NATOMAS
FAMILY PRACTICE INC.
convenience, compassion, community

Steve D. Hwang, D.O. Patrick C.Lau, M.D.

2410 Del Paso Rd. Sacramento, Ca 95834
Office: (916) 928-0856 Fax: (916) 928-1584

PATIENT DEMOGRAPHICS

DATE: _____ ☐MALE ☐FEMALE

PATIENT FULL NAME: _____

Date of Birth: _____ Social Security #: ___-___-____

EMAIL: _____

Circle One: Single Married Separated Divorce Widowed

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Patient Phone ( ) ___-____ Message Phone ( ) ___-____

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

Guarantor/Responsible Party Name: _____

Guarantor/Responsible Party Name SSN: _____

Relationship to Patient: _____ Date of Birth: _____

_____

Street City State Zip

Name of Primary Insurance: _____

Subscriber's Name: _____ Date of Birth: _____ SSN: ___-___-____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER: _____

Ins. ID/ Policy #: _____ Group #: _____ Effective Date: _____

Name of Secondary Insurance: _____

Subscriber's Name: _____ Date of Birth: _____ SSN: ___-___-____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER: _____

Ins. ID/ Policy #: _____ Group #: _____ Effective Date: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone ( ) ___-____

Emergency Contact Address: _____

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:			

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Sharndip Taggar, NP

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FINANCIAL AGREEMENT

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION 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 COLLECTIONS EXPENSES. **I UNDERSTAND THAT NATOMAS FAMILY PRACTICE DOES NOT HAVE A MEDI-CAL (GOVENEMENT SPONSORED INSURANCE) CONTRACT, AND THAT THEY WILL NOT BE BILLED. THEREFORE ANY EXPENSE INCURRED BY THIS PLAN WILL BE MY RESPONSIBILITY.** I CERTIFY THAT EVERYTHING ABOVE IS FILLED OUT TO THE BEST OF MY KNOWLEDGE.

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

SIGNATURE: _____ **DATE:** _____

(INSURED OR AUTHORIZED PERSON)

MEDICAL INFORMATION RELEASE FORM

NAME_____, DATE OF BIRTH_____

RELEASE OF INFORMATION

{} SPOUSE NAME_____

{} GRANDPARENT NAME_____

{} OTHER NAME_____

{} INFORMATION IS NOT TO BE RELEASED TO ANYONE

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTILL TERMINATED BY MYSELF IN WRITING

PLEASE CALL {} CELL {} MY HOME {} MY WORK _____

IF UNABLE TO REACH ME:

{} YOU MAY LEAVE A DETAILED MESSAGE

{} PLEASE LEAVE MESSAGE ASKING ME TO RETURN YOUR CALL

OTHER_____

BEST TIME TO REACH ME IS (DAY)_____ BETWEEN (TIME)_____

SIGNED: _____DATE_____

NATOMAS FAMILY PRACTICE INC.
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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 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 ➔ ➔ ➔

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No-Show/Late Cancellation Policy

I, _____, have been made aware
(patient name, if minor then parents name)

that as of July 1st 2014, there will be a No-Show/Late Cancellation Policy in effect. I understand that I must give the office notice of appointment cancellation at least 24 hours prior to my scheduled appointment time. If I fail to give 24 hours notice, I understand that I will be charged a fee of $25.

_____ _____

Patient/Parent Signature Date