

HEALTH QUESTIONNAIRE

Name: _____
 Birthdate: _____

Date: _____
 PCP: _____

For **Established Patients**, please review and **only** note **changes** since you last completed our form.

Medications

Use the back of this form for more space

Please list any medications that you currently take regularly (including non-prescription medications, vitamins, or supplements) and the strength and dosage: (If prescribed by someone other than Irvine Family Care, please list that doctor's name)

Allergies

Please list any allergies to medications, foods, or other, the kind of reaction you had to each, and your age at the time.

Illnesses/Conditions

Do you have or have you ever had any of the following:

Note type of/Kind of	Age Diagnosed
_____ Anemia	_____
_____ Anxiety/Panic Attacks/Phobias	_____
_____ Arthritis/Rheumatoid Processes	_____
_____ Asthma/Allergic Rhinitis	_____
_____ Birth Defects	_____
_____ Cancer: Type: _____	_____
_____ Colitis	_____
_____ Concussion	_____
_____ Depression/Suicidal Thoughts	_____
_____ Diabetes	_____
_____ Emphysema	_____
_____ Heart Attack/Heart Disease	_____
_____ High Blood Pressure	_____
_____ High Cholesterol	_____
_____ Kidney Disease	_____
_____ Liver Disease	_____
_____ Low Blood Sugar	_____
_____ Mitral Valve Prolapse/Murmur	_____
_____ Osteoporosis	_____
_____ Pneumonia	_____
_____ Rheumatic Fever	_____
_____ Seizure Disorder	_____
_____ Sexually Transmitted Disease	_____
_____ Stoke	_____
_____ Thyroid Disorder	_____
_____ Tuberculosis	_____
_____ Ulcer	_____

Surgical Procedures/Hospitalizations

Year

If you know, note the name of surgeon

_____	_____
_____	_____
_____	_____
_____	_____

Serious Injuries

_____	_____
_____	_____
_____	_____

Childhood Diseases

Year

_____ Chickenpox	_____
_____ Measles	_____
_____ Mumps	_____
_____ Polio	_____
_____ Other	_____

Gynecological History (Women Only)

Are you pregnant?	_____
Are you breast feeding?	_____
First Day of your Last menstrual period:	_____
How many pregnancies have you had?	_____
How many children do you have?	_____
How many miscarriages have you had?	_____
At what age did you start having periods?	_____
Have you ever had an abnormal Pap?	_____
Have you had HPV?	_____
Have you had the HPV vaccine? Dates: _____ / _____ / _____	

Family History

Has any blood relative ever had any of the following: Note if M (mother's side) or P (paternal-father's side) and Age

Relative (mother, father, sister, aunt, grandmother, etc.)	Age		Living Age	Deceased Age (at death) & Cause
Anesthesia Complications:	_____			
Bleeding Problems	_____	Father	_____	_____
Cancer: type	_____	Mother	_____	_____
Diabetes	_____	Brother/Sister	_____	_____
Heart Attack or Disease	_____			
Alcoholism/Drug Abuse	_____			
High Blood Pressure	_____	Husband/Wife	_____	_____
Mental Illness/Anxiety/Suicide	_____	Son/Daughter	_____	_____
Stroke	_____			
Other	_____			

Continue on other side ➡

Health Questionnaire Continued

Name: _____ Date: _____

For **ESTABLISHED** Patients: You only need to **Update** us

When, if ever, did you last have any of the following:

Cholesterol check _____
Colonoscopy _____
EKG/Cardiogram _____
Mammogram _____

Pap Smear _____
Prostate exam _____
Tetanus (Last shot) _____
Treadmill stress test _____

Social History

Are you married? **YES / NO** Living with a partner? **YES / NO**

Have you ever felt unsafe or abused, either physically or emotionally? **YES / NO** Currently? **YES / NO**

Do you have children/dependents at home? Names & birthdates: _____

Are you employed? **YES / NO** What field? _____

What is your highest level of education? _____

Do you or have you ever smoked or chewed tobacco? **YES / NO**

 Packs per day _____ / yrs _____ Quit? _____ When? _____

Do you or have you ever used illegal drugs? **YES / NO** Type: _____

Do you drink alcohol? **YES / NO** What kind? _____ How much per week? _____

Have you been exposed to toxic substances? **YES / NO** What? _____

Do you drink caffeine daily? **YES / NO** How much? _____

Do you wear seat belts? **YES / NO**

Do you use car seats for your children if under 60lbs? **YES / NO / N/A**

Do you have a living will or advance directives? **YES / NO**

 No matter how old you are, you should consider having an advanced directive on file with us

 You can print out a copy from our website: **irvinefamilycare.com**

We want to emphasize that **REGULAR EXERCISE** is one of the most important things you can do to maintain your health!

What kind are you doing? _____ How often? _____

Review of Symptoms

Please circle any of the following that you are experiencing

General

Fatigue Fever Hopelessness Hot flashes Insomnia Night sweats Poor coordination
Recent weight loss or gain Loss of interest in usual activities

Skin

Change in pigmentation Eczema Hives Jaundice Rashes

ENT

Change in vision / hearing Dizziness Enlarged glands Glaucoma Headaches Hearing loss
Neck stiffness Nose bleeds Chronic sinus or ear problems

Respiratory

Asthma Difficulty breathing Frequent colds / coughing Shortness of breath Spitting up blood

Cardiac

Angina Chest pain Difficulty walking 2 blocks Heart murmur High blood pressure Palpitations
Swelling of hands / feet

Gastrointestinal

Abdominal pain / cramping Blood or dark stool Change in bowel habits Frequent diarrhea
Frequent indigestion / heartburn / gas / bloating Hepatitis Hemorrhoids Vomiting blood

Genitourinary

Difficulty urinating Frequent urination Loss of bladder control Unsatisfactory sex life

Musculoskeletal

Joint pain or swelling Difficulty walking Muscle cramping or weakness Varicose veins

Neuropsychiatric

Prior treatment for depression / psychiatric care? Fainting spells Paralysis Convulsions

Hematologic

Easy bruising Excessive bleeding after cuts Slowing healing after cuts

Anything else you want us to know?

PATIENT INFORMATION

Name: _____, _____, _____ ☐ Male ☐ Female
Last First M.I.

Address: _____, _____, _____
Street City State Zip

Home Phone: (____) _____ Business Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SSN: _____ E-Mail: _____

Driver's License Number: _____ Physician you are here to see: _____

Referred By: _____ Have you or any family member been seen here before? ☐ Yes ☐ No

Preferred Pharmacy: _____ Address: _____ Phone: (____) _____

GUARANTOR INFORMATION – *Must* be completed (Patient and/or Responsible Party)

Responsible Party Name: _____, _____, _____ ☐ Male ☐ Female
Last First M.I.

Date of Birth: _____ Driver's License #: _____ SSN: _____

Employer Name: _____ Employer Phone: (____) _____

Employer Address: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ ☐ HMO ☐ EPO ☐ PPO ☐ Private

Named of Insured (Policy Holder): _____, _____, _____
Last First M.I.

Address: _____, _____, _____
Street City State Zip

Date of Birth (Insured): _____ ☐ Male ☐ Female

Social Security Number: _____ Insurance ID Number: _____

Group Number: _____ Employer: _____

Relationship to ☐ Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ ☐ HMO ☐ EPO ☐ PPO ☐ Private

Named of Insured (Policy Holder): _____, _____, _____
Last First M.I.

Address: _____, _____, _____
Street City State Zip

Date of Birth (Insured): _____ ☐ Male ☐ Female

Social Security Number: _____ Insurance ID Number: _____

Group Number: _____ Employer: _____

Relationship to ☐ Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

EMERGENCY CONTACT INFORMATION

Name of Person to Contact: _____ Relationship: _____

Address: _____, _____, _____
Street City State Zip

Home Phone: (____) _____ Work Phone: (____) _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the insurance company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs, and any related fees to your bill. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency, the debt shall be void and unenforceable. I hereby acknowledge that I have read, understood, and agree to hereby give consent for treatment.

Patient's Signature: _____ **Date:** _____



Communicating With You

To effectively communicate with you about your medical and financial needs, we request that you complete this form identifying the best ways to provide you with your confidential information. We need to communicate test results, prescription information, financial information, or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email (Secure Patient Portal), and telephone, including text messages, leaving messages on your answering machine/voicemail.**

Please check all boxes that you give Irvine Family care permission to use for your communications:

☐ You may contact me by telephone	Phone Number: _____	☐ Cell	☐ Home	☐ Work
☐ You may leave a message/voicemail	Phone Number: _____	☐ Cell	☐ Home	☐ Work
☐ You may contact me through email (Secure Patient Portal)				
☐ You may contact me through secure texting	Cell Phone Number: _____			

Please list any person(s) you would like to have access to your billing, appointment, or health information, such as your spouse, caretaker, or other family member. We will ask for additional consent prior to releasing information related to psychiatric services and/or HIV test results.

Name/Phone Number	Relationship	Options
1:		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2:		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I have made.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of the notice of Privacy Practices for the above medical practice. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended notice of Privacy Practices will be made available at my next appointment.

If not signed by the patient please indicate the relationship to patient.

- ☐ Parent or guardian of minor patient
- ☐ Legal Guardian or conservator of an incapacitated patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

Signature of Patient/Responsible Party

Patient Date of Birth

Today's Date

Name of Patient/Responsible Party (Print)

Relationship to Patient



2 Osborn, Suite 180

Irvine, CA 92604

Phone: (949) 417-9820 Fax: (949) 417-9830

www.irvinefamilycare.com

Dear Patient,

We are concerned about you and want to provide the best possible quality of care for you. We have found by experience that we cannot do this without your active participation and cooperation. We ask that you read and sign the following statement to attest to your willingness to do so. Thank you.

The Physicians and staff of Irvine Family Care

By signing this form, I declare my understanding of the importance of follow-up as directed by the medical provider at Irvine Family Care. This includes the need for office visits and scheduling annual physical examinations as well as visits to recommended specialists and completing ordered labs/test. I further understand that it is my responsibility to retrieve test results from the patient portal (e-mail) (if instructed) from Lab Talk, or calling the office for test results if they are not in my (email) patient portal, after 14 days of the test being performed. I understand that if I do not follow-up as directed, I could be worsening a problem beyond the point of cure.

As a result of my failure to follow-up, I understand that I may be discharged as a patient of Irvine Family Care.

Please Print Name _____ **D.O.B** _____

Patient/Parent Signature _____ **Date** _____



2 Osborn, Suite 180

Irvine, CA 92604

Phone: (949) 417-9820 Fax: (949) 417-9830

IMPORTANT NOTICE

Irvine Family Care makes every effort to refer you to “in network” providers, laboratories and imaging facilities that are members of most health plans. However, due to changes in the healthcare industry, some insurance carriers have chosen to “contract” only with specific facilities for their members.

If your insurance carrier chooses to contract with a specific laboratory or imaging facility, it is your responsibility to notify the office so that we can refer you to that contracted provider. With more than 100 plans for which we are providers it is not possible for us to know the details of each of these plans as we are not always notified by your insurance carrier.

PLEASE BE AWARE THAT IT IS YOUR RESPONSIBILITY TO KNOW THE DETAILS OF YOUR HEALTH PLAN

If you are in doubt as to whether a procedure, laboratory test, imaging request, specialist or which types of office visits (sick vs. preventative) are covered and where it must be performed, please contact your insurance carrier and check.

Our office is not responsible for out-of-pocket expenses resulting from the use of a non-contracted provider/facility or for tests or procedures not covered under your specific benefit plan.

Thank you for your understanding.

Patient/Parent Signature

Date of Birth

Printed Name

Date



No Show/Late Cancellation Policy

This policy has been established to help us serve you better. It is necessary for us to make appointments in order to see our patients as efficiently as possible. When an appointment is not kept, this takes away valuable time which could have been used by another patient. No-shows and late cancellations delay the delivery of healthcare to other patients, some who are quite ill. A “no-show” is missing a scheduled appointment. A “late cancellation” is cancelling an appointment with less than 24-hour notice. We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case-by-case basis.

A charge of \$50 will be assessed for each no-show or late cancellation office visit appointment if less than 24-hour notice is given.

Please understand that insurance companies consider this charge to be entirely the patient’s responsibility. To cancel or reschedule an appointment please call our office and speak with the front desk. This policy is in effect to ensure that all of our patients have the opportunity to be seen in a timely manner.

Patient Name: _____ DOB: _____ Date: _____

Patient Acknowledgement (Please sign): _____