diseases	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings (Sister, Brother)	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Sonora Primary Care

Medication List

Patient Name: _____ D.O.B.: _____

Medication/Dosage:	Directions:	**ALLERGIES:**
		Supplements:
		Updates:

Review of Systems: Please indicate any personal history below:

Constitutional
- € Chills
- € Fatigue
- € Fever
- € Night Sweats
- € Unintentional Weight Gain
- € Unintentional Weight Loss

Eyes
- € Blurred Vision
- € Eye Drainage
- € Eye Pain
- € Glasses/contacts
- € Infection, abrasion

Ears/Nose/Throat
- € Ear Pain
- € Hearing Problems
- € Ringing in ears
- € Nosebleeds
- € Nasal Congestion
- € Non-healing nasal ulcer
- € Runny nose
- € Bleeding gums
- € Periodontal Disease
- € Dentures Present
- € Hoarseness
- € Sore/Ulcer in mouth
- € Sore Throat
- € Sore Tongue
- € Thrush (White coating on tongue)
- € Tooth Pain

Cardiovascular
- € Chest Pain
- € Calf Pain While Walking
- € Dizziness
- € Short of Breath While Laying Flat
- € Palpitations
- € Awakening with Shortness of breath
- € Swelling in feet
- € Rapid Heart Beat
- € Varicose Veins

Respiratory
- € Acute Cough
- € Chronic Cough
- € Shortness of Breath
- € Exposure to TB
- € Hemoptysis
- € Pleuritic Pain
- € Wheezing

Gastrointestinal
- € Abdominal Pain
- € Acid Reflux
- € Loss of Appetite
- € Bloating
- € Difficulty Swallowing
- € Clay-colored stool
- € Constipation
- € Diarrhea
- € Heartburn
- € Vomiting Blood
- € Bright Red Blood From Rectum
- € Hemorrhoids
- € Black, tarry stools
- € Nausea
- € Vomiting
- € Painful Swallowing
- € Stool Change- Partial Obstruction

Genitourinary Female:
- € Painful Menstruation
- € Painful Intercourse
- € Painful Urination
- € Genital Lesions
- € Blood in Urine
- € High Risk Sexual Behavior
- € Frequent UTI's
- € Recurrent bacterial
- € Irregular Menstrual Cycle
- € Excessive Menstrual Bleeding
- € Frequent Urination at Night
- € Frequent Urination
- € Post-coital Vaginal Bleeding
- € Post-menopausal Bleeding
- € Rape (History of)
- € Sexual abuse (History of)
- € Urinary Incontinence
- € Vaginal discharge
- € Vaginal Itching

Genitourinary Male:
- € Painful Urination
- € Genital Lesions
- € Blood In Urine
- € High Risk Sexual Behavior
- € Unprotected Intercourse
- € Frequent UTI's
- € Impotence
- € Frequent Urination at Night
- € Frequent Urination
- € Urinary Incontinence
- € Urine Stream Change

Musculoskeletal
- € Joint Pain
- € Back Pain
- € Joint Stiffness
- € Limb Pain
- € Muscle Pain

Integumentary (Skin)
- € Acne
- € Atypical Mole(s)
- € Dry Skin
- € Fungal Nail Infection
- € Jaundice
- € Diffuse Itching
- € Rashes
- € Wart(s)
- € Breast Mass
- € Breast Skin Changes
- € Nipple Discharge
- € Self Breast Exams?

Neurological
- € Clumsy, Uncoordinated
- € Dizziness
- € Fainting
- € Headaches
- € Memory Loss
- € Numbness
- € Seizures
- € Tremor
- € "Room-Spinning"
- € Weakness

Hematologic/Lymphatic
- € Easy Bruising
- € Excessive Bleeding
- € Blood transfusion?
- € Enlarged Lymph Nodes

Endocrine
- € Enlarging Hands/Feet
- € Hair Loss
- € Heat/Cold Intolerance
- € Excessive Hair Growth
- € Hot Flashes
- € Increased Skin Pigmentation
- € No Longer Can Have Children
- € Excessive Thirst
- € Excessive Hunger
- € Purple Stretch Marks
- € Excessive Sweating

Allergic/Immunologic
- € Seasonal Allergies
- € Perennial Allergies
- € Frequent URI
- € HIV Risk Factors
- € Urticaria
- € Drug Allergies

_____

_____

Psychiatric
- € Anxiety
- € Crying Spells
- € Depression
- € Feeling Stressed
- € Loss of interest
- € Mood Swings
- € Personality Changes
- € PMS
- € Poor Concentration
- € Recreational Drug Use
- € Sadness
- € Sleep Disturbance
- € Suicidal Thoughts

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my heath care, Sonora Primary Care originates and/or electronic records describing my heath history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be uses or disclosed to carry out treatment, payment, or health care operations.

I understand that Sonora Primary Care is not required to agree to the restricted request. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking the consent, this organization may refuse to treat me as permitted by Section 164.506 of the ode of Federal Regulations.

I further understand that Sonora Primary Care reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Sonora Primary Care change their notice, they will send a copy of a revised notice to the address I've provided (whether U.S. Mail, or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of the organization's treatment, payment, or heath care operations, it may become necessary to disclose my protected heath information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature Relation to Patient

Sonora Primary Care
Timothy Hooper, M.D.
13951 Mono Way , Suite A
Sonora, CA 95370
P(209)532-3370 F(209)532-3340

Authorization to Release Medical Information

Patient Name:_____ Address:_____

Date of Birth:_____ City/State/Zip:_____

Phone:_____

Please OBTAIN information FROM:	Please SEND my medical information TO:
_____ Physician's Name	Dr. Timothy Hooper
_____ Name of Organization	Sonora Primary Care
_____ Street of Address	13951 Mono Way Suite A.
_____ City/State/Zip	Sonora, CA 95370
_____ Telephone Number	209-532-3370
_____ Fax Number	209-532-3340

Purpose of disclosure: __Changing Primary Care Physician __Referral __Other:_____
List specific date of records to be released:_____
This authorization shall begin immediately and remain in effect for one (1) year unless otherwise specified.

TYPE OF INFORMATION TO BE RELEASED: ____All items listed below

__Medication Summary	__History & Physical	__Pathology Reports
__Consults	__Laboratory Reports	__X-Ray Reports
__Progress Notes	__Operative Reports	__X-Ray Films

__Other:_____
__Most Recent 2 yr History *OR* Dates of Service: From: _____/_____to_____/____

PROTECTED OR SENSITIVE INFORMATION: I understand that certain information cannot be released without specific authorization as required by Federal/State Law. **BY INITIALIZING**, I authorize the release of the following protected or sensitive information:

__Drug Abuse Diagnostic/Treatment __Alcoholism Diagnosis/Treatment
__Mental Health/Treatment __AIDS/HIV/STD test results & related information

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. (*Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code* #56.10(*x*), *may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.)*
Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may insect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be affective upon receipt, but will not be affective to the extent that this organization has taken action in reliance upon this authorization. I have the right to obtain a copy of this authorization.

Signature: _____ Date:_____
(Patient/Parent/Conservator/Guardian)
If signed by other than patient, indicate relationship:_____

Sonora Primary Care

The purpose of our practice is to give our patients the utmost in care and service. Please take a moment to read our billing policies and procedures:

- Co-payments or Cash Payments are due at time of service.
  $15 Late Charge Fee, if we bill for your co-pay.
  Cash patients are rescheduled.

- Returned checks will have a minimum fee of $25, plus written amount.

- We require at least a 24-hour notice for canceling appointments.
  $50 No Show Fee
  $15 Late Cancellation Fee

- Refill requests need to be made 48 hours prior to pick up.
  - Have pharmacy fax request; please do not call office for refills.
  - If Dr. Hooper has not previously written the prescription, schedule an appt to be seen.

Thank you so much for your cooperation.

We appreciate you choosing us as your heath care provider!

I have read and understand the policies and procedures of Sonora Primary Care:

_____ _____
SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

SONORA PRIMARY CARE
Timothy D. Hooper, M.D.
13951 Mono Way Suite A
Sonora, Ca. 95370
P(209)532-3370 F(209)532-3340

ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT

Because of changes in the health care industry, insurance does not always pay for all care. As per our contract, we must bill your private insurance company or Medicare on your behalf. Please be aware that your insurance coverage is a contract between you and your insurance provider. We are not a party to that contract. If your injury is the result of an automobile accident, we do not bill auto insurance carriers, but would be happy to bill your private insurance. **Please be aware Dr. Hooper is not contracted with MediCal, and so in accordance with billing protocol will be unable to bill MediCal even as a secondary insurance provider**. Please read the following and sign your name where indicated.

I hereby instruct and direct my insurance company or Medicare to pay by check made out and mailed to:

Timothy Hooper
18701 Tiffeni Dr. St. 1A
Twain Harte, Ca 95323-9406

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.
I also authorized the release of any information pertinent to my case to any insurance company.

Dated signed: _____

_____
Patient Name (Print)

_____ _____
Signature of Policyholder Witness

Signature of Claimant if other than Policyholder _____

☐ Patient Given Copy