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 ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
Street address:		City, State Zip	DOB:	Sex: M☐ F☐
SSN#	Home Phone:	Cell Phone:	Email Address:	
Student Status: ☐Full-Time ☐Part-Time	Smoker: ☐Yes ☐No	Veteran: ☐Yes ☐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☐ F☐
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 7-18 years

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

PARENTS/GUARDIANS

Mother_____ Occupation_____ Phone_____
Father _____ Occupation_____ Phone_____

Allergies to Medications_____
Current Medications _____
Vaccinations up to date? Y N (Please provide records)

_____
_____

PAST MEDICAL HISTORY: Has the child had any of the following? **Circle Y for Yes and N for No**

Asthma	Y	N	Anemia	Y	N	Kidney Infections	Y	N
Chicken Pox	Y	N	Dehydration	Y	N	Heart Murmur	Y	N
Ear Infections	Y	N	Seizures	Y	N	Eczema	Y	N
History of Molestation or Abuse			……..	Y	N			

Has the child ever been hospitalized? If yes, please explain:

_____
_____

Has the child been under a doctor's care for any continuing illness or condition? If yes, please explain:

_____
_____

Has there been any surgery or major injury? If yes, please explain:

_____
_____

FAMILY HISTORY

Has any Blood Relative ever had:

Cancer	Y	N	Diabetes	Y	N	Heart Trouble	Y	N
Stroke	Y	N	High Blood Pressure	Y	N	Seizures	Y	N
Mental Illness	Y	N	Alcohol or Drug Abuse	Y	N	Bleeding Problem	Y	N
Asthma	Y	N	Bleeding Tendencies	Y	N	Arthritis	Y	N
Any other illnesses run in the family?.....				Y	N	Hereditary Disease	Y	N

Please list the general health and list any illnesses for each family member:

Father _____
Mother _____
Brothers/Sisters _____
Maternal Grandparents _____
Paternal Grandparents _____

SOCIAL HISTORY

Circle one: Are parents Single Married Separated Divorced Widowed Other
Any smokers in the house? Y N
Do you have pets? Y N
Brothers/Sisters and ages _____
Extracurricular activities/hobbies (sports, arts, etc.) _____
_____

DIET HISTORY	Servings/day		Servings/day
Dairy	_____	Meat	_____
Fruit	_____	Caffeine	_____
Vegetables	_____	Junk Food	_____
Juice	_____	Other	_____

REVIEW OF CURRENT HEALTH

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

General:

Fever	Y	N
Chills	Y	N
Night Sweats	Y	N
Weight loss	Y	N
Weakness or fatigue	Y	N

School:

Homework Problems	Y	N
Behavior Problems	Y	N
School Problems	Y	N
Attention Problems	Y	N
Hyperactivity	Y	N
Other _____		

Skin:

Hives, eczema or rash	Y	N
Frequent infections	Y	N
New or changing moles	Y	N
Change in hair or nails	Y	N
Abnormal pigment	Y	N
Itching	Y	N

Head, Eyes, Ears, Nose & Throat

Wear glasses	Y	N
Headaches	Y	N
Sneezing/runny nose	Y	N
Sinus problems	Y	N
Nosebleeds	Y	N
Decreased hearing	Y	N
Dental problems	Y	N
Ear problems or disease	Y	N

Gastrointestinal:

Nausea or vomiting	Y	N
Heartburn or indigestion	Y	N
Diarrhea	Y	N
Constipation	Y	N
Blood w/ bowel movements	Y	N
Pain w/ bowel movements	Y	N
Abdominal pain or cramping	Y	N

Nerves & Mental Health:

Numbness or tingling	Y	N
Dizziness or vertigo	Y	N
Fainting spells	Y	N
Depression (feeling sad often)	Y	N
Anxiety (afraid often)	Y	N
Unusual eating habits	Y	N

Urinary:

Loss of urine	Y	N
Urinates more frequently	Y	N
Night time urination	Y	N
Painful or burning urination	Y	N

Musculoskeletal:

Painful joints (including back)	Y	N
Leg pain w/ walking	Y	N
Weakness of muscles or joints	Y	N
Hand and feet swelling	Y	N

Respiratory:

Cough	Y	N
Shortness of breath	Y	N
Upper respiratory infection	Y	N
Wheezing or asthma	Y	N

Blood System:

Any bleeding problems	Y	N
Easy bruising	Y	N
Bleeding gums	Y	N

Cardiovascular:

Chest pain or pressure	Y	N
Irregular or rapid heartbeat	Y	N
Heart murmur	Y	N

Neck:

Thyroid problems or goiter	Y	N
Swollen or enlarged glands	Y	N

Allergies:

Hay fever	Y	N
Other _____		

Gynecological:

Period started	Y	N
Are they regular?	Y	N

Social:

Dating	Y	N
Ever had intercourse	Y	N
Currently sexually active	Y	N
Ever smoked	Y	N
Ever done drugs	Y	N
Ever drank alcohol	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
   Phone: 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: _____

HIPAA Notice of Privacy Practices - Acknowledgement of Receipt

Beach Family Doctors Medical Group
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AND
2001 Westcliff Dr. Suite 200
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714-845-5900 Office
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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:_____

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.

_____