

**Natomas Family Practice
Patient History Form**

(This medical document is strictly confidential and will not be released without your written authorization)

Last Name: _____ **First Name:** _____ **Middle:** _____

Date of Birth: _____ **Birth Place(City, State, Country):** _____

MEDICAL HISTORY

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemorrhoids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		
Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		

Date of Last: _____ **Tetanus Shot:** _____ **Sigmoidoscopy/Colonoscopy:** _____
Mammogram: _____ **Pap Smear:** _____

Previous Surgeries:	Date(s):	Hospital,City,State:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (please include prescription, over the counter, vitamins, herbal remedies, etc):

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES: _____

SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed
Alcohol Use: Never Rarely Moderate Daily Binge
Tobacco Use: Never Previously, but quit in: _____ Current Use (packs/day): _____
Drug Use: Never Previously, but quit in: _____
 Current Use (type/frequency): _____
Education: High School _____ Yrs College _____ Yrs Post Graduate _____ Yrs
Current Occupation: _____ **Prior Occupation:** _____
Have you ever experienced physical, emotional or sexual abuse in your home or relationship? _____
Please name a unique or interesting fact about yourself: _____

FAMILY HISTORY

Name, Age(s)	Disease	If deceased, age and cause
Father: _____	_____	_____
Mother: _____	_____	_____
Siblings: _____	_____	_____
_____	_____	_____
Children: _____	_____	_____
_____	_____	_____

HIPAA NOTICE OF PRIVACY PRACTICES AND POLICIES

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH THE HIPAA NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPAA COMPLIANCE OFFICER IN PERSON OR BY PHONE AT OUR MAIN PHONE NUMBER **(916) 928-0856**.

SIGNATURE BELOW IS ONLY ACKNOWLEDGEMENT THAT YOU HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THE HIPAA POLICY.

SIGNATURE: _____ DATE: _____

IF NOT SIGNED BY PATIENT:

NAME OF PERSON SIGNING FOR PATIENT: _____

RELATIONSHIP TO PATIENT: _____

NATOMAS FAMILY PRACTICE
LATE AND MISSED APPOINTMENT POLICY
(PLEASE READ CAREFULLY)

SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THE NATOMAS FAMILY PRACTICE LATE AND MISSED POLICY.

SIGNATURE: _____ DATE: _____

IF NOT SIGNED BY PATIENT:

NAME OF PERSON SIGNING FOR PATIENT: _____

RELATIONSHIP TO PATIENT: _____

CONSENT FOR TREATMENT OF A MINOR

I, _____ THE PARENT/GUARDIAN OF
(CHILD'S NAME) _____ CONSENT TO THE MEDICAL TREATMENT(S) RENDER
TO MY CHILD HERE AT NATOMAS FAMILY PRACTICE. THIS AUTHORIZATION REMAINS IN EFFECT UNTIL A WRITTEN
NOTICE IS GIVEN REVOKING THIS CONSENT.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

RELEASE OF PATIENT INFORMATION

Natomas Family Practice

Patrick C. Lau, M.D. Steve D. Hwang, D.O.
2410 Del Paso Road
Sacramento, Ca 95834
Ph# (916) 928-0856

MY MEDICAL INFORMATION MAY BE RELEASED OR DISCUSSED WITH THE FOLLOWING PERSON(S) ON MY BEHALF:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

If any details, please explain: _____

I DO NOT WISH FOR MY MEDICAL INFORMATION TO BE RELEASED OR DISCUSSED WITH ANYBODY AT THIS TIME.

EXPIRATION: This authorization is effective immediately and will remain in effect until _____, or for one year from the date of the signature below.

REVOCACTION: This authorization is subject revocation by written notice by the undersigned below. Revocation of this authorization will not effect any action taken in reliance to this authorization before receipt of the revocation notice.

REDISCLASURE: The request may not lawfully further the protected health information unless another authorization is obtained or required by law.

SIGNATURE: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents with my direction to the health provider. I understand that, by signing this form, I am confirming my authorization that the healthcare provider may use and/or disclose to the person(s) on this form the protected health information described on this form. I understand that I have the right to receive a copy of this authorization.

SIGNATURE: _____ Date: _____

IF NOT SIGNED BY PATIENT:

NAME OF PERSON SIGNING FOR PATIENT: _____

RELATIONSHIP TO PATIENT: _____



Patient Name: _____

Date Of Birth: _____

PATIENT DEMOGRAPHICS QUESTIONNAIRE

We are asking for your race and ethnicity because some people have higher risk of developing certain diseases, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly. We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care. Thank You!

Please provide the information below. We greatly appreciate your participation!

1. Race. Please mark what best describes you.

(If more than one, please rank your selection by marking your primary race with a number 1, your secondary race with a number 2 and so on.)

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Japanese | <input type="checkbox"/> Gaumanian or Chamorro |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Korean | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other _____ |

I Prefer Not To Answer

2. Are you of Hispanic Origin? *(Please mark the ONE statement that best describes you.)*

No, not Hispanic/Latino

If Yes:

- Cuban
- Puerto Rican
- Mexican, Mexican American, Chicano
- Other Spanish/Hispanic/Latino
For Example: Argentinean, Colombian, Dominican, Nicaraguan, Salvadorian, Spaniard, etc.

I Prefer Not To Answer

3. What is your primary ancestry or ethnic origin? *(Write up to FOUR ancestries)*

For example: Italian, Jamaican, African American, Cambodian, Cape Verdean, Norwegian, Dominican, French Canadian, Haitian, Korean, Lebanese, Polish, Mexican, Taiwanese, Ukranian, etc.

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I Prefer Not To Answer

4. Please indicate your preferred spoken language.

(We are required by law (CA Health and Safety Code AB800, Section 123147) to request this information.)

I Prefer Not To Answer

5. Interpreter Services: Would language interpreter services be helpful to you during your medical visit?

Yes No I Prefer Not To Answer

The Importance Of Collecting Patient Data

1. Why are we collecting this information?

- To improve clinical quality of care and provide the best care for all patients.
- To better understand and address health differences among many communities.
- To-date, we have used this information to help identify new health risks or predispositions among certain patient populations.

2. Where do these questions come from?

- The questions we are asking come directly from the U.S. Census 2000*
- This allows us to compare our information to national healthcare studies.

3. What happens to the information from the survey?

- Your response will become part of your electronic medical record and your doctor will have access to this information.
- This will help your doctor better evaluate your individual health risks.

4. Is this Legal?

- The state of California requires that we collect patient's race, ethnicity and language for their health records**.
- The office of Statewide Healthcare Planning and Development (OSHPD) requires all healthcare agencies to collect patient race/ethnicity/language as of 1/1/09***.

5. What else will my response be used for?

- To measure and anticipate interpreter service needs.
- To better develop patient communication materials.
- To develop and implement cultural competence staff training.

<http://www.census.gov/dmd/www/pdf.d02p.pdf>

**Senate Bill 680: Patient Health and Safety Code, 2001; Assembly Bill 800, 2006

***www.oshpd.state.ca.us/HID/MirCal/Text.../POAPLSNOTICE.pdf