(Please print and complete as thoroughly as possible)

PATIENT REGISTRATION SHEET

(please circle one)
MR MRS MISS MS DR : _____ TODAYS DATE : _____

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding Appointment Changes/Reminders, Lab Results, Insurance/Financial matters, etc. Only list the phone number(s) you want us to call.

HOME PH: _____ WORK PH: _____ CELL PH: _____

Please indicate the address that you would like us to use for mailing out any and all correspondence.

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS #: _____ - _____ - _____ DRIVER'S LICENSE: _____

(please circle one)
AGE: _____ DATE OF BIRTH: _____ - _____ - _____ GENDER: M F

(please circle one)
MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

PRIOR/MAIDEN NAME: _____

(please circle one)
SPOUSE'S / PARENT'S NAME: _____

REFERRED BY: _____ **PHONE:** _____

Please advise us of any and all persons you would like us to disclose medical and/or financial information to. If no one, please write "none".

IN CASE OF EMERGENCY, PLEASE CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

ADDITIONAL CONTACT(S): _____ PHONE: _____

FAMILY PHYSICIAN / INTERNIST: _____ PHONE: _____

ADDRESS: _____

GYNECOLOGIST: _____ PHONE: _____

ADDRESS: _____

OTHER: _____ PHONE: _____

ADDRESS: _____

INSURANCE : IT IS ESSENTIAL THAT YOU INDICATE WHO IS THE ACTUAL PERSON LISTED AS THE SUBSCRIBER ON THE INSURANCE POLICY IN ORDER TO HAVE YOUR SERVICE(S) CONSIDERED BY YOUR CARRIER. FAILURE TO PROVIDE ACCURATE INFORMATION WILL CAUSE DENIAL OF YOUR CLAIM(S). PATIENT/GUARANTOR WILL BE HELD RESPONSIBLE FOR ANY AND ALL UNPAID SERVICES BY THE INSURANCE CARRIER(S).

PRIMARY INSURANCE: _____ SUBSCRIBER: _____

POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE: _____ SUBSCRIBER: _____

POLICY #: _____ GROUP #: _____

**** PLEASE CONTINUE TO SECOND PAGE****

OFFICE USE ONLY:
NEEDS DICTATION [ ]
DICTATION DONE [ ]
DICTATION RCVD [ ]

EMPLOYMENT:

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____

(please circle one)
SPOUSE'S / PARENT'S EMPLOYER : _____

ADDRESS: _____ PHONE: _____

AS A COURTESY, OUR OFFICE WILL GLADLY BILL YOUR SERVICE(S) TO THE INSURANCE CARRIER(S) PROVIDED. IF YOU WOULD LIKE US TO SUBMIT YOUR CLAIM(S) ON YOUR BEHALF, NOW OR IN THE FUTURE, PLEASE SIGN BOTH AREAS BELOW.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS.

(please circle one)
PATIENT / GUARDIAN SIGNATURE: **X**_____ DATE: _____

I AUTHORIZE THE RELEASE OF PAYMENT FOR MEDICAL BENEFITS TO MY PHYSICIAN.

(please circle one)
PATIENT / GUARDIAN SIGNATURE: **X**_____ DATE: _____

PATIENT INSTRUCTIONS FOR REGISTRATION

STEP 1: COMPLETE THE PATIENT REGISTRATION FORM. BE SURE TO SIGN BOTH SIGNATURE FIELDS.

STEP 2: COMPLETE THE MEDICAL HISTORY QUESTIONNAIRE.

STEP 3: SIGN (ONLY) THE MEDICAL RECORDS RELEASE FORM – DO NOT COMPLETE, LEAVE BLANK

STEP 4: COMPLETE THE PHOTOGRAPHY CONSENT FORM (OPTIONAL)

STEP 6: FAX ALL SIX (6) PAGES ALONG WITH YOUR DRIVERS LICENSE AND THE FRONT AND BACK OF YOUR INSURANCE CARD(S) TO THE OFFICE WHERE YOU HAVE SCHEDULED YOUR APPOINTMENT.

BEVERLY HILLS FAX: (310) 271-7003

FULLERTON FAX: (714) 449-1988

CASH ACCOUNTS AND/OR PROCEDURES REQUIRE PAYMENT TO BE MADE AT THE TIME OF SERVICE.

THANK YOU!

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____

REFERRED BY: _____ PHONE: _____

1.) HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? IF YES, PLEASE EXPLAIN:

	YES	NO	EXPLANATION
DIABETES	____	____	_____
HIGH BLOOD PRESSURE	____	____	_____
HEART PROBLEM	____	____	_____
RESPIRATORY PROBLEM (I.E., ASTHMA, BRONCHITIS, ETC.)	____	____	_____
GASTROINTESTINAL PROBLEM (I.E., STOMACH/INTESTINES)	____	____	_____
NEUROLOGICAL (STROKE, BELL'S PALSY, ETC.)	____	____	_____
THYROID	____	____	_____
GENITOURINARY (I.E., KIDNEY, BLADDER, PROSTATE)	____	____	_____
HEMOTOLOGICAL (I.E., BLEEDING, ANEMIA, CLOTTING, ETC.)	____	____	_____
MUSCULOSKELETAL (I.E., MUSCLE OR JOINT PAIN, ETC.)	____	____	_____
PSYCHIATRIC	____	____	_____
CANCER	____	____	_____

2.) LIST ALL MAJOR ILLNESSES AND INJURIES YOU HAVE HAD IN THE PAST:

_____

_____

_____

3.) LIST ALL SURGERIES YOU HAVE HAD IN THE PAST:

_____

_____

_____

Please continue to next page

4.) CURRENT MEDICATIONS AND DOSAGES:

1.)_____ 5.)_____

2.)_____ 6.)_____

3.)_____ 7.)_____

4.)_____ 8.)_____

5.) ALLERGIES: **YES** **NO**

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ____ ____

IF YES, PLEASE EXPLAIN: _____

_____

6.) FAMILY HISTORY: **YES** **NO** **RELATIONSHIP TO YOU**

BLINDESS ____ ____ _____

CATARACT ____ ____ _____

GLAUCOMA ____ ____ _____

MACULAR DEGENERATION ____ ____ _____

RETINAL DETACHMENT ____ ____ _____

7.) SOCIAL HISTORY:

CURRENT OCCUPATION: _____

DO YOU SMOKE? : YES _____ NO _____ IF YES, HOW MANY PACKS PER DAY? : _____

DO YOU DRINK ALCOHOL? : YES _____ NO _____ IF YES, HOW MANY/HOW OFTEN? : _____

BLOOD TRANSFUSION? : YES _____NO _____

DO YOU DRIVE? : YES _____ NO _____

PATIENT / GUARDIAN SIGNATURE: _____ **DATE:** _____