Inland Physicians Medical Group

9525 Monte Vista Ave Ste 105 Montclair, CA 91763
Phone: (909) 621-0009
Fax: (909) 399-9265

Dear Sir or Madam,

Welcome to Inland Physicians Medical Group, we are honored to be your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

You have an appointment scheduled with _____ on _____ _____

at _____ am / pm. If this is not correct, please call the office.

In order to make your appointment run more smoothly, please bring/fill out the following:

- **FORMS:** Please fill out the enclosed forms and return to our office prior to your scheduled appointment.
- **MEDICAL RECORDS:** Insure you bring Medical Records from prior Primary Care office.
- **INSURANCE CARD:** (primary or secondary cards). We will need to make copies of your cards.
- **CO-PAYs:** (HMO's and other insurances that require a co-pay). All Co-Pays must be paid at the time of your visit. There will be an additional processing charge for any Co-Pay billing.
- **MEDICATIONS:** Please bring in a complete list of current medications.

Please arrive promptly to your schedule appointment. If you are more than 15 minutes late to your appointment you might be rescheduled.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

THIS NEW PATIENT PACKET MUST BE RETURNED BY MAILING, FAXING, OR EMAILING IT BACK TO OUR OFFICE PRIOR TO YOUR APPOINTMENT WITH PHYSICIAN. THANK YOU FOR YOUR COOPERATION.

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, A 24-HOUR NOTICE IS REQUESTED. PLEASE CALL (909)621-0009 TO INFORM OUR STAFF OF ANY CHANGES. SHOULD YOU FAIL TO DO SO, A FEE WILL BE DIRECTLY BILLED TO YOU.

Thank you. We look forward to meeting you and taking care of you.

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Last Name_____ **First Name** _____ **M.I.** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Soc. Sec. # _____ **Age** _____ **DOB** _____ **Phone #** _____

CA DL# _____ **Marital Status:** ❑ Married ❑Widow ❑ Divorce ❑ Single ❑Separated ❑Dating

Gender: ❑ Male❑ Female Race: _____ **Religion**: _____

Ethnicity: _____ **Preferred Language:** _____ ❑ **Refused** ❑ **Decline**

Preferred Pharmacy Name/Address: _____

Employer _____ **Occupation** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

PRIMARY INSURANCE
Name _____ **Policy #** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

SECONDARY INSURANCE
Name _____ **Policy #** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

INSURED PARTY INFORMATION IF DIFFERENT THAN ABOVE

Name _____ **Phone #** _____

DOB _____ **Soc. Sec. #** _____ **Relation** _____

Address _____ **City** _____ **State** _____ **Zip** _____

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

Address _____ **City** _____ **State** _____ **Zip** _____

EMERGENCY CONTACT:

Name _____ **Relation**: _____ **Phone #** _____

Prior or current Primary Care Physician:_____ **Phone #:** _____

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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, A $35 CANCELLATION FEE FOR NEW PATIENTS/$25 CANCELLATION FEE FOR FOLLOW-UP PATIENTS/ $50 PFT CANCELLATION /$100 NO-SHOW FEE FOR PFTS /$50 NO-SHOW FOLLOW-UP PATIENTS/$100 FOR NO SHOW NEW PATIENT/ SLEEP STUDY CANCELLATION $175.00 /NO SHOWS $300.00 UNLESS A 48 HOUR NOTICE IS GIVEN. ALL FEES WILL BE DIRECTLY BILLED TO YOU, THE PATIENT. HEALTH INSURANCES DO NOT COVER THIS EXPENSE.

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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PATIENT NAME: _____ **DATE:** _____

DOB: _____ **AGE** _____ **SEX** _____ **HT.** _____ **WT.** _____

CURRENT MEDICAL PROBLEM

What problem brought you here? _____
What symptoms are you having? _____
When did the symptoms begin? _____
Has your appetite changed in the last six months? Increased Decreased Stayed the same
Has your weight changed in the last six months? No Yes If yes, Gained _____lbs Lost _____lbs
Has your overall energy level changed? Increased Decreased Stayed the same

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 5 years? 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

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		

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PATIENT NAME: _____ **DOB:** _____

SURGICAL HISTORY

Please list any previous operations or procedures.

Procedure / Operation	Date	Surgeon	Hospital

FAMILY HISTORY

Relation	Problem (Heart disease, cancer, stroke, diabetes, etc)	Onset Age	Died of Age	Notes

WOMEN'S HEALTH HISTORY:

Total number of pregnancies:_____Number of births:_____
Date (month/day if know) 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: ❑Never ❑Yes ❑No Quit Date: _____ How Long: _____ # Packs: _____ # Cigs: _____

OTHER TOBACCO:

Cigar ❑Never ❑Yes ❑No Quit Date: _____ How Long: _____ # Packs: _____ # Cigs: _____
Pipe ❑Never ❑Yes ❑No Quit Date: _____ How Long: _____ # Packs: _____ # Cigs: _____
Snuff ❑Never ❑Yes ❑No Quit Date: _____ How Long: _____ # Packs: _____ # Cigs: _____
Chew ❑Never ❑Yes ❑No Quit Date: _____ How Long: _____ # Packs: _____ # Cigs: _____

ALCOHOL USE: ❑Yes ❑No Quit Date: _____ **How often**: ❑ Daily ❑ Frequently ❑ Social ❑ Rarely

DRUG USE:

Do you use marijuana or recreational drugs? ❑Yes ❑No Type: _____
Have you ever used needles to inject drugs? ❑Yes ❑No Type: _____

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PATIENT NAME: _____ **DOB:** _____

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

Patient Name: _____
Date of Birth: _____

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

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

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PATIENT NAME: _____ **DOB:** _____

CURRENT MEDICATION RECORD

MEDICATIONS: Please list all medications you currently take, including appetite suppressants, vitamins, etc.

MEDICATION NAME	STRENGTH	FREQUENCY	START/END DATE	PRESCRIBING PHYSICIAN	DISPENSING PHARMACY

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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 Pulmonary 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 Pulmonary 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 9635 Monte Vista Ave #205 Montclair, CA 91763

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 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
  (909) 621-0009
  (909) 399-9265

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: _____