SIERRA MADRE COMMUNITY MEDICAL GROUP

147 W. Sierra Madre Boulevard, Sierra Madre, CA 91024

PATIENT REGISTRATION

Welcome to Sierra Madre Community Medical Group

Full Name (Last, First, Middle): _____

Title (circle one): Mr. Mrs. Miss Dr.

Marital Status (circle one): Single Married Divorced Separated Widowed

Address: _____ Apt #: _____

City/State/Zip: _____

Email Address: _____ Occupation: _____

Home Telephone: _____ Employer: _____

Cellular Phone: _____

Emergency Contacts

Name: _____ Relationship to Patient: _____ Tel: (____)_____

Name: _____ Relationship to Patient: _____ Tel: (____)_____

Driver License #: _____

How Were You Referred to Sierra Madre Community Medical Group?

_____

- If you would like to give authorization to share your protected health information or allow somebody to pick up your prescriptions or laboratory slips, please ask the receptionist for the form titled "AUTHORIZATION OF RELEASE OF MEDICAL RECORD."

- If the patient is a minor, ask the receptionist for "AUTHORIZATION FOR SERVICES RENDERED TO A MINOR."

- The physicians of Sierra Madre Community Medical Group might order some laboratory tests that need to be performed for diagnostic and screening purposes. We are going to direct you to a laboratory contracted with your insurance. You are responsible to check if the tests ordered on the laboratory slip are covered by your insurance and if they apply toward your deductible.

- I hereby authorize the office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage.

_____ _____

Signature of Patient or Representative Date

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MEDICATION

Patient Name: _____ DOB: _____

ALLERGIES (please list any medication allergy or any known allergy)

Allergen/Medication	Reaction

PHARMACY

Name:	Address:	Phone:

PRESCRIPTION MEDICATION

Medication Name	Dosage	Frequency

OVER THE COUNTER MEDICATION

Medication Name	Dosage	Frequency

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Health Assessment

Patient Name: _____ DOB: _____

Personal Medical History (please list all medical conditions)

_____
_____
_____

Personal Surgical History (please list all prior surgery and dates)

_____
_____

Family History (please list known conditions of family members)

Mother:
Father:
Siblings:
Maternal Grandparents:
Paternal Grandparents:
Uncle/Aunts:
Other:

Social History

Do you smoke? (Y / N) # of years: #of cigarettes per day:	Do you drink alcohol? (Y / N) # of drinks/day:
History of illicit drug use? (Y / N) Please list any:	Do you exercise? (Y / N) Activities: Frequency per week:

Health Maintenance Screening (please list test dates and known results)

Sigmoid/colonoscopy	PSA
Mammogram	Cholesterol
Bone Density	Hemoglobin A1C

Vaccinations (please list dates of vaccine received)

Flu Shot	Pneumonia	Tetanus/TDAP	Gardacil
Meningococcal	Hepatitis B	Hepatitis A	

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Notice of Privacy Practice Acknowledgement Form

I was given and read the *Notice of Privacy Practice* or I have read the *Notice of Privacy Practice* posted on the Sierra Madre Community Medical group website.

_____
Patient's Signature

_____
Printed Name

_____
Date of Birth

_____
Today's Date

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Sierra Madre Medical Group
Advance Directives

The Natural Death Act
This is another type of advance directive most often called a "Declaration." This document DOES NOT require you to appoint an agent to make health decisions for you.

The Declaration is for terminally ill patients. While you still have decision-making capabilities, you make sign a Declaration, which tells your doctors that you don't want any treatment that would prolong the dying process. The Declaration must be followed in these circumstances:

- If you fall into a permanent unconscious state or a terminal condition (certified by two doctors)
- At the time you cannot make your own health care decisions

Those persons who are witnesses to the signing of the Declaration must meet the same requirement as those needed for the Durable Power of Attorney for Health Care.

Do I need a special form for the Durable Power of Attorney for Health Care?
Yes. Use a Durable Power of Attorney for Health Care form, not a plain Durable Power of Attorney. You can ask your physician, nurse, or social worker about the form

The California Medical Association has printed forms that meet legal requirements.
California Medical Assc. P.O. Box 7690, San Francisco, CA 94120-7690 (415) 882-5175
The form is also carried by:
The California Health Decisions, 500 south Main St., Orange CA 92668 (714) 647-4920
Many stationary stores carry the form. There is a small charge for these forms from all sources.

Other Documents
Other documents that help determine your health care desires IF and WHEN you are UNABLE to make such decisions for yourself:
"Do Not Resuscitate" This form allows your doctor to without "resuscitative measures" should that be your desire. This should be signed by you, your doctor, and a surgeon. The law does not require witness and notarization. NO ONE CAN MAKE YOU SIGN A "DO NOT RESUSICTATE" ORDER. **"Preferred Intensity of Care"** This is a document of your preferences for care under special circumstances. A discussion with your physical and/or legal representative occurs prior to creating this document. **"Living Will"** This list is NOT a legally binding agreement, although it is often accepted as an accurate statement of one's wishes.

For more information about Advanced Directives, contact the State Ombudsman (916) 323-6681 or set up a time to speak with your personal physician.

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Sierra Madre Medical Group
Advance Directives

I have been informed of my right to formulate an Advance Directive and I have been provided with information regarding the execution of Advance Directive.

Please check the following statement which applies to you:

- ☐ I have previously completed an Advance Directive and have provided copy for inclusion in my record.
- ☐ A copy of my Advance Directive is on file with _____ (name of physician or Healthcare).
- ☐ I have not executed an Advance Directive and I am not interested in further information
- ☐ I am interested in formulating an Advance Directive and will discuss my options with my primary care provider.

_____
Patient's Signature

_____
Printed Name

_____
Date of Birth

_____
Today's Date

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Insurance Eligibility Waiver

It is very important that you confirm your insurance information with us before each visit with your physician. It is ultimately your responsibility to know which providers and services are covered by your insurance. Please ask us.

Billing

We need to know your current insurance carrier in order to meet their deadlines for billing our services. If you have changed insurance and do not inform us, we will bill the last health plan that we have in your medical records. When the insurance denies the claim, we will bill you directly for payment and you must seek reimbursement from your current insurance provider.

Referrals

If you have to be referred for services outside our office, your physician will try to direct you to a contracted service covered by your insurance. Otherwise, you may be referred to a non-contracted service which will provide you with the service and you will be responsible for the bill. We are not responsible for non-covered services or for the cost of services provided by a non-contracted provider.

Laboratory Services

Your physician may order some laboratory tests that may benefit you for detecting some health conditions. Your health plan may, or may not, cover these tests. Since each plan has different polies on services covered, the office would know which tests are covered. You will be responsible for the bill from the laboratory for services not covered.

Waiver

I understand that if I am not eligible for insurance benefits for today's visit, I will be financially responsible for the service performed by the physicians of Sierra Madre Community Medical Group.
I understand that if my insurance assigns me a primary care physician (PCP), and that the PCP is not from Sierra Madre Community Medical Group, I will be held financially responsible for the services performed by the physician of Sierra Madre Community Medical Group.
I understand that if I have an HMO plan, the IPA managing the Health plan must be HealthCare Partners/Physician Associates of San Gabriel Valley.

_____ _____
Signature of Patient or Representative Today's Date

_____ _____
Print Patient Name Date of Birth

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best health requires a partnership between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with Your Doctor for Routine Physical Exams and Other Recommended Health Screenings
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, colonoscopy, pap smears, etc.). These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Lab and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my tests results.

Inform my Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan may have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his recommendations to that he or she may fully inform me of any risk associated with my decision to delay or refuse treatment.

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Thank you for your partnership. As a patient, you have the right to be informed about your healthcare. We invite you at any time to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health condition, please ask.

Sincerely,

The Physicians of Sierra Madre Community Medical Group

_____ _____

Signature of Patient or Representative Today's Date

_____ _____

Print Patient Name Date of Birth