# NATOMAS FAMILY PRACTICE

**STEVE D. HWANG, D.O. PATRICK C. LAU, M.D.**
**2410 DEL PASO ROAD**
**SACRAMENTO, CA 95834**
**(916) 928-0856**

## NEW PATIENT DEMOGRAPHICS

DATE: _____ ☐ **MALE** ☐ **FEMALE**

PATIENT NAME: _____
FIRST MIDDLE LAST

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____-_____-_____

**CIRCLE ONE:** SINGLE MARRIED SEPARATED DIVORCE WIDOWED

PATIENT ADDRESS: _____
STREET NAME

_____
CITY STATE ZIP

PATIENT PHONE ( ) _____-_____ MESSAGE PHONE ( ) _____-_____

## ***IF PATIENT IS UNDER 18 YEARS OF AGE***

**GUARANTOR/RESPONSIBLE PARTY NAME:** _____ **DATE OF BIRTH:**_____
**FIRST** **LAST**

_____
**ADDRESS** **CITY** **STATE** **ZIP**

**RELATIONSHIP TO PATIENT:**_____ **GUARANTOR/RESPONSIBLE PARTY SSN #:**_____-_____-_____

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NAME OF PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____

DATE OF BIRTH: _____ SUBSCRIBER SSN# _____-_____-_____

PATIENT RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER

INS ID/POLICY #: _____GROUP #: _____EFFECTIVE DATE: _____

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EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE ( ) _____-_____

EMERGENCY CONTACT ADDRESS: _____
STREET CITY STATE

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EMPLOYER'S NAME:_____ EMPLOYER'S PHONE ( )_____-
_____

EMPLOYER'S ADDRESS: _____
STREET CITY STATE ZIP

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I AUTHORIZE THE RELEASE OF ANY MEDICAL INFROMATION NECESSARY TO PROCESS THE CLAIM AND REQUEST THAT PAYMENT OF ANY BENEFITS BE MADE TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED BENEFITS AND ALL DEDUCTIBLES NOT COVERED BY THIS AUTHORIZATION. SHOULD THE ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION, THE UNDERSIGNED SHALL PAY ACTUAL ATTORNEY FEES AND COLLECTION EXPENSES. I CERTIFY THAT EVERYTHING ABOVE IS FILLED OUT TO THE BEST OF MY KNOWLEDGE.

**SIGNED (INSURED OR AUTHORIZED PERSON)** _____ **DATE** _____

**IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES TO YOUR INSURANCE, HOME OR MAILING ADDRESS AND PHONE NUMBER(S). PLEASE RETURN THIS FORM TO THE RECEPTIONIST, THANK YOU FOR YOUR COOPERATION.**

**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 | ▫ Yes | ▫ No | Heart Disease | ▫ Yes | ▫ No | Migraines | ▫ Yes | ▫ No |
| Anemia | ▫ Yes | ▫ No | Heart Murmur | ▫ Yes | ▫ No | Polio | ▫ Yes | ▫ No |
| Arthritis | ▫ Yes | ▫ No | Hemorrhoids | ▫ Yes | ▫ No | Seizures | ▫ Yes | ▫ No |
| Asthma | ▫ Yes | ▫ No | Hepatitis | ▫ Yes | ▫ No | Stroke | ▫ Yes | ▫ No |
| Bleeding | ▫ Yes | ▫ No | Hernia | ▫ Yes | ▫ No | Thyroid Disease | ▫ Yes | ▫ No |
| Cancer | ▫ Yes | ▫ No | High Cholesterol | ▫ Yes | ▫ No | Tuberculosis | ▫ Yes | ▫ No |
| Depression | ▫ Yes | ▫ No | High Blood Pressure | ▫ Yes | ▫ No | Ulcer | ▫ Yes | ▫ No |
| Diabetes | ▫ Yes | ▫ No | Kidney Disease | ▫ Yes | ▫ No | Venereal disease | ▫ Yes | ▫ No |
| Glaucoma | ▫ Yes | ▫ No | Low Blood Pressure | ▫ Yes | ▫ No | Other:_____ | | |
| Heartburn | ▫ Yes | ▫ No | Low Back Pain | ▫ Yes | ▫ 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: _____

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## 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: _____

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## 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.

**REVOCATION:** 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.

**REDISCLOSURE:** 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:**_____

NATOMAS FAMILY PRACTICE INC.

**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 then one, please rank your selection by marking your primary race with a number 1, your secondary race with a number 2 and so on.)*

| | | |
|---|---|---|
| ☐ White/Caucasian | ☐ Filipino | ☐ Native Hawaiian |
| ☐ Black/African American | ☐ Japanese | ☐ Gaumanian or Chamorro |
| ☐ American Indian or Alaska Native | ☐ Korean | ☐ Samoan |
| ☐ Asian Indian | ☐ Vietnamese | ☐ Other Pacific Islander |
| ☐ Chinese | ☐ Other Asian | ☐ 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.*

☐ I Prefer Not To Answer

Turn Over ➡ ➡ ➡

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 communties.
   - 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

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