EL NORTE MEDICAL GROUP

PATIENT REGISTRATION

How did you hear about us?
- ☐ Newspaper
- ☐ Social media/Web site
- ☐ Insurance referral
- ☐ Family/Friend

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTHDATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX

BILLING ADDRESS	APT #	CITY	STATE	ZIP
PHYSICAL ADDRESS (If different from billing address)	APT #	CITY	STATE	ZIP

CELL PHONE ( )	HOME PHONE ( )	DAY PHONE ( )	EMAIL ADDRESS

PREFERRED CONTACT METHOD ☐ CELL ☐ HOME ☐ DAY ☐ EMAIL	MARITAL STATUS	MOTHER'S MAIDEN NAME	RACE	ETHNICITY

EMERGENCY CONTACT NAME	PHONE NUMBER ( )

PRIMARY EMPLOYER		SECONDARY EMPLOYER (If applicable)	
ADDRESS	SUITE #	ADDRESS	SUITE #
CITY, STATE, ZIP		CITY, STATE, ZIP	
WORK PHONE ( )	OCCUPATION	WORK PHONE ( )	OCCUPATION

POLICYHOLDER/GUARANTOR (If different than patient)

NAME (Last, First, M.I.)	SSN	BIRTHDATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX

BILLING ADDRESS	APT#	CITY	STATE	ZIP
PHYSICAL ADDRESS (If different from billing address)	APT#	CITY	STATE	ZIP

CELL PHONE ( )	HOME PHONE ( )	DAY PHONE ( )	EMAIL ADDRESS

PREFERRED CONTACT METHOD ☐ CELL ☐ HOME ☐ DAY ☐ EMAIL	MARITAL STATUS	MOTHER'S MAIDEN NAME	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF POLICY HOLDER	DOB	GROUP #	
RELATIONSHIP TO PATIENT		COPAY AMT $	
ADDRESS OF INSURANCE COMPANY	SUITE #	DEDUCTIBLE AMT $	
CITY, STATE, ZIP	PHONE ( )	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF POLICY HOLDER	DOB	GROUP #	
RELATIONSHIP TO PATIENT		COPAY AMT $	
ADDRESS OF INSURANCE COMPANY	SUITE #	DEDUCTIBLE AMT $	
CITY, STATE, ZIP	PHONE ( )	EFFECTIVE DATE	EXPIRATION DATE

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant El Norte Medical Group, Inc. to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Graybill Medical Group.

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE | DATE | RELATIONSHIP TO PATIENT

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EL NORTE
MEDICAL GROUP

PATIENT
FINANCIAL AGREEMENT

- All co-pays are due at the time of your office visit.
- If your health insurance plan r**equires a deductible that has not been met**, please be prepared to pay $100 toward your deductible at the time of service.
- If you are a **Medicare** beneficiary, we will bill Medicare for you. You will be responsible for deductibles and all non-covered services according to Medicare guidelines**. Please provide a copy of your most recent Medicare cards and any secondary insurance or supplement you may have.**
- **It is your responsibility to know your insurance, including Medicare.** Preventive care, such as routine exams, may not always be covered by your insurance. Please be aware that if an additional new problem is addressed at the time of your visit, an additional co-pay, deductible or office visit fee may be charged. If services are denied for payment by your insurance or we have not received your correct insurance information, you will be responsible for payment for these services.
- We will bill your insurance company for you. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred.
- Payment from your insurance company is expected within **45 days**. After 45 days, we will look to you for payment in full. Accounts that are 90 days past due are subject to submission to a collection agency or small claims court for the unpaid bills.
- If you are a **cash pay** patient, the amount you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment include, but are not limited to: laboratory tests, x-rays, injections, special procedures or additional office visit charges.
- Any laboratory procedures that are ordered during today's visit will be billed separately by the laboratory.
- If at any time you should experience financial hardship and need to make special arrangements, please contact our Billing Office at (760) 291-6621.
- A **$25 cancellation fee** will apply for missed appointments or failure to cancel within one business day.

I have read and understand the above statements. I agree to comply with the financial policies of the office and I am financially responsible for my account.

Patient Name (please print) _____ Patient DOB _____

Patient/Guardian Signature_____ Date _____

Assignment of Benefits

Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim. Payment of medical benefit is to be paid directly to Graybill Medical Group for all services rendered. *Initials* _____

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PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to El Norte Medical Group to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

	NAME	DOB
Spouse		
Children		
Guardian		
Caregiver		
Sister		
Brother		
Friend		
Emergency Contact		
Other		

You may discuss my (please check all that apply)

☐ Visit Notes ☐ Laboratory Results ☐ X-rays ☐ Reports ☐ All Services and Treatment Rendered

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print)_____ Patient Date of Birth_____

Patient/Guardian Signature_____ Date_____

PLEASE COMPLETE BOTH SIDES

EL NORTE MEDICAL GROUP

LATEX ALLERGY QUESTIONNAIRE

Patient Name _____ Date of Birth_____

(5).... 1. Have you ever had an anaphylactic reaction to latex devises or products? ..... ☐ Yes ☐ No

(1).... 2. Do you have spina bifida, myeloma, or myelodysplasia?..... ☐ Yes ☐ No

(*).... 3. Have you had a reaction to the following common sources of latex? ..... ☐ Yes ☐ No

Check all that apply:

☐ Balloons	☐ Rubber gloves	☐ Belts, bras, suspenders
☐ Latex birth control devices	☐ Dental cofferdams	☐ Cuffs, elastic waistbands
☐ Erasers	☐ Face masks	☐ Rubber grips
☐ Hot water bottles	☐ Rubber bands, balls	☐ Ostomy bags
☐ Foam pillows	☐ Baby bottles, nipples	☐ Footwear
☐ Pacifiers, teething rings	☐ Elastic bandages	

(4).... If you have checked any of the above in #3, have you experienced any of the following reactions?..... ☐ Yes ☐ No

☐ Wheezing/shortness of breath ☐ Immediately on contact to the food (Urticaria, Hives)
☐ Chest tightness

(*).... "YES" answers to the following indicate potential for latex sensitivity:

☐ Runny nose / congestion ☐ Swelling
☐ Itching (e.g., hands, eyes) ☐ Chapping or "cracking" of the hands

(*).... 4. Do you have any allergies/sensitivities to the following foods? ..... ☐ Yes ☐ No

Check all that apply:

☐ Avocados	☐ Potatoes	☐ Kiwis	☐ Papaya
☐ Bananas	☐ Chestnuts	☐ Peaches	☐ Tomatoes

(3).... If you have checked any of the above in #4, have you experienced any of the following reactions? ☐ Yes ☐ No

☐ Wheezing /shortness of breath ☐ Immediately on contact to the food (Urticaria, Hives)
☐ Chest tightness

(*).... "YES" answers to the following indicates potential for latex sensitivity:

☐ Runny nose / congestion ☐ Swelling
☐ Itching (e.g. hands, eyes) ☐ Chapping or "cracking" of the hands

(1).... 5. As an infant / child did you have multiple surgeries? ..... ☐ Yes ☐ No

(1).... 6a. Are you a health care worker and have repeated exposure to products containing LATEX?..... ☐ Yes ☐ No

If yes, to which products do you have repeated exposure? _____

(1).... 6b. Does your job involve working in a factory where rubber or latex products are manufactured? ☐ Yes ☐ No

If yes, what products do you manufacture? _____

OFFICE USE ONLY

MAXIMUM SCORE POSSIBLE: 16-4 or below complete #1A & 1B

1. TOTAL SCORE_____
   If 5 or ABOVE, complete # 2&3 and INITIATE LATEX PRECAUTIONS
   If 4 or BELOW and "YES" ANSWERS are marked for SENSITIVITY - questions 3&4

1a. PHYSICIAN(S) NOTIFIED Yes (Name of MD / Time)_____ ☐ No

1b. Does Physician want to initiate LATEX PRECAUTIONS? ☐ Yes ☐ No
   If 5 or above continue the following questions

2. Identification of the patient and room _____
   LATEX added to allergy computer screen? ☐ Yes - patient banded with "LATEX PRECAUTIONS" armband ☐ No
   LATEX PRECAUTIONS sticker ☐ Yes - on door ☐ Yes - on bed ☐ Yes - on wall ☐ Yes - on chart
   KARDEX marked with "LATEX PRECAUTIONS" ☐ Yes

3. Physician(s) Notified: Patient placed on "LATEX PRECAUTIONS" (Name of MD / Time) _____

_____ _____
RN/ LVN/ RT/ OT/ MA Date

PLEASE COMPLETE BOTH SIDES

EL NORTE
MEDICAL GROUP

TB QUESTIONNAIRE

Patient Name _____ Date of Birth _____

Today's Date _____

1. Have you ever had TB (Tuberculosis)?	☐ Yes	☐ No
2. Have you been living with anyone in the past 2 years who has been diagnosed with TB?	☐ Yes	☐ No
3. Have you had a persistent cough and night sweats for more than 2 weeks?	☐ Yes	☐ No
4. Have you had a persistent cough and fever for more than 2 weeks?	☐ Yes	☐ No
5. Have you had a persistent cough and loss of appetite for more than 2 weeks?	☐ Yes	☐ No
6. Have you been coughing up or spitting up bloody sputum (saliva)?	☐ Yes	☐ No

PLEASE COMPLETE BOTH SIDES

ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE

PATIENT NAME		TODAY'S DATE
PATIENT DATE OF BIRTH	☐ MALE ☐ FEMALE	NAME OF SPOUSE/SIGNIFICANT OTHER

SOCIAL HISTORY

BIRTHPLACE	PATIENT'S OCCUPATION
NATIONALITY	EDUCATION
RELIGION	MARITAL STATUS / # YEARS?
RECREATIONAL DRUG USE? ☐ YES ☐ NO / TYPE	CHILDREN
TOBACCO USE? ☐ YES ☐ NO / TYPE	
# PACKS PER DAY / # YEARS / LAST USED	PETS
ALCOHOL USE? ☐ YES ☐ NO / # DRINKS _____ per ☐ Day ☐ Week ☐ Month	EXERCISE ☐ YES ☐ NO / TYPE / HOW OFTEN?
IF HEAVY USE, HOW MANY YEARS? / LAST USED	RECENT OR FREQUENT TRAVEL DESTINATIONS
CAFFEINE USE? ☐ YES ☐ NO / TYPE / # SVGS/ DAY	

MEDICAL CONDITIONS

Have YOU ever had (check appropriate boxes):

- ☐ Cancer / Type _____
- ☐ Heart attack
- ☐ Coronary artery disease
- ☐ Rheumatic fever
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Gallstones
- ☐ Liver disease
- ☐ Hepatitis/Jaundice
- ☐ Ulcer disease
- ☐ Heartburn / Reflux
- ☐ Asthma
- ☐ Seizures
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Positive TB skin test
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Frequent bladder infection
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Polio
- ☐ Chicken pox
- ☐ Infectious mono
- ☐ Anemia
- ☐ Frequent sinus infections
- ☐ Glaucoma
- ☐ Thyroid issues
- ☐ Hives
- ☐ Depression
- ☐ Head injury
- ☐ Broken bones
- ☐ Blood transfusions
- ☐ Sexually transmitted diseases: Herpes, HIV, etc.
- ☐ Gonorrhea, Chlamydia
- ☐ Syphilis
- ☐ Intravenous drug abuse
- ☐ Needle injury
- ☐ Mumps
- ☐ Migraines
- ☐ Prostate enlargement
- ☐ Cystic fibrosis
- ☐ Malaria
- ☐ Other: _____

IMMUNIZATIONS

- ☐ Measles, Mumps and Rubella Vaccine
- ☐ Chicken Pox Vaccine
- ☐ Hepatitis B Vaccine
- ☐ Influenza Vaccine
- ☐ Pneumococcal Vaccine
- ☐ Tetanus Booster

PAST SURGICAL HISTORY (If applicable, please check the box and enter the year)

	YEAR		YEAR		YEAR
☐ Eyes (laser or vision corrected)	_____	☐ Gall bladder	_____	☐ Spinal surgery/back	_____
☐ Eyes (cataract/glaucoma)	_____	☐ Intestine/colon	_____	☐ Orthopedic (hips/knees)	_____
☐ Ears	_____	☐ Hemorrhoids	_____	☐ Shoulders/feet/hands	_____
☐ Sinus/nasal septum	_____	☐ Hernia	_____	☐ C-Section	_____
☐ Tonsils/adenoid	_____	☐ Breast	_____	☐ Vasectomy	_____
☐ Thyroid	_____	☐ Uterus/hysterectomy	_____	☐ Tubal ligation	_____
☐ Heart	_____	☐ Ovaries	_____	☐ OTHER _____	_____
☐ Stomach	_____	☐ Spinal surgery/neck	_____	_____	_____
☐ Varicose veins	_____	☐ Prostate	_____	_____	_____

PLEASE COMPLETE BOTH SIDES

ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE (continued)

PATIENT NAME	PATIENT DATE OF BIRTH

CURRENT MEDICATIONS

NAME	DOSE	TIMES/DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Allergies or adverse reactions to medications? _____

FAMILY MEDICAL HISTORY

Has anyone in your FAMILY ever had any of the following (check appropriate boxes and list relationship):

	Relationship		Relationship		Relationship
☐ Cancer/Type _____	_____	☐ Dialysis	_____	☐ Crohn's/colitis	_____
		☐ Chronic lung disease	_____	☐ Alzheimer's	_____
☐ Diabetes	_____	☐ Tuberculosis	_____	☐ Alcoholism	_____
☐ Cardiac/dysrhythmia	_____	☐ Rheumatoid arthritis	_____	☐ Bleeding tendency	_____
☐ Congestive heart failure	_____	☐ Thyroid issues	_____	☐ Anemia	_____
☐ Coronary artery disease	_____	☐ Osteoporosis	_____	☐ Gout	_____
☐ Valvular heart disease	_____	☐ Cystic fibrosis	_____	☐ Depression	_____
☐ High blood pressure	_____	☐ Asthma	_____	☐ Mental illness	_____
☐ High cholesterol	_____	☐ Peptic ulcer	_____	☐ Seizures	_____
☐ Stroke	_____	☐ Gallstones	_____	☐ Migraine headaches	_____
☐ Kidney stones	_____				
☐ Kidney disease	_____				

☐ OTHER _____ Relationship _____

GYNECOLOGICAL / OBSTETRICAL HISTORY

Name of OB/GYN (please print): _____

Age when you started menstruating: _____

Date of last Pap smear: _____

History of abnormal Pap smears? ☐ Yes ☐ No

Date of last mammogram: _____

History of abnormal mammograms? ☐ Yes ☐ No

Menstrual cycles? ☐ Regular ☐ Irregular

Painful periods? ☐ Yes ☐ No

Age at menopause: _____

Number of pregnancies: _____

Number of births: _____

☐ Vaginal ☐ C-Section

Method of contraception: _____

PLEASE COMPLETE BOTH SIDES

ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE (continued)

PATIENT NAME	PATIENT DATE OF BIRTH

Have you been feeling any of these symptoms recently?

GENERAL

☐ Fever ☐ Fatigue ☐ Night sweats

☐ Other _____

HEAD, EYES, EARS, NOSE & THROAT

☐ Vision changes ☐ Headaches

RESPIRATORY

☐ Shortness of breath ☐ Cough

CARDIOVASCULAR

☐ Chest pain ☐ Palpitations

VASCULAR

☐ Leg cramps with exercise

GASTROINTESTINAL

☐ Vomiting ☐ Diarrhea ☐ Constipation

GENITOURINARY

☐ Burning with urine ☐ Blood in the urine

METABOLIC/ENDOCRINE

☐ Cold intolerance ☐ Heat intolerance

NEURO/PSYCHIATRIC

☐ Dizziness ☐ Anxiety ☐ Depression

DERMATALOGIC

☐ Rash ☐ Itching

MUSCULOSKELETAL

☐ Back pain ☐ Joint pain

HEMATOLOGIC

☐ Easy bruising ☐ Easy bleeding

IMMUNOLOGICAL/ALLERGY

☐ Food allergies ☐ Environmental allergies

Any other symptoms not mentioned above?

_____

_____

_____

_____

_____

_____

_____

PLEASE COMPLETE BOTH SIDES

ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE (continued)

PATIENT NAME	PATIENT DATE OF BIRTH

PHARMACY

Your prescriptions will be sent electronically to the pharmacy of your choice. To which pharmacy may we send your prescriptions? (Please check below.)

☐ CVS ☐ Wal-Mart ☐ Rite Aid ☐ Walgreens ☐ Target ☐ Sav-On ☐ Costco

Other: _____

Location (cross street and city): _____

Best number to reach you if we have additional questions: _____

HEALTH MAINTENANCE

When was your last physical? _____

When was your last cholesterol blood work? _____

If over age 50, when was your last colon cancer screening? _____ ☐ Sigmoidoscopy ☐ Colonoscopy

If over age 65, when was your last DEXA (bone density) screening? _____

If female, when was your last Pap smear? _____

If female over age 40, when was your last mammogram? _____

VACCINATIONS

Please list, to the best of your knowledge, the most recent date you received the following vaccine(s):

1. Tetanus _____
2. Flu vaccine (given annually from the Fall to Spring) _____
3. Pneumonia vaccine (if over 65 or certain health conditions) _____
4. Shingles vaccine (if over age 60) _____

Are you interested in receiving any of the above? ☐ Yes ☐ No

ADVANCE DIRECTIVE

Do you have an Advance Directive? ☐ Yes ☐ No

Would you like to discuss Advance Directives? ☐ Yes ☐ No