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*

Adult Health Questionnaire

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

PAST MEDICAL HISTORY: Had you ever had any of the following? **Circle Y for Yes and N for No**

Measles	Y	N	Heart Disease	Y	N	Lung Disease	Y	N
Chicken Pox	Y	N	High Blood Pressure	Y	N	Liver Disease	Y	N
Tuberculosis	Y	N	Thyroid Disease	Y	N	Anemia	Y	N
Alcoholism	Y	N	Venereal Disease	Y	N	Asthma	Y	N
Drug Abuse	Y	N	Intestinal Problems	Y	N	Seizures	Y	N
Depression	Y	N	Stroke	Y	N	Ulcers	Y	N
Eating Disorder	Y	N	Diabetes	Y	N	Cancer	Y	N
History of Molestation or Abuse ……..				Y	N			
Have you ever thought about suicide?.....				Y	N			

ALLERGIES TO MEDICATIONS: Penicillin / Aspirin / Morphine / Codeine / Sulfa / Iodine Dye/ Adhesive Egg / Tetanus / Vaccine / Flu Vaccine / Other Medications

_____

_____

CURRENT MEDICATIONS	**PAST HOSPITALIZATIONS**		**SURGERIES**	
	Reason	Year	Type	Year
_____	_____		_____	
_____	_____		_____	
_____	_____		_____	
_____	_____		_____	
_____	_____		_____	
_____	_____		_____	
_____	_____		_____	

Vitamins/herbs/nonprescription

_____

_____

_____

Describe any chronic illness or disease:

_____

_____

_____

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 -	Y	N
Asthma	Y	N	Bleeding Tendencies	Y	N	Tendencies		
Any other illnesses run in the family?.....				Y	N			

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

Father _____

Mother _____

Brothers/Sisters _____

Grandparents _____

SOCIAL HISTORY

Marital Status:	Dependents:	Do you exercise?	Y	N	Sexual History:		
Single _____	_____	Days per week	_____				
Married _____	_____	Do you use Tobacco?	Y	N	Is your sex life		
Divorced _____	_____	Pack per week	_____		satisfactory?	Y	N
Separated _____	_____	Do you drink Alcohol?	Y	N	Do you use		
Widowed _____	_____	Drinks per week	_____		contraception?	Y	N
		Any Street Drugs like			What type?	_____	
		Marijuana or Cocaine?	Y	N	_____		

What is your current profession?_____ Any exposure to fumes, dust or chemicals? Y N

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

PLEASE ENTER THE LAST DATE OF YOUR LAST

Immunization		**Screening Tests**	
Tetanus	_____	Pap	_____
Pneumonia	_____	Mammo	_____
Hepatitis B	_____	Prostate	_____
MMR	_____	Cholesterol	_____
Hepatitis A	_____	Colon Cancer	_____
Chickenpox	_____	Bone Density	_____

GYNECOLOGY

Number of Pregnancies		_____
Miscarriages		_____
Living Children		_____
Periods every _____ days		
Painful Periods	Y	N
Heavy Periods	Y	N
Last Period		_____
Abnormal Pap Smear	Y	N

Please review the following list of symptoms. Circle Y if you are CURRENTLY HAVING or if you FREQUENTLY HAVE the symptom listed.

GENERAL		
Fevers	Y	N
Chills	Y	N
Night Sweats	Y	N
Weight Loss	Y	N
Weakness	Y	N
Fatigue	Y	N
Snoring	Y	N
Insomnia	Y	N

SKIN		
Hives	Y	N
Eczema	Y	N
Changing skin lesion	Y	N
Change in Hair	Y	N
Change in Nails	Y	N
Abnormal Pigment	Y	N
Itching	Y	N

GASTROINTESTINAL		
Nausea	Y	N
Vomiting	Y	N
Heartburn	Y	N
Indigestion	Y	N
Diarrhea	Y	N
Constipation	Y	N
Gal Bladder Prob.	Y	N
Hemorrhoids	Y	N
Blood in Stool	Y	N
Pain w/ Stool	Y	N
Change in Bowel Habits	Y	N
Abdominal Pain	Y	N
Tarry or Dark Stool	Y	N
Food Sticking in Throat	Y	N

RESPIRATORY		
Cough	Y	N
Shortness of Breath	Y	N
Infections	Y	N
Wheezing	Y	N
Asthma	Y	N
Coughing up Blood	Y	N

HEAD EARS NOSE THROAT		
Headache	Y	N
Ringing Ears	Y	N
Ear Problems	Y	N
Sneezing	Y	N
Runny Nose	Y	N
Sinus Problems	Y	N
Hay Fever	Y	N
Allergies	Y	N
Nose Bleeds	Y	N
Hearing Loss	Y	N
Dizziness	Y	N
Dental Problems	Y	N

URINARY TRACT		
Loss of Urine	Y	N
Frequent Urination	Y	N
Nighttime Urination	Y	N
Painful Urination	Y	N
Kidney Stones	Y	N
Blood in Urine	Y	N
Frequent Infections	Y	N
Weakened Stream	Y	N
Difficulty Starting	Y	N
Prostate Trouble	Y	N

HEART CIRCULATION		
Chest pain	Y	N
Chest Pressure	Y	N
Shortness of Breath w/ walking	Y	N
Shortness of Breath w/ Laying Down	Y	N
Irregular Heartbeat	Y	N
Rapid Heartbeat	Y	N
Feeling Smothered at Night	Y	N
Bleeding Problems	Y	N
Easy Bruising	Y	N
Bleeding Gums	Y	N

MUSCLES AND JOINTS		
Painful Joints	Y	N
Back Pain	Y	N
Walking Leg Pain	Y	N
Weakness	Y	N
Swelling Joints	Y	N

NERVES MENTAL HEALTH		
Numbness	Y	N
Tingling	Y	N
Dizziness/Vertigo	Y	N
Fainting Spells	Y	N
Nerve Problems	Y	N
Depression	Y	N
Anxiety	Y	N
Panic	Y	N
Other Mental Prob.	Y	N

ENDOCRINE		
Thyroid	Y	N
Hormone Therapy	Y	N
Hot Flashes	Y	N

SPECIAL QUESTIONS FOR THE DOCTOR:

_____

_____

_____

_____

_____

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

9131 Adams Ave.
Huntington Beach, CA 92646
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Newport Beach, CA 92660

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 ☐

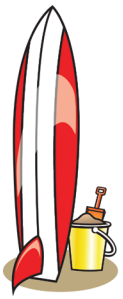
E-Mail Address: _____Acceptable ☐

Message with Spouse: _____ Acceptable ☐

Message with Other: _____ Acceptable ☐

X_____ _____ _____
Signature Print Name Date

Emergency contact: _____Phone:_____



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.

_____