

Beach Family Doctors Medical Group

9131 Adams Ave.
Huntington Beach, CA 92646
AND
2001 Westcliff Dr. Suite 200
Newport Beach, CA 92660

714-845-5900 Office
714-845-5922 Fax

Welcome to our practice!

Office Hours / After Hours

Office hours are 8:30am-5:00pm Monday through Friday. Phone hours are 9:00am-12:00pm and 2:00pm-5:00pm. We are closed all major holidays.

For urgent medical issues after regular office hours that can't wait until the next business day, please call our office and leave a message with our service so they can page the doctor. For all other issues, please call us during our regular phone hours.

Same Day/ Urgent Appointments

We understand that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please call the office if you feel you have an urgent matter that needs same day attention. If your doctor is unavailable, we have a Nurse Practitioner and a Physician Assistant who are able to assist you. For our GNP HMO members, Urgent Care is not authorized during business hours. Call 9-1-1 for emergencies.

Medication Refills

We don't want you to run out of your medications. We recommend that you notify the pharmacist to send us a "refill request" and allow us at least 48 hours to process your routine refill. If you prefer to call us, please do so during our regular phone hours and allow 3-4 business days for us to refill your medications.

Canceling Appointments and No-Shows

We require a 24 hours advance notice if you are unable to make it to your scheduled appointment.

We charge a \$50.00 no show fee if you fail to keep your scheduled appointment or are more than 15 minutes late for your scheduled appointment time.

Communication

We believe in having good communication between our staff and our patients. We encourage you to express any question or concerns so we may better serve you. We ask that you treat our staff in a polite manner for they are here to help you.

Our online patient portal, MyChart allows you to communicate with our office, request appointments and view and print lab/radiology orders and results. Please ask the office staff to sign you up with your email address.

Treatment without an Office Visit

If you are sick and treated over the phone, there may be a \$25.00 fee for services rendered without an office visit.

Co-pays and Deductibles/New Patients/Returned Checks

Co-pays and deductibles are due at time of service. We will only accept cash or credit for a new patient's first visit. There will be a \$25.00 service charge for returned checks.

I have read and understand these policies including the NO SHOW FEE POLICY.

X Print name: _____ Date: _____

X Signature: _____

BEACH FAMILY DOCTORS

PATIENT INFORMATION

Name (Last, First, Middle)				Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>			
Street address:			City, State Zip		DOB:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>
SSN#		Home Phone:		Cell Phone:		Email Address:	
Student Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact Name:		Emergency Contact Number:	
Primary Employer:				Secondary Employer (if Applicable)			
Address:				Address:			
City, State Zip		Work Phone:		City, State Zip		Work Phone:	

RESPONSIBLE PARTY INFORMATION (if Different than above)

Name (Last, First, Middle)			SSN#		DOB:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Street address:			City, State Zip		Phone:		
Relationship To Patient:							

PRIMARY INSURANCE

Name of Insurance Company:			Policy #:				
Name of Insured:			DOB:		Group #:		
Address of Insurance Company:				Relationship to Patient:			

SECONDARY INSURANCE

Name of Insurance Company:			Policy #:				
Name of Insured:			Group #:				
Address of Insurance Company:				Relationship to Patient:			

I hereby assign my insurance benefits to be made directly to my physician or assisting physicians, for services rendered. I attest that the above information is accurate. I understand that I am responsible for knowing my benefits/coverage and will be financially responsible for all charges not covered by my insurance company. I 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 agree that a photocopy of this agreement shall be as valid as the original. All charges are the direct responsibility of the patient. I understand that services cannot be rendered on the assumption that charges will be paid by the insurance company. If there are problems collecting payment, attorney's fees, collection agency costs and any related fees will be added to my bill. I acknowledge that I have read, understand and agree to give consent to assess, treat, test.

Signature of Patient/Guardian

Date

Health Questionnaire - Birth to 6 years

Name: _____ DOB: _____ Age: _____ Date: _____

PARENTS/GUARDIANS

Mother _____ Occupation _____ Phone _____
Father _____ Occupation _____ Phone _____
Marital Status _____

Allergies to Medications _____

Current Medications _____

Vaccinations up to date? Y N (Please provide records)

MEDICAL HISTORY

Birth History: (circle one) Vaginal _____ Cesarean (reason why) _____

Birth weight _____ Days in Hospital _____

Any Complications? _____

Hospitalizations/Surgeries? _____

CHILDHOOD ILLNESSES: Has the child had any of the following? Circle Y for Yes and N for No

Asthma	Y N	Bronchitis	Y N	Allergies	Y N
Chicken Pox	Y N	Strep Throat/Pharyngitis	Y N	Eczema	Y N
Ear Infections	Y N	Seizures/Convulsions	Y N	Urinary Infections	Y N

FAMILY HISTORY

Has a Blood Relative ever had:

Cancer	Y N	Heart Disease	Y N	Tuberculosis	Y N
Diabetes	Y N	High Blood Pressure	Y N	Seizures	Y N
Birth Defects	Y N	High Cholesterol	Y N	Asthma	Y N

DEVELOPMENT

Roll over _____ months Crawled _____ months Walked _____ months

Mama/Dada _____ months Toilet trained _____ months

NUTRITIONAL HISTORY

Breast fed _____ months

Milk	_____	Servings/day	_____	Type	_____
Fruit	_____				
Vegetables	_____				

SOCIAL HISTORY

Any smokers in the house? Y N Daycare _____

Brothers/Sisters and ages _____

Do you have pets? Y N

Any other concerns you want to tell the doctor?

Person completing this form: _____ Relationship: _____

Signature: _____ Date: _____

Request for Medical Information

1. **Authorization** : I authorize disclosure of information and health records as described below:

Name of Patient: _____ Date of Birth: _____

Telephone: _____

2. **Record Holder:** _____

Address: _____

Phone: _____ Fax: _____

3. **Records May Be Released To:**

Beach Family Doctors

9131 Adams Ave.

Huntington Beach, CA 92646

AND

2001 Westcliff Dr. Suite 200

Newport Beach, CA 92660

Office: 714-845-5900

Fax: 949-999-8113

4. **Type of Information:** This authorization is limited to the following types of information -

All Records

Discharge Summary

Progress Notes

Operative/Procedure

History/Physical Exam

Treatment for Alcohol/Drug Abuse

Consultation Reports

HIV Test Results

Emergency Department Reports

Psychiatric Records

Laboratory Reports

Billing Information

Radiology/Nuclear Medicine Reports

Other _____

5. **Dates of Service:** All or From _____ To _____

6. **Use if Information:** The individual or entity identified above is permitted to use my information for the following purposes: **Please check all that apply.**

Continuing Medical Care

Second Opinion

Personal

Insurance

Legal

Other (please specify) _____

7. **Duration:** This authorization is valid for 90 days from the date next to my signature, unless otherwise noted here: _____

8. **Signature:**

Print Name: _____

Signature: _____

Date: _____

If signed by other than patient, indicate your relationship to the patient: _____

Witness Signature: _____

Date: _____

AUTHORIZATION FOR OTHER ADULT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize

_____ (an adult into whose care the minor(s) has been entrusted)

to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of

_____ (name(s) and address of minor(s))

deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code §6910.

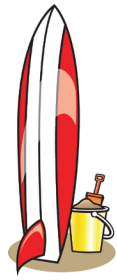
Signed: _____ Dated: _____

Print Name: _____

Please specify relationship to minor:

parent with legal custody

guardian with legal custody



**BEACH
FAMILY
DOCTORS**
714-845-5900

Release of Medical Information

I authorize disclosure of medical information and health records as described below:

Name of Patient: _____

Date of Birth: _____

Any and All Records May Be Released to:

Another Physician, Hospital, Laboratory or other Medical Entity Involved in my Medical care.

Signature: _____

Print Name: _____ **Date:** _____

If signed by Guardian, indicate relationship to patient.

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I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our office.

X _____
Signature Print Name Date

If not signed by the patient, please indicate relationship:

Parent of minor Guardian of minor Conservator of an incompetent patient

Communication:

Our general office policy is that no information may be left with anyone but the patient. We realize that many patients may find multiple methods of communication acceptable, even though total confidentiality cannot be guaranteed. Below is a list of communication options. Please place a check mark next to the methods that are acceptable means of communicating information regarding your healthcare, **and write the corresponding information on the line provided**. Please understand that by checking a box you are granting us permission to COMMUNICATE ANY AND ALL INFORMATION TO YOU IN THIS MANNER. Again, a check mark means that we can leave information in that manner. If in doubt, we recommend NOT checking a box.

Home Answering Machine or Voice Mail: _____ Acceptable

Office Voice Mail: _____ Acceptable

Cell Phone Voice Mail: _____ Acceptable

E-Mail Address: _____ Acceptable

Message with Spouse: _____ Acceptable

Message with Other: _____ Acceptable

X _____
Signature Print Name Date

Emergency Contact: _____ Phone: _____