Dr. _____

Redding Family Medical Group, Inc.

New/Updated Patient Information

IT IS THE PATIENT'S RESPONSIBILITY TO UPDATE THIS FORM WHENEVER THERE IS ANY CHANGE
****Patients 18 years and older cannot be on their parent's account and must have their own billing account****

Person responsible for this account: Self ❑ Father/Mother* ❑ Other* ❑ Whom? _____

PATIENT INFORMATION

PATIENT'S FULL NAME _____
Last Name First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Age _____ Sex: Male ❑ Female ❑

Employer/Occupation _____
IF RETIRED, Please write RETIRED

Employer Address _____ Phone _____

Marital Status: Married ❑ Single ❑ Widowed ❑ Divorced ❑ Date: _____ Separated ❑ Date: _____

Social Security No. _____ Drivers License No. _____ E-mail _____

Name of Spouse _____ Birthdate _____ Social Security No. _____

Spouse's Employer _____ Address _____ Phone _____

Do you have medical insurance? Yes ❑ No ❑ ***PLEASE PROVIDE RECEPTIONIST WITH YOUR CARD***

If yes, Insurance Company: _____ ID#/Group Number _____

Do you have secondary insurance? Yes ❑ No ❑

If yes, Insurance Company: _____ ID#/Group Number _____

*** IF PATIENT IS A MINOR, OR MOTHER/FATHER/OTHER IS RESPONSIBLE FOR THIS ACCOUNT, PLEASE COMPLETE THE FOLLOWING:**

MOTHER'S NAME _____
Last Name First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____ Birthdate _____

Social Security No. _____ Drivers License No. _____ E-mail _____

Insurance: _____ Policy Holder _____ ID#/Group Number _____

FATHER'S NAME _____
Last Name First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____ Birthdate _____

Social Security No. _____ Drivers License No. _____ E-mail _____

Insurance: _____ Policy Holder _____ ID#/Group Number _____

PLEASE TURN FORM OVER TO COMPLETE

Nearest relative not residing with you: _____

Emergency Contact: _____ Phone: _____

INSURANCE AUTHORIZATION/FINANCIAL RESPONSIBILITY

Your signature below is also consenting to having
RFMG, Inc. use (1) billing account per family including children under 18 years old.
(Please note that all balances over 60 days will be patient's responsibility as secondary insurances are only billed one time as a courtesy)

Insurance Authorization/Financial Responsibility
I understand that payment is requested and expected at time service is rendered. However, in case of larger than usual fees (surgery, x-rays, lab, hospitalization, etc.) where insurance is to be billed, I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits otherwise payable to me for his/her services as billed. Further, I understand that a "Bank Service Charge" of $25.00 will be made on all returned checks.

Signed: _____ **Dated:** _____
Responsible party for payment must be Parent/Other who brings child to RFMG, Inc./Self if 18 years and older.

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize Redding Family Medical Group, Inc. to perform any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of _____

_____[name(s) and address of minor(s)] deemed advisable by a licensed physician and mid-level practitioner and provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code § 6910.

Signed: _____ **Dated:** _____

Print Name: _____

Please specify relationship to minor: [ ] Parent with legal custody [ ] Guardian with legal custody

MEDICARE PATIENTS ONLY

(Please note that all balances over 60 days will be patient's responsibility as secondary insurances are only billed one time as a courtesy)

Lifetime Beneficiary Authorization

Name of Beneficiary _____ Medicare No._____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Redding Family Medical Group, Inc. for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signed: _____ **Dated:** _____

REDDING FAMILY MEDICAL GROUP
HEALTH HISTORY

REVIEW OF SYSTEMS: (Check problems you are having now or have had recently and explain below)

❑ Frequent or severe headaches	❑ Weight loss	❑ Excessive thirst
❑ Frequent sore throat	❑ Change in bowel habits	❑ Rising at night to urinate (how often)
❑ Ear pain or discharge	❑ Blood in stools	❑ Progressive weakness
❑ Eye disease or impaired vision	❑ Black, tarry stools	❑ Wasting of muscles
❑ Chronic cough	❑ Recurring abdominal pain	❑ Back or neck pain
❑ Chest pains	❑ Recurring attacks of vomiting	❑ Pain or unusual sensation in extremities
❑ Shortness of breath	❑ Abnormal bleeding tendency	❑ Difficulty sleeping
❑ Coughing or spitting up blood	❑ Frequency of urination	❑ Nervous, crying spells, depression
❑ Impaired appetite	❑ Painful urination	
❑ Fainting spells		

Comments: _____

_____

FAMILY HISTORY: (Check whether living or deceased. If living, give age; if not, give age at time of death & cause of death.)

Father:	❑ Living _____ ❑ Deceased _____	Mother:	❑ Living _____ ❑ Deceased _____
Brothers: (ages)	❑ Living _____ ❑ Deceased _____	Sisters: (ages)	❑ Living _____ ❑ Deceased _____

Check any of the following diseases occurring in your immediate family:

❑ Tuberculosis	❑ Kidney disease	❑ High blood pressure
❑ Diabetes	❑ Cancer	❑ Migraine headaches
❑ Epilepsy	❑ Neurological disease	❑ High cholesterol
❑ Heart disease	❑ Allergies/Asthma/Eczema	❑ Alcoholism or drug abuse

Comments: _____

_____

For Women:

Number of children: _____ Ages: _____

Complications of pregnancy, labor or delivery: _____

Miscarriages or abortions: _____ Present method of contraception: _____

Age at onset of menses: _____ Date of last menstrual period? _____

Date of last pap smear: _____ Was it normal? _____

Date of last mammogram: _____ Was it normal? _____

Comments: _____

_____

NAME: _____ **DATE OF BIRTH:** _____

PAST HISTORY: (Check any of the following illnesses you have had)

❑ Tuberculosis	❑ Kidney disease, including stones	❑ High blood pressure
❑ Diabetes	❑ Cancer	❑ High cholesterol
❑ Epilepsy	❑ Stroke	❑ Migraine headaches
❑ Heart attack or heart disease	❑ Allergies/Asthma/Eczema	❑ Depression, anxiety or other mental health problems
❑ Rheumatic fever	❑ Arthritis	❑ Alcoholism or drug use
❑ Ulcers	❑ Colitis	❑ Other _____
❑ Hepatitis	❑ Sexually transmitted infection	
❑ Back or neck problems	❑ Frequent urinary infections	

Comments: _____

_____

Operations: (List operation, year of surgery, and any complications) _____

_____

_____

Other Hospitalizations: (Where and when) _____

_____

_____

Serious accidents or injuries not listed above: _____

_____

Medications taken currently (include non-prescription drugs, vitamins & herbs): _____

_____

_____

_____

Habits: (check all that apply)

❑ Smoker, amount per day _____	❑ Alcohol, amount per day _____ per week _____
❑ Past smoker, when quit _____ years smoked _____	❑ Illicit drug use, type & frequency _____
❑ Never smoked	❑ Regular exercise _____
❑ Chew tobacco	❑ Caffeinated beverages _____

Blood Transfusions: (Date and reason) _____

Immunizations: (Type and dates, if known) _____

Allergies: (Drugs, food, hay fever) _____

_____

SOCIAL HISTORY: Where born? _____ How long there? _____

Other places you have lived & visited outside the U.S. _____

Marital Status: M S D W Family problems (recent death or illness of close relative, marital problems, etc.)

_____

_____

Present occupation: _____ How long? _____

SIGNATURE: _____ **TODAY'S DATE:** _____

PF-2000 **CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

PAGE TWO

SIGNATURE

I HAVE REVIEWED THIS CONSENT FORM AND GIVE MY PERMISSION TO REDDING FAMILY MEDICAL GROUP, INC. TO USE AND DISCLOSE MY HEALTH INFORMATION IN ACCORDANCE WITH IT. I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES.

REDDING FAMILY MEDICAL GROUP, INC. CAN DISCLOSE ALL OF YOUR HEALTH INFORMATION TO YOUR REPRESENTATIVE; I.E., ALL TEST RESULTS, APPOINTMENTS, PATIENT'S FINANCIAL ACCOUNT INFORMATION, ETC.

_____

PATIENT REPRESENTATIVE (PLEASE PRINT)

_____

RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT

REDDING FAMILY MEDICAL GROUP, INC. HAS PATIENT'S PERMISSION TO LEAVE TEST RESULTS AND APPOINTMENTS ON THE ANSWERING MACHINE NUMBER THAT IS GIVEN TO US.
YES_____NO_____

_____

NAME OF PATIENT (PLEASE PRINT) DATE OF BIRTH

_____

SIGNATURE OF PATIENT DATE
IF 18 YEARS OR OLDER

_____

SIGNATURE OF PARENT DATE
IF PATIENT IS UNDER 18 YEARS

REDDING FAMILY MEDICAL GROUP, INC.
2510 AIRPARK DRIVE, SUITE 104, 201
REDDING, CALIFORNIA 96001

PF-2000 CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION
YOUR PROTECTED HEALTH INFORMATION WILL BE USED BY REDDING FAMILY MEDICAL GROUP, INC. OR DISCLOSED TO OTHERS FOR THE PURPOSES OF TREATMENT, OBTAINING PAYMENT, OR SUPPORTING THE DAY-TO-DAY HEALTH CARE OPERATIONS OF THE PRACTICE.

NOTICE OF PRIVACY PRACTICES
YOU SHOULD REVIEW THE NOTICE OF PRIVACY PRACTICES FOR A MORE COMPLETE DESCRIPTION OF HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED OR DISCLOSED. YOU MAY REVIEW THE NOTICE PRIOR TO SIGNING THIS CONSENT.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION
YOU MAY REQUEST A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

REDDING FAMILY MEDICAL GROUP, INC. MAY OR MAY NOT AGREE TO RESTRICT THE USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

IF REDDING FAMILY MEDICAL GROUP, INC. AGREES TO YOUR REQUEST, THE RESTRICTION WILL BE BINDING ON THE PRACTICE. USE OR DISCLOSURE OF PROTECTED INFORMATION IN VIOLATION OF AN AGREED UPON RESTRICTION WILL BE A VIOLATION OF THE FEDERAL PRIVACY STANDARDS.

REVOCATION OF CONSENT
YOU MAY REVOKE THIS CONSENT TO THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. YOU MUST REVOKE THIS CONSENT IN WRITING. ANY USE OR DISCLOSURE THAT HAS ALREADY OCCURRED PRIOR TO THE DATE ON WHICH YOUR REVOCATION OF CONSENT IS RECEIVED WILL NOT BE AFFECTED.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES
REDDING FAMILY MEDICAL GROUP, INC. RESERVES THE RIGHT TO MODIFY THE PRIVACY PRACTICES OUTLINED IN THE NOTICE.