Inland Physicians
Medical Group

9525 Monte Vista Ave Ste #105, Montclair CA 91763
1113 Alta Ave Ste #220, Upland CA 91786
Ph: (909)626-1205 F: (909)625-1977
www.inlandphysiciansmg.com

PATIENT INFORMATION

Last Name______________ **First Name**______________ **M.I.**____ **Email**______________

Address ______________ **City** ______________ **State** ______ **Zip** ______________

Soc. Sec. # ______________ **Age** ________ **DOB** ______________ **Phone #** ______________

Gender: ☐ Male ☐ Female **Race:** ______________ **Religion:** ______________

Ethnicity: ______________ **Preferred Language:** ______________ ☐ **Refused** ☐ **Decline**

PHARMACY NAME & ADDRESS: ______________

PRIMARY INSU RANCE:

Name ______________ **Policy #** ______________ **Phone #** ______________

SECONDARY INSURANCE:

Name ______________ **Policy #** ______________ **Phone #** ______________

INSURED PARTY INFORMATION IF DIFFERENT THAN ABOVE

Name ______________ **Phone #** ______________

DOB ______________ **Soc. Sec. #** ______________ **Relation** ______________

Address ______________ **City** ______________ **State** ________ **Zip** ______________

Ins. Co. Name ______________ **Policy #** ______________ **Phone #** ______________

EMERGENCY CONTACT:

Name ______________ **Relation**: ______________ **Phone #** ______________

PRIOR OR CURRENT PRIMARY CARE PHYSICIAN:

NAME:______________ **Phone #:** ______________

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PATIENT NAME: ______________________________ **DATE:** ____________________

DOB: ____________ **AGE** __________ **SEX** _______ **HT.** _________ **WT.** _________

ALLERGIES

Are you allergic to any medications, pills, food, etc.?

Drug/ Allergen	Reactions	Onset Date:

VACCINATIONS

Have you received a pneumonia vaccine with the past year? No Yes, Date ________ Don't know

Have you received a flu vaccine this season? No Yes, Date _______ Don't know

When was your last tetanus? Date: ______________ Don't know

Have you received a Covid-19 vaccine No Yes, Dates: _____ Don't Know

PAST MEDICAL: Please circle Yes or No to any medical problems.

Anemia	Y / N	Headaches/Migraine	Y / N
Anxiety	Y / N	Hepatitis	Y / N
Arthritis and/or Gout	Y / N	High Blood Pressure	Y / N
Asthma	Y / N	High Cholesterol	Y / N
Bleeding Problems	Y / N	Kidney Disease/Stones	Y / N
Coronary Artery Disease	Y / N	Overweight/Obesity	Y / N
Congestive Heart Failure	Y / N	Pneumonia	Y / N
Cancer (If yes, specify type)	Y / N	Sexually Transmitted Disease	Y / N
Convulsions/Seizures	Y / N	Stroke	Y / N
Dental/Oral Problems	Y / N	Thyroid Disease	Y / N
Depression	Y / N	Tuberculosis (or positive Tb test)	Y / N
Diabetes	Y / N	Gastritis/Ulcer	Y / N
HIV/AIDS	Y / N		

SURGICAL HISTORY: Please list any previous operations or procedures.

Procedure / Operation	Date	Surgeon	Hospital

FAMILY MEDICAL HISTORY:

Relation	Problem	Onset Age	Died of Age	Notes

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WOMEN'S HEALTH HISTORY:

Total number of pregnancies:_______ Number of births:________

Date (month/day if known) of last menstrual period if you are still menstruating:_______________________

Age at beginning of periods (menstruation):_______________________

Age at end of periods (menopause): _______________________

SOCIAL HISTORY

TOBACCO USE: Quit? ☐ Yes ☐No If so, when? ___________

Smoke Cigarettes/Cigar/Pipe: ☐Never ☐No ☐Yes; How Often: __# Packs: _____

Snuff ☐Never ☐Yes ☐No Quit Date: ____________________How Long: __________________

Chew ☐Never ☐Yes ☐No Quit Date: ____________How Long: _____

ALCOHOL USE: ☐Yes ☐No Quit Date: ______ **How often**: ☐ Daily ☐ Frequently ☐ Social ☐ Rarely

DRUG USE:

Do you use marijuana or recreational drugs? ☐No ☐Yes Type: ____________________________

Have you ever used needles to inject drugs? ☐No ☐Yes Type: _____________________________

CURRENT MEDICATION RECORD

MEDICATIONS: Please list all medications you currently take, **including appetite suppressants, vitamins, e**

MEDICATION NAME	STRENGTH	FREQUENCY	START/END DATE

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SYMPTOM REVIEW

Gastrointestinal
☐ poor appetite
☐ abdominal pain
☐indigestion
☐trouble swallowing
☐ diarrhea
☐constipation
☐change in bowel habits
☐nausea or vomiting
☐rectal bleeding or blood in stool
☐ history of liver disease or abnormal liver tests

Cardiovascular
☐chest pain
☐history of angina or heart attack
☐history of high blood pressure
☐history of irregular heart beat
☐history of poor circulation

Pulmonary (lungs)
☐shortness of breath
☐persistent cough
☐coughing up blood
☐asthma or wheezing

Muscle/joint/bone
☐swelling of ankles or legs
☐pain, weakness, or numbness in arms, hands, back , legs , feet, neck or shoulders

Neurologic
☐history of stroke
☐blackouts or loss of consciousness

Anything else?
☐are you experiencing any unusually stressful situation
☐are they any specific personal issues you would like to discuss?

General
☐ poor sleep
☐weight gain/loss of 10 + lbs in last 6 mths
☐fever
☐headache
☐depression

Eyes, ears, nose, throat

☐blurred vision
☐other change in vision
☐history of glaucoma or cataracts
☐loss of hearing
☐ringing in ears
☐sinus problems
☐hoarseness

Genitourinary
☐frequent or painful urination
☐blood in urine

Skin
☐itching
☐easy bruising
☐change in moles

Endocrine
☐history of diabetes
☐history of thyroid disease
☐change in tolerance to hot or cold weather
☐excessive thirst

Women only
☐abnormal bleeding
☐bleeding between periods, date of last mammogram_______

Men only
☐ PSA

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TB Risk Assessment Questionnaire

*A person who is at increased risk for TB should have a yearly TB test.

You may be at increased risk for TB if you answer YES to any of the following questions:	
Do you have a family member or close contact with history of confirmed or suspect TB?	**Yes Date(s):** **No**
Are you from Asia, Africa, Central/South America? (These areas have a higher prevalence of TB)	**Yes Date(s):** **No**
Do you live in an "out of home" placement facility?	**Yes Date(s):** **No**
Do you have a history of confirmed or suspected HIV infection	**Yes Date(s):** **No**
Do you live with an individual who is HIV positive?	**Yes Date(s):** **No**
Have you been or do you live with an individual that has been incarcerated in the last 5 years?	**Yes Date(s):** **No**
Do you live among or are you frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, resident in a nursing home?	**Yes Date(s):** **No**

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Financial Policy

All Patients: The patient is responsible for all services rendered regardless of insurance coverage. The full responsibility of payment rests with you, the patient or responsible party.

Cash Patients: All services rendered on a cash basis must be paid in full at the time of service.

Private Insurance: We must have a fully completed and signed insurance form at the time of service. If you cannot supply us with all the necessary billing information, your account will be handled the same as a cash patient. Deductible and co-payment amounts are due at the time of service.

Medicare: We must have a copy of your Medicare card and any secondary insurance(s). We do accept assignment on Medicare claims, which means that you will be responsible only for your deductible and 20% of allowed charges. There are certain procedures and supplies, which are NON-COVERED services for Medicare patients. If you need such services you will be informed that they are NON-COVERED and if you still wish to receive such services in this office they will be on a cash basis at the time of service.

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, A 24-HOUR NOTICE IS REQUESTED. PLEASE CONTACT OUR OFFICE TO INFORM OUR STAFF OF ANY CHANGES. SHOULD YOU FAIL TO DO SO, THE FOLLOWING FEES MAY APPLY: A$35 CANCELLATION FEE FOR CONSULTATIONS/$25 CANCELLATION FEE FOR FOLLOW-UP VISITS/ $35 PFT CANCELLATION /$75 NO-SHOW /$50 NO-SHOW CONSULTATION VISITS/ $35 NO SHOW FOLLOW-UP VISITS/ $25 CANCELLATION TELEHEALTH/$35 NO SHOW TELEHEATH VISIT/ A 48 HOUR NOTICE REQUIRED FOR ALL SLEEP STUDIES. $175 FOR CANCELLATION /NO SHOWS $300.00. ALL FEES WILL BE DIRECTLY BILLED TO YOU, THE PATIENT. HEALTH INSURANCES DO NOT COVER THIS EXPENSE. OTHER CHARGES MAY APPLY; A COPY OF THE FEE SCHEDULE CAN BE PROVIDED UPON REQUEST.

IF AT ANY TIME YOU SHOULD EXPERIENCE FINANCIAL HARDSHIP, PLEASE MAKE OUR OFFICE AWARE OF THE SITUATION. WE ARE ALWAYS WILLING TO MAKE SPECIAL ARRANGEMENTS FOR THOSE PATIENTS WHO NEED EXTRA HELP. IF YOU NEED TO MAKE ARRANGEMENTS, PLEASE ASK TO SPEAK WITH THE OFFICE MANAGER.

Financial Agreement: I, the undersigned, hereby authorize you to make payments directly to Inland Physicians Medical Group for all basic and major medical expenses. I fully understand that I am financially responsible for any balance.

Medical Records: I, the undersigned, hereby grant authorization for the release of any information required to process the medical claims. A copy of this authorization is as valid as the original.

Consent for Treatment: I, the undersigned, hereby consent to the administrator of and performance of all diagnostic procedures and treatment, which, in the judgment of my physician, may be considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my attending physician, the physician will not be liable for the consequences of such decision.

I have carefully read and understand all of the above and accept, approve, and agree to **Inland Physicians Medical Group** *Office Financial Policy*.

____ ________________

Patient or Responsible Party Signature **Date**

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Notice of Privacy Practices

I hereby give my consent for Inland Physicians Medical Group, to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation (TPO). (The Notice of Privacy Practices provided by Inland Physicians Medical Group, describes such uses and discloses more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Inland Physicians Medical Group, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Inland Physicians Medical Group, Attention: Privacy Official at 9525 Monte Vista Ave #105 Montclair, CA 91763

NOTICE TO PATIENTS OPEN PAYMENTS DATABASE, EFFECTIVE JANUARY 1, 2023: For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospital be made available to the public. You may search this federal database for payments made to physicians and teaching hospitals by visiting this website: https://openpaymentsdata.cms.gov/

Signed: ______________________________ Date: ______________________________________

Print Name: __________________________ Telephone: __________________________________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: ____

____

____

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Patient Partnership Plan

Dear Patient:

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your *best possible health* requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.). These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment. Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

______________________________ _______________
Patient Signature Date

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

- ☐ **Home Telephone No. ______________________________**
  - ☐ Acceptable to leave message with detailed information.
  - ☐ Leave message with call back number only.
- ☐ **Work Telephone No. ______________________________**
  - ☐ Acceptable to leave message with detailed information.
  - ☐ Leave message with call back number only.
- ☐ **Written Communication**
  - ☐ Acceptable to mail to my home address.
  - ☐ Acceptable to mail to my work/office address.
  - ☐ Acceptable to fax to this number __________________________
- ☐ **Other ____**
  ____

I authorize Inland Physicians Medical Group physicians and/or staff to disclose *PHI* to the following members of my family or person/s responsible for my healthcare (check all that apply):

- ☐ Spouse: Name _______________________________________
- ☐ Daughter/s: Name/s ____
- ☐ Son/s: Name/s ____
- ☐ Extended Care Facility ____
- ☐ Other: ____
  ____

____ ________________________
Print Name **Date of Birth**

____ ________________________
Patient Signature **Date**

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Request for Release of Medical Records

Dates: From: ____________ to ________________

PLEASE RELEASE RECORDS TO:

- ☐ **Inland Physicians Medical Group**
  9525 Monte Vista Ave #105
  Montclair, CA 91763
  P: (909) 626-1205
  F: (909) 625-1977

- ☐ **Inland Physicians Medical Group**
  637 N 13th Ave
  Upland, CA 91763
  P: (909) 985-8321
  F: (909) 985-0842

I HEAREBY REQUEST A COPY OF THE FOLLOWING REPORT:

- ☐ **Consultation**
- ☐ **Laboratory**
- ☐ **History and Physical**
- ☐ **Progress Notes**
- ☐ **EKG**
- ☐ **Laboratory**
- ☐ **X-Ray**
- ☐ **CT Scan**
- ☐ **PET Scan**
- ☐ **Any and all Radiology**

Other: ____

Date: ______________

Patient Name: ____________________________
Patient DOB: _____________________________
Patient Signature: ________________________________

Expires: Indefinitely