MEDICAL HISTORY QUESTIONAIRE

NAME _____ **DATE** _____

AGE _____ **BIRTHDATE** _____/_____/_____ **MALE / FEMALE**

Present Problems

1. _____ 2. _____
3. _____ 4. _____

Please list all medications you take at present:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies/Drug Reactions:

_____ _____ _____ _____

PMH: Are you known to have any medical condition below

- ☐ Anemia
- ☐ Stroke
- ☐ Cancer or tumor
- ☐ Hepatitis
- ☐ Ulcer or stomach trouble
- ☐ Arthritis
- ☐ Other: _____
- ☐ High blood pressure
- ☐ Sadness/Depression
- ☐ Asthma
- ☐ Heart trouble
- ☐ Sexual problems
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Venereal disease (STD)
- ☐ High cholesterol
- ☐ Gout

Do you smoke? _____ If yes, how much per day? _____ How many years? _____

Do you drink alcoholic beverages? _____ If yes, how much in an average week? _____

and for how many years? _____

When did you last have the following:

Shots for: Tetanus _____ Pneumonia _____ Shingle _____ TDAP _____
Pap smear (women only) _____ Chest x-ray _____ EKG (cardiogram) _____
Mammography _____ Bone Density _____ Colonoscopy _____

List of dates and reasons for previous hospitalization:

DATE	PROBLEM	TREATMENT OR OPERATION
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all your previous surgeries & dates:

_____ _____
_____ _____

If more space needed, attached additional sheet.

FAMILY HSTORY: Any one in your family or relatives has or had:

- ☐ Asthma
- ☐ Sickle disease
- ☐ Heart disease
- ☐ OTHERS/SPECIFY _____
- ☐ Cancer or tumor
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Mental Illness
- ☐ Stroke
- ☐ Tuberculosis

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received a copy of the Privacy Practices for California Cardiovascular Consultants

I hereby give my consent for California Cardiovascular Consultants to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. The physicians reserve the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: The Privacy Official at *2333* Mowry Ave, Ste 300 Fremont, CA *94538.*

With this consent, the physicians or office staff may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to clinical care, including laboratory results among others.

With this consent the physicians may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that the physicians restrict how they use or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to the physician's use and disclosure of my PM to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the physicians may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

CCCMA INFORMATION RECORD

Physicians Name for Today's Appointment: _____

Referred By: _____Today's Date: _____

PLEASE PRINT CLEARLY

PATIENT

Last Name	First Name	Middle	Sex	Home Phone # Cell Phone #	
Address		Apt #	City	State Zip	
Birth Date	Social Security #	Drivers License #		Email Marital Status	
Employer	Address	Apt #	City	State	Zip
Occupation	Work Phone #	Emergency Contact NOT living w/ you		Relationship	
Emergency Contact Phone	Ethnicity/Race	Person Responsible for the Bill			

SPOUSE

Last Name	First Name	Middle	Sex	Occupation Birth Date ____/____/____	Work Phone # Cell Phone #

INSURANCE

Primary Insurance Company Name	Primary Insurance ID #	Secondary Insurance Company Name	Second Insurance ID #

Preferred Language	☐ English ☐ Burmese ☐ Farsi	☐ Vietnamese ☐ Cantonese ☐ Spanish	☐ Tagalog ☐ Mandarin ☐ Armenian	☐ Russian ☐ Korean ☐ Others/Specify
Interpreter Needed?	☐ Yes (Accepted) If Yes, note date ____/_____/____	☐ No (Declined) If No, note date ____/____/_____	Hearing impaired? (ASL) Interpreter? If No, note date ____/____/_____	☐ Yes ☐ No ☐ Yes ☐ No

If member is a minor, identify decision maker:

☐ Mother ☐ Father ☐ Legal Guardian ☐ Self (emancipated minor)

Name: _____

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

Phone #: (_____)_____-_____ Cell: (_____) _____-_____

Do you have an Advanced Healthcare Directive (patients 18 years and over) [ ] Yes [ ] No

****Power of attorney agreement listing instructions about your healthcare wishes.**
If you do not have an Advanced Healthcare Directive, would you like a copy as an example to refer to? [ ] Yes [ ] No

1. **I understand that I am financially responsible for all charges not covered by my insurance company.**
2. **I authorize release of any information to the Insurance Company.**
3. **I authorize direct payment of any and all insurance benefits to my doctor.**
4. **All the above information is correct.**

Signature of Patient or Legal Guardian _____ DATE _____/_____/_____

FINANCIAL RESPONSIBILITY WAIVER

PATIENTS WITH INSURANCE: Although we will bill your insurance company/ Medical Group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan/Medical Group, we will contact you for assistance. Should your health plan/Medical Group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

DUAL COVERAGE: abides by the California State insurance laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information for primary, secondary and tertiary health plans.

PATIENTS WITHOUT INSURANCE: Our fees cannot always be determined in advance, since they depend on services rendered. You will, therefore, be quoted a deposit amount, which must be paid at the time of service. Any charge over the deposit amount will be billed to you and will be due in full within thirty (30) days from the date of your billing statement. Please make payment arrangements for costly services in the Credit Department.

RETURNED CHECKS: There is a $20.00 service fee for returned checks.

COPAY POLICY: Your health plan requires that you make your copay at the time of visit. However, in an emergency situation when you are unable to make your copayment, you will be granted a 10 day grace period in which to make payment without penalty.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I authorize the release of any medical information which may have a bearing on the determination and/or payment of my claim. I request that payment be made directly to _____, and I acknowledge that I am responsible for payment if this assignment is not honored.

EMPLOYMENT AND CREDIT VERIFICATION: I authorize_____ to contact my employer for employment and/or benefit verification and to request a credit report when deemed necessary.

I have read and understand the above policies and I agree to comply with them. I attest that all information given is true and accurate to the best of my knowledge.

_____ _____

Patient Signature **Date**

I/we wish to accept financial responsibility for medical expenses incurred by the above named patient.

_____ _____

Guarantor Signature **Date**

ELIGIBILITY GUARANTEE FORM

PATIENTS NAME/NOMBRE DEL PACIENTE		**EFFECTIVE DATE/FECHA EFECTIVA**
PATIENTS DATE OF BIRTH/FECHA DE NAIMIENTO DEL PACIENTE	**PATIENTS ID # / NUMERO DE IDENTIFICACION**	
NAME IF INSURED, IF DIFFERENT/NOMBRE DEL ASEGURAD, SI DIFERENTE		**RELATIONSHIP TO PATIENT/RELACION AL PACIENTE**
INSURANCE (HMO) / SEGURO (HMO)	**EMPLOYER OR GROUP/LUGAR DE TRABAJO OR GRUPO**	**ID#**
PRIMARY CARE PROVIDER/NOMBE DEL DOCTOR		

I, the above named patient, hereby certify that the information stated above is true, to the best of my knowledge.

I understand and agree that if I am not eligible, I am responsible for all charges incurred for services rendered.

Yo, el paciente nombrado(a) arriba, declaro que Ia informacion proporcionada es correcta y verdadera:

Entiendo y estoy de acuerdo que si no soy elegible, soy responsable por todos los gastos iricurridos.

_____ _____

Signature of Patient / Firma del Paciente **Date / Fecha**

_____ _____

Signature of Insured / Firma del Asegurado **Date / Fecha**

_____

Name of contact person in PCP's office