Today's Date____________

PATIENT REGISTRATION FORM

Social Security # ______-_____-________ Patient Name:____

Date of Birth:_____/_____/________ Sex: _____Female _____Male

Address:____________________________ Apt #:_______ City:________________State:_____ Zip____________

Home phone:____________________________________ Cell phone:________________________________

Email Address:___________________________________ Would you like informational emails? _____Yes ______No

Preferred method of communication? ☐ Email ☐ Home phone ☐ Cell ☐ Mail or ☐ Other:_____________

Reason For Today's Visit: ____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Race (check one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other__________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Language:** ________________________

Employer/Occupation:______________________________ Work phone:__________________________

Employment Status: ____ Full Time ____ Part Time ____ Retired ____ Self ____ Not Employed

Primary Care Physician(optional)_________________________ phone/fax #:_____________________________

Pharmacy name/Location______________________________ Pharmacy phone #: ______________________

FINANCIAL RESPONISIBLE PARTY, IF SAME AS PATIENT check here ☐, IF NOT THE PATIENT **COMPLETE THIS SECTION**

Last Name:___________________________________ First:____

Date of Birth:______/_____/________ Social Security # _______-______-__________

Address:____________________________ Apt #:_______ City:________________State:_____ Zip____________

Employer:____________________________________ Employer phone:_____________________________

Employer Address:____ Occupation:____________________

INSURANCE INFORMATION

Name of Insurance Carrier:_________________________ Do you have a Secondary ?_________________________

Subscriber's name: _______________________________________ **Date of Birth:** ______/_____/________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _________________________

How did you hear about us?

☐ Insurance Co. website ☐ Referral by MD ☐ Friend / Family

☐ PVMC website ☐ YELP ☐ Other:____

☐ Employer ☐ Returning Patient

PLAYA VISTA MEDICAL CENTER
PATIENT INFORMATION

Welcome to Playa Vista Medical Center. To better serve you, please be as complete as possible.

NAME: ____

MAIN PROBLEM (5 words or less): ____

PAST MEDICAL PROBLEMS (check if you have had):

___migraine headaches ___tuberculosis (TB) ___elevated cholesterol ___kidney/bladder problems
___blood transfusion ___seizures ___lung problems ___elevated triglycerides
___stomach ulcers ___blood clots ___diabetes ___high blood pressure
___heart problems ___blood from rectum ___leg swelling ___other problems____________

____

__surgery (please list operations and year done):____

____

____

___Been pregnant? How many times?_______ How many children?_______ Date of last period.____________

PLEASE LIST YOUR MEDICATIONS (frequency of use and dosage): ____

____

____

PLEASE LIST YOUR ALLERGIES TO MEDICATIONS (and what kind of allergic reaction you have): ____________

____

____

PUT A CHECK IF YOU:

___smoke cigarettes How many a day?______ How many years?______
___drink alcohol How many a week?_____ How many years?______
___use any non-prescription drugs?

LIVING SITUATION: ___alone ___with spouse ___with family ___other

What is/was your occupation?____Retired?____________

PUT A CHECK IF THERE IS A FAMILY HISTORY OF:

___strokes ___high blood pressure ___heart disease ___stomach problems ___cancer
___asthma ___emphysema ___diabetes ___kidney problem ___psychiatric problems

__parents alive
__mother deceased Cause?____________________________________ Age:____________
__father deceased Cause?____________________________________ Age:____________

PUT A CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE LAST 24 HOURS:

___fever ___eye problems ___nausea ___fast heart beat ___leg swelling
___sore throat ___ear problems ___vomiting ___urinary problems ___headache
___cough ___irregular heartbeat ___diarrhea ___abdominal pain ___weakness
___difficulty breathing ___chest pain ___shortness of breath ___pain with urinating ___wheezing

___Are there any questions you would like to discuss with the physician in private?

____

PLAYA VISTA MEDICAL CENTER

SAFE ENVIRONMENT FOR PATIENT CARE: Weapons or other dangerous objects, illegal drugs and drugs not prescribed by the patient's physician are not permitted in the patient treatment area. The medical center's obligation to provide a safe environment for patient care must override the patient's right to privacy. The medical center reserves the right to search the patient treatment area and to confiscate such objects upon reasonable probable cause.

FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she here by individually obligates himself/herself to pay the account of the medical clinic in accordance with the regular rates and terms of the medical clinic and or as set forth by the terms of managed care contracts entered into by medical center, and/or applicable Workers' Compensation regulation. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fees and collection expense. All delinquent account shall bear interest at the legal rate.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, the medical clinic or attending physician may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the hospital's charge, including but not limited to, insurance companies, health care services plan, or worker's compensation carriers. (Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.)

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she as agent or patient, direct payment to the medical clinic or physicians, medical groups, and practitioners of any insurance benefits otherwise payable to the undersigned for his/her services at the rate not to exceed medical clinic regular charges. It is agreed that payment to the clinic, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

MEDICARE INSURANCE BENEFITS AND EXCLUSIONS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers and information needed for this or a related medical claim. I request that payment of authorized benefits be made on my behalf. Some services may not be covered by Medicare, such as the following: 1) Worker's Compensation 2) dental 3) cosmetic surgery 4) custodial care 5) personal comfort items, and any service determined to be unnecessary or unreasonable by Medicare. The undersigned understand that the Department of Health and Human Services Health Care and Financing Administration requires that the patient's signature be released Medicare/Medi-Cal eligibility information. The undersigned authorizes the Social Security Administration to release the following information to medical health center.

PATIENT ENROLLED IN MANAGED CARE HEALTH PLAN: I understand that I am responsible for guarantee of my eligibility and obtaining approval for services from my HMO/PPO plan. Or I must plan for payment of services rendered at this time. I agree to be financially responsible for any and all charges for the visit if not covered by my health plan.

HEALTH CARE SERVICES PLANS: This clinic maintains a list of health care services plan with which it has contracted. A list of such plans is available upon request from the financial office. The medical clinic has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full cost of all services rendered to him/her by the clinic if he/she belongs to a plan which does not appear on the above mentioned list.

MEDICAL AND SURGICAL CONSENT: The patient is in the care and supervision of his/her attending physicians and it is the responsibility of the medical clinic and its staff to carry out the instructions of such physician. The undersigned hereby consents to x-ray examinations, laboratory procedures, emergency treatment, medical or surgical treatments or medical clinic services rendered to the patient under general and special instructions of the physician.

NOTICE OF PRIVACY PRACTICE: The privacy practice notice is posted in Playa Vista Medical Center. I have read and understand how my health information may be used and disclosed. If I have questions or concerns I may request a copy of the Notice of Privacy Practice from Playa Vista Medical Center.

CLAIMS PROCESSING: We have verified your eligibility on-line. In order for us to see you today, we will need to collect $ ________ . Once the insurance processes your claim, you will receive an explanation of benefits notifying you of the final amount you are responsible for. If we have under collected, we will balance bill you, if we have over collected, we will send you a refund after the first of next month. ________ ***INITIAL HERE***

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof, and is the patient, or is duty authorized by the patient as patient's general agent to execute the above and accept its terms.

SIGN HERE

______________________________ ____________________
Signature of Patient or Responsible party — Date

______________________________ ____________________
Signature of Witness — Date