Covina, CA Glendora, CA Ontario, CA Riverside, CA Pasadena, CA
Phone: (626)859-2249 Fax: (626)859-2248

Physicians of Southern California

Patient: _____ Sex: ____ Date of Birth: _____ SSN: _____
(Last, First Middle Initial)

Name of Spouse: _____ Maiden Name: _____

Cell Phone: _____ Home phone: _____ Business Phone: _____

Email Address: _____

Mailing Address: _____

Street Adress: _____ City: _____ State: ____ Zip: _____

Patient Employed By: _____ Preferred Pharmacy: _____

Please circle which method of contact for appointment reminder: Home phone Cell phone Email Decline reminders

How did you hear about us? ☐ Website ☐ Social Media ☐Friend/Family referral ☐Other: _____

Race (Please circle one): White, American Indian, Asian, Black/African American, Hawaiian/Pacific Islander, Other Race

Ethnicity (Please circle one): Hispanic/Latino, Non-Hispanic/Latino, Decline

Tobacco Status (please circle one): Never Former Current Frequency: _____

Primary Insurance: _____ Subscriber Name: _____

ID Number: _____ Group Number: _____ DOB: _____

Previous Doctor: _____ Phone Number: _____

By supplying my home phone number, cell phone number, email address, and any other contact information, I authorize Physicians of Southern California Family Practice to employ a third-party automated outreach and messaging system to use my contact information to make appointment reminder calls via text, phone, and email. I also authorize my healthcare provider to disclose to third parties who may intercept these messages limited protected health information for the purpose of notifying me of a pending appointment, the time and place of my appointment, missed appointment.
Initial: _____

Emergency contact information that is different than the patients:

Name: _____ Phone: _____ Relationship: _____

Patients are responsible for all fees regardless of insurance coverage. It is Customary to pay for services when rendered unless other arrangements have been made in advance. I authorize Physicians of Southern California to release to my insurance company its intermediaries, any information needed for insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization remains in effect unless a request by the patient is received in writing.

Signature: _____ Date: _____

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Acknowledgement and Consent

- I understand that will use and disclose health information about me.
- I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may included information about my health history, health status, symptoms, examination, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.
- I understand and agree that this practice may use and disclose my health information ass described in a Notice of Privacy Practices.
- I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices which is at the front desk.

Name: _____ DOB: _____ Date: _____

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Patient Health History

Past Medical History:

Disease Name:	First Diagnosed:	Treatment/Notes:

Past Surgical History:

Procedure Name:	Surgeon:	Date:	Reason for Procedure:

Family Medical History:

Disease Name:	Relative:	Age of Diagnose:	Treatment/Outcome

Social History:

Marital Status (status, spouse name, date):	
Children (sex/age):	
Education (level/degree):	
Occupation (type, name of employer):	
Diet(type/limitations):	
Code status (full code, life support, advance directive):	
Spiritual Belief System:	

Immunization History (please bring immunization record):

Immunization:	Last Booster/Shot Date	What Facility:

Reproductive History (For Women Only)

Age of 1st Menstruation: _____ Cycle Interval (# of Days- 1st day of period to 1st day of next period): _____

Menese Duration (# of days): _____ Flow (circle one): Light Medium Heavy Last Menstruation Date: _____

Sexually Active (circle one): Yes No Method of Birth Control: _____ Monogamous (circle one): Yes No

Pregnancy (# of times): _____ Delivered (# of times): _____ Premature (# of times): _____ Miscarried (# of times): _____

Aborted (# of times): _____ Hormone Replacement Therapy (circle one): Yes No

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Medication List

Name: _____ DOB: _____ Pharmacy: _____ Phone: _____

Medication:	Dosage:	Date:	Time:	Remark:

List of any Allergies (medication/food/environmental): _____

_____

_____

_____

_____

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Patient Consent to Treat Form

1. I _____ give permission for **Physicians of Southern California** to give me medical treatment.
2. I allow **Physicians of Southern California** to file for insurance benefits to receive payment for the care I receive. I understand that.
    - **Physicians of Southern California** will have to send my medical record information to my insurance company.
    - I must pay my share of the costs.
    - I must pay for the cost of these services if my insurance does not pay or, I do not have insurance.
3. I understand:
    - I have the right to refuse any procedure or treatment.
    - I have the right to discuss all medical treatment with my children.

_____ _____

Patient's Signature Date

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Preventative Health Evaluation

Patient Name: _____ DOB: _____ Date: _____

1. What specialist do you see? (Name and phone)

a) Dentist: _____ Phone: _____
b) Opthalmologist: _____ Phone: _____
c) Other: _____ Phone: _____

2. What activities of daily living are difficult for you (please circle):

Yard work House work Driving Finances Medical Decisions Meal prep Eating

Dressing Bathing Toilet

3. Which of the following best describes your choices for the "End of Life" planning? (Please circle)
   a. I want Full Resuscitation.
   b. I **do not** want Full Resuscitation.
   c. I want Life Support Measures.
   d. I **do not** want Life Support Measures.
   e. Life Support Measures are OK, if there is hope of recovery.
4. Who is your healthcare representative/ emergency contact, Name: _____ Phone: _____

5. Can you provide us with an **Advanced Directive to Physician**? Yes No

6. Immunizations, when traveling to foreign countries. Let us know so we can advise you about any other vaccines or medications that may be needed.

   a. Last tetanus: _____ b. Last influenza: _____ c. Last Pneumonia: _____

   d. Last shingles: _____

7. Can you give us a copy of your immunization record: Yes No

8. SCREENING TEST:

   a. Last colonoscopy was: _____ Doctor: _____ Results: _____

   b. Last chest x-ray was: _____ Results: _____

   c. Last EKG was: _____ Results: _____

   d. Last preventive health lab was: _____ Where: _____

   e. (For Men) Last PSA was: _____

   f. (For Men) Last Prostate exam was: _____

   g. (For Women) Last PAP Smear was: _____ Results: _____

h. (For Women) Last Mammogram was: _____ Results: _____

i. (For Women) Last Dexa/bone density scan was: _____ Results: _____

9. Do you do self-breast exams (circle one): Yes No

10. Do you want a hearing test (circle one): Yes No

11. How often do you exercise (circle one): Yes No

12. What type of exercise do you like: _____

13. How many hours of sleep do you usually get each night: _____

14. How many cups of water do you drink daily: _____

15. Do you engage in any uncontrolled habits such as:

a. Tabacco: _____ cigarette per day

_____ pack per week

b. Alcohol: _____ drinks per week

c. Recreational drugs: _____

d. Controlled substances: _____

e. Gambling: _____ times per month

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Authorization to Use and Disclose Health Information

I hereby authorize (Previous Dr.): to disclose to:

_____ **Physicians of Southern California**
Name of Disclosing party Name of Recipient

_____
Address

_____
City State Zip

Records and information pertaining to:

_____ _____ _____
Patients Name: Social Security Number: Date of Birth:

_____ _____
Patient's Address: Phone Number:

For the purpose of: _____Transfer of Care_____
Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____. (Date)

Revocation: This authorization is also subject to written revocation by the Patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or other have acted in reliance upon authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box. Initial and/or sign to specify which type of information is to be disclosed:

- ☐ Medical information _____ Initial
- ☐ Psychiaatric Information _____ Initial
- ☐ Drug/Alcohol Information _____ Initial
- ☐ Results of HIV Test _____ Initial
- ☐ Genetic Records _____ Initial

A copy of this authorization is valid as the original. Patient has a right to a copy of this authorization.

Signature: _____ Date: _____