Orange County Primary Care Medical Group

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PATIENT INFORMATION SHEET

Date of Birth _____ Sex _____

First Name _____ Middle Initial _____ Last Name _____

Patient Address Line 1 _____ Patient Address Line 2 _____

City _____ State _____ Zip _____

Social Security Number _____

Phone Numbers:

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Phone _____

Primary Care:

Physician _____ City/Town _____ Phone#: _____

Pharmacy Name _____ Pharmacy Tel #: _____

Emergency Contact Name _____ Emergency Contact Home Phone _____ Emergency Contact Cell Phone _____ Email _____

INSURANCE INFORMATION

(Subscriber) _____ Insured's Birth Date _____

Primary Insurance Name _____ Primary Plan Name _____ Primary Subscriber ID _____ Primary Group No. _____

Secondary Insurance Name _____ Secondary Plan Name _____ Secondary Subscriber ID _____ Secondary Group No. _____

I hereby assign all medical benefits to, include major medical benefits to which I am entitled, including Medicare, Private insurance and other health plans to Orange County Primary Care. This assignment will remain in effect until revoked by me in writing. A Photocopy of the agreement is to be considered as valid and and an original; I understand that I am financially responsible for all the charges whether or not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I also acknowledge receipt of a copy of the
HIPAA Privacy Policy

_____

Signed (Patient, Parent or Legal Guardian)

Date:

_____

The Patient Health Questionnaire-2 (PHQ-2)

First Name _____ Last Name _____ Date of Visit: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

0 = Not at all
1 = Several Days
2 = More than half the days
3 = Nearly every day

1. Little interest or pleasure in doing things

- 0
- 1
- 2
- 3

2. Feeling down, depressed or hopeless

- 0
- 1
- 2
- 3

Email

_____

The Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

0 = Not at all

1 = Several Days

2 = More than half the days

3 = Nearly every day

1. Little interest or pleasure in doing thigns

- 0
- 1
- 2
- 3

2. Feeling down, depressed, or hopeless

- 0
- 1
- 2
- 3

3. Trouble falling or staying asleep, or sleeping too much

- 0
- 1
- 2
- 3

4. Feeling tired or having little energy

- 0
- 1
- 2
- 3

5. Poor appetite or overeating

- 0
- 1
- 2
- 3

6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down

- 0
- 1
- 2
- 3

7. Trouble concentrating on things, such as reading the newspaper or watching television

- 0
- 1
- 2
- 3

8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual

- 0
- 1
- 2
- 3

9. Thoughts that you would be better off dead, or of hurting yourself in some way

- 0
- 1
- 2
- 3

Total Score:

1-4 minimal depression

5-9 mild depression

10-14 moderate depression

15-19 moderately severe depression

20-27 severe depression

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

First Name _____ Last Name _____ Date of Birth _____

Signature

Date _____

ADVANCE MEDICAL DIRECTIVES

Definition

Advance directives can protect your right to refuse or accept medical care if you ever become mentally or physically unable to choose or communicate your wishes due to an illness or injury.

Why have an "Advance Directive"?

This protects your right to make medical choices that can affect your life. It helps your family by allowing them to avoid the responsibility and stress of making difficult decisions. It helps your physician by providing guidelines for your care.

What kind of situation might cause me to need an Advance Directive?

IF YOU EVER:

1. Have irreversible brain damage or brain disease, which can affect your ability to think as well as communicate.
2. Have a permanent coma or other unconscious state which can leave you without hope of recovery.
3. Have a terminal illness in which you are expected to die within a short period of time.

What kinds of things can Advance Directives discuss:

1. CPR- A procedure is used to restore stopped breathing or heartbeat.
2. IV therapy (intravenous) This is used to provide food, water, and / or medication through a tube placed in a vein.
3. Feeding tubes- Are inserted through the nose, throat or through a hole in the abdomen (stomach wall) to provide liquid food/nutrition when you cannot eat, chew or swallow yourself.
4. Respirators- Are machines used to keep a patient breathing when they are unable to breathe on their own. (previously called "iron lungs")
5. Dialysis- A method of cleansing the blood by a machine when kidneys are no longer working properly.

Advance Directives allow you to state whether you choose any of these procedures or wish to refuse them.

How do I get an "Advance Directive"?

You can make a "living will" or a durable power of attorney for health care. You can contact an attorney to get one of these forms, or you can simply put your wishes in writing; be as specific as possible, then sign the document and have it witnessed and notarized.

Give a copy of your advanced directive to your physician as part of your medical records, and inform your family that you have done so. You can also make special request or statements such as regarding organ donation, etc.

Where can I get more information or help in preparing advance directives?

Any family lawyer or attorney

The state Attorney General's Office

The internet @ **http://www.echonvc.com/choice**

Local hospitals

Local hospice agencies

Local home health agencies

Long term care facilities, such as local nursing homes

First Name _____ **Last Name** _____

Please SIGN your name (acknowledging that you have read the above):

Orange County Primary Care Medical Group

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.P.A., the Health Insurance Portability and Protection Act requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe. **Orange County Primary Care** requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature of Patient/Guardian:

Date

_____

Name of Patient/Guardian:

_____

Authorization To Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory/pathology results to the family members indicated below. This consent form will not allow **Orange County Primary Care** to release any other information to these family members.

I authorize **Orange County Primary Care** to release my laboratory/pathology results and reports to the following individuals.

1.	**Relationship to Patient**
_____	_____
2.	**Relationship to Patient**
_____	_____
3.	**Relationship to Patient**
_____	_____

Signature of Patient/Guardian:

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives **Orange County Primary Care** to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab, pathology or procedure results, or to ask a patient to call Orange County Primary Care. regarding an issue or concern. At no time will a representative of Orange County Primary Care discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature of Patient/Guardian:

Monarch HealthCare A Medical Group, Inc.

HEALTH QUESTIONNAIRE

First Name _____ Last Name _____

Age _____ Date _____

Social Security Number _____

PAST MEDICAL HISTORY:

Measles	Mumps	Chicken Pox	Polio
No	No	No	No
Yes	Yes	Yes	Yes
Rheumatic Fever	**Scarlet Fever**	**Cancer**	**Stroke**
No	No	No	No
Yes	Yes	Yes	Yes
Seizure	**Heart Disease**	**Hypertension**	**Tuberculosis**
No	No	No	No
Yes	Yes	Yes	Yes
Pneumonia	**Asthma**	**Hepatitis**	**Liver Disease**
No	No	No	No
Yes	Yes	Yes	Yes
Peptic Ulcer	**Kidney Disease**	**Diabetes**	**Thyroid Disease**
No	No	No	No
Yes	Yes	Yes	Yes
Venereal Disease	**Anemia**	**Phlebitis / Blood Clot**	**Gout**
No	No	No	No
Yes	Yes	Yes	Yes

PAST SURGICAL HISTORY:

Any other significant illnesses, injuries or hospitalizations:

Year	Illness
_____	_____
Year	Illness
_____	_____
Year	Illness
_____	_____

Year _____ Illness _____

Year _____ Surgery _____

Year _____ Surgery _____

Year _____ Surgery _____

Year _____ Surgery _____

Allergies:

(Medications & Food)

1. _____ Reaction _____

2. _____ Reaction _____

3. _____ Reaction _____

4. _____ Reaction _____

List Current Medications:

1 _____ 2 _____ 3 _____ 4 _____

5 _____ 6 _____ 7 _____ 8 _____

IMMUNIZATIONS:

Influenza _____ Tetanus _____ Pneumococcal _____

Other _____ If "Other" list Year _____

Social History:

Marital Status _____ Number of Children _____

Professional Title _____ Hrs/Wk _____

Job Satisfaction

Yes

No

Patient Smoking Status

Patient Smoking Frequency

Patient Smoking Start Date

Patient Smoking End Date

Caffeine

- Yes
- No

Cups/Drinks per Day

Alcohol

Amount

Frequency

Recreational Drugs

Advance Directive / Living Will

- Yes
- No

PATIENT FAMILY HISTORY:

Name

Age

Health

Age - at death

Cause

Name

Age

Health

Age - at death

Cause

Name

Age

Health

Age - at death

Text Input

Name

Age

Health

Age - at death

Cause

Name

Age

Health

Age - at death

Cause

PATIENT'S HUSBAND / WIFE'S FAMILY HISTORY:

Name

Age

Health

Age - at death

Cause

Name

Age	Health	Age - at death	Cause

Name

Age	Health	Age - at death	Cause

Name

Age	Health	Age - at death	Cause

Have any blood relatives ever had:

Cancer
- No
- Yes

Tuberculosis
- No
- Yes

Diabetes
- No
- Yes

Heart Trouble
- No
- Yes

High Blood Pressure
- No
- Yes

Stroke
- No
- Yes

Convulsions
- No
- Yes

Suicide
- No
- Yes

Mental Illness
- No
- Yes

Bleeding tendency
- No
- Yes

Gout or other arthritis
- No
- Yes

Hereditary Defects
- No
- Yes