

Ocean Breeze Medical Group, Inc.

Registration Form

By initialing next to the phone number(s) below, I authorize Ocean Breeze Medical Group, Inc, its physicians and staff to provide to me detailed messages on my voicemail regarding medical information such as: test results, medications, referrals, authorization determination, etc. for my benefit of receiving the information in a timely manner.

Name:	Date of birth:	Sex: M/F	Social Security Number:
-------	----------------	----------	-------------------------

Address:	City:	State:	Zip Code:
----------	-------	--------	-----------

Marital Status:	Spouse Name:	Home Phone Number:	Cell Phone Number:
		INITIAL:	INITIAL:

Occupation:	Employer:	Employer Phone #:
-------------	-----------	-------------------

Address:	City:	State:	Zip Code:
----------	-------	--------	-----------

In case of emergency, name and phone number of person we may contact (not living with you):

Pharmacy Name:	City:	Phone #:
----------------	-------	----------

Email Address:

I the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Ocean Breeze Medical, Inc, Dr. Davalos, and/or Dr.Ebrahimzadeh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Responsible Party Signature	Relationship	Date

Ocean Breeze Medical Group, Inc.

Notice Of Privacy Practices Acknowledgement

Privacy Official: Ricardo Davalos, M.D.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signature: _____ Date: _____

Patient Name: _____

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Print Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

Please list those individuals and their relationships to you with whom we can communicate via phone and/ or in person **your medical information which may include: test results, diagnosis, plan of care, referrals, medications prescribed, personal discussions, etc.**

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Ocean Breeze Medical Group, Inc. Staff signature/ Witness: _____

Ocean Breeze Medical Group, Inc.

Practice Policies

Welcome to Ocean Breeze Medical Group, Inc. The physicians greatly appreciate you selecting them as your family physician. Our office is committed to offering you state of the art care in a stress-free atmosphere. In order for us to fulfill this commitment to you, we ask that you play a key role and extend the following courtesies:

My Signature below acknowledges my understanding of the following:

Article 1: I understand that my insurance contract is between my insurance company and me. It is the responsibility of the patient to know and understand their medical insurance benefits. I agree that I am required to provide Ocean Breeze Medical Group, Inc. with the most correct and updated information about my insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. I also agree I am responsible for any charges my insurance may not cover. I understand that failure to pay my account or make suitable financial agreements may result in my account being placed in a state of delinquency. If this becomes necessary, I agree to pay all collection fees, which include but are not limited to collection fees, court fees, attorney fees and any other fees for the collection of my account balance.

Article 2: Ocean Breeze Medical Group, Inc. accepts cash, checks, and Visa/ MasterCard payments. I understand that I am required to pay my co-payment or co-insurance at the time of the service. Any other arrangement must be made prior to the appointment. There will be a fee of \$25.00 for a returned check. I agree that full payment and returned check fee will be paid in ten days to avoid dismissal from practice. All outstanding balances greater than \$100 or balances in collection must be paid and brought current prior to any appointment.

Article 3: OCEAN BREEZE MEDICAL GROUP, INC. REQUIRES A 24 HOUR CANCELLATION NOTICE. IF CANCELLED WITHIN 24 HOURS OR "NO SHOW" FOR YOUR APPOINTMENT THERE IS A \$150.00 MISSED FEE FOR EITHER IN OFFICE OR TELEHEALTH VISITS. A \$200 FEE WILL INCUR FOR MISSED PHYSICAL EXAMS. REPETITIVE MISSED APPOINTMENTS WITHOUT NOTIFICATION WILL RESULT IN DISMISSAL FROM THE PRACTICE. INITIAL HERE:

Article 4: Walk in patients will be accommodated but will not supersede those with appointments.

Article 5: Referrals will not be granted over the phone until an Ocean Breeze Medical Group, Inc. physician evaluates the patient. As your referral is processed, elements of your medical record may be forwarded to the specialist along with your referral. I authorize to provide the necessary information to the designated specialist.

Article 6: Ocean Breeze Medical Group, Inc. will phone in a prescription to the appropriate pharmacy only under special circumstances. It is the patients' responsibility to provide the pharmacy's name and phone number. Ocean Breeze Medical Group, Inc. will not refill prescriptions written by another physician. Ocean Breeze Medical Group, Inc. will provide you with enough refills to last until your next appointment. Approval of refill request in between appointments is at the discretion of the physician. Due to liability issues, no refills for controlled substances will be granted over the phone unless the patient is re-evaluated by an Ocean Breeze Medical Group, Inc. physician. Lost prescriptions for a controlled substance will not be refilled. Failure to comply with this policy will result in dismissal from the practice.

Article 7: At the discretion of Ocean Breeze Medical Group, Inc. treatments or consultations may be performed over the phone. A charge of \$45.00 will be assessed to the caller, which may not be a covered insurance benefit.

Article 8: I allow Ocean Breeze Medical Group, Inc. to photograph my medical and or surgical condition and their treatments. These pictures may be added to my medical records. On rare occasion, once your identity is concealed, these pictures may be used in scientific, educational, or research purposes.

Article 9: I have been offered information on creating an advance directive and understand that information. If I already have an advance directive, I understand it is my responsibility to provide a copy to Ocean Breeze Medical Group, Inc.

Article 10: If you are a Medicare beneficiary: There are many items that are not covered under the Medicare program. To name a few: Pre-operative exams and associated lab work, and some screening tests. It is your responsibility to be aware of your covered benefits. Federal regulations require that we inform you of the above. Your signature on this form will indicate that you have been informed, and that you will be responsible for charges of this nature, should they occur during one of your visits.

Article 11: If you are a Medi-Cal Beneficiary: Be advised that Ocean Breeze Medical Group, Inc. does not participate with the California Medicaid program and cannot bill your services to the Medi-Cal plan.

Article 12: We may use and disclose medical information to contact and remind our patients about appointments.

Article 13: Ocean Breeze Medical Group, Inc. will not discuss results or other medical information with anyone other than the patient unless written consent is provided on **Notice of Privacy Practices Acknowledgement Form.**

Print Patient Name

Responsible Party Name/Signature

DATE



Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a “partnership” between you and your doctor. As our “partner in health,” we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I DO Not Hear the Results of Labs and Other Tests

I understand that my physician’s goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician’s office within two weeks, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decisions to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature

Date

Ricardo Davalos, MD

Physician Name

Patient Name (PRINT)

OCEANBREEZE MEDICAL GROUP, INC.

HEALTH QUESTIONNAIRE

Name _____ Age _____ Date _____
 SSN# _____

PAST MEDICAL HISTORY:

NO YES		NO YES		NO YES	
Measles.....		Seizure.....		Peptic Ulcer.....	
Mumps.....		Heart Disease.....		Kidney Disease.....	
Chicken Pox.....		Hypertension.....		Diabetes.....	
Polio.....		Tuberculosis.....		Thyroid Disease.....	
Rheumatic Fever.....		Pneumonia.....		Venereal Disease..	
Scarlet Fever.....		Asthma.....		Anemia.....	
Cancer.....		Hepatitis.....		Blood Clot.....	
Stroke.....		Liver Disease.....		Gout.....	

Past Hospitalizations:

Year _____ Illness _____
 Year _____ Illness _____
 Year _____ Illness _____
 Year _____ Illness _____

Past Surgeries:

Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____

Allergies: (Medication & Food)

1.) _____ Reaction _____
 2.) _____ Reaction _____
 3.) _____ Reaction _____
 4.) _____ Reaction _____

Current Prescription Medications:

Name: _____ Dosage: _____
 Name: _____ Dosage: _____
 Name: _____ Dosage: _____
 Name: _____ Dosage: _____

Non-Prescription Medications:

Name: _____ Dosage: _____
 Name: _____ Dosage: _____
 Name: _____ Dosage: _____
 Name: _____ Dosage: _____

Immunizations:

Social History:

Year		Marital Status:	# of Children _____
	Influenza	Occupation:	
	Tetanus	Job Satisfaction:	
	Pneumococcal	Smoker: _____	In the Past? _____
	Other	Caffeine: _____	Cups per Day _____
		Alcohol: Type _____	Amount _____
	Childhood vaccine's	Recreational Drugs: _____	
	Up to date?	Advance Directive/Living Will: YES	NO

Family History	If Living:		If Deceased:		Has any blood relative Ever had:	Relationship	NO	YES
	Age	Health	Age	Cause				
Father					Cancer: YES NO			
Mother					Type of Cancer:			
Husband/Wife					Type of Cancer:			
Son/Daughter					Type of Cancer:			
					Diabetes			
					Heart Trouble			
					High Blood Pressure			
					Stroke			
Brother/Sister					Convulsions			
					Suicide			
					Mental Illness			
					Bleeding Tendency			
					Gout or other arthritis			
					Hereditary Defects			

GENERAL

Do you eat a well balance diet?
Approx. weight now ____ 1 yr ago ____
Maximum weight: _____
Exercise? Frequency / wk _____
Activities _____
Any sexual concerns?
Year of last complete physical _____
Headaches
Glasses/contacts
Double Vision
Eye disease or injury
Year last checked for glaucoma _____
Itching eyes or nose/hay fever
Septal deviation/polyps
Nosebleeds
Sinus trouble
Ear disease
Impaired hearing
Ringing in ear
Hoarseness

NECK

Stiffness
Enlarged glands
Injury

RESPIRATORY

Coughing up blood
Chronic cough (including Smoker's Cough)
Wheezing
Shortness of breath
How many blocks can you walk without
having to stop to catch your breath? ____
Night sweats
Skin test for tuberculosis
If yes, year tested and results _____
Year of last chest x-ray _____

CARDIOVASCULAR

Chest pain or angina pectoris
Shortness of breath when lying flat
Pain in legs on walking, relieved by rest
Varicose veins
Ankles often badly swollen
Heart murmur
Rapid, hard or skipped heart beats
Year of last EKG _____
Have you had a stress treadmill? Year ____

GASTROINTESTINAL

Change in appetite
Heartburn or indigestion
Sour taste in throat or mouth
Intolerance to spicy foods, coffee or alcohol
Ever vomited blood?
Do foods stick in throat
Gallbladder trouble/intol. to greasy foods
Intolerance to milk products
Hiatal Hernia
Pancreatitis
Do you often vomit?
Crampy abdominal pain
Chronic constipation
Frequent diarrhea
Change in bowel habits
Bloody or black bowel movements
Hemorrhoids or piles

NO YES

GENITORURINARY

Loss of urine when cough or sneeze
Kidney or bladder infection
Burning or frequent urination
Feeling must go immediately
Do you have to get up at to urinate?
Blood in urine
Kidney Stones
Swelling of hands and feet
Difficulty starting urination?
Decrease in strength of stream
Penile Discharge
Date of last prostate exam

MUSCULOSKELETAL

Significant arthritis/joint pain
Low back pain
Muscle weakness or tenderness
Difficulty walking
Fractures (list)

SKIN

Skin disorders (list) _____

NEUROLOGIC/ PSYCHIATRIC

Numbness/ paralysis
Fainting spells
Memory Loss
Dizziness
Do you have trouble sleeping?
Are you often depressed?
Are you often anxious or nervous?
Do you ever wish you were dead and away
from it all?
Do you often worry?
Have you ever been under psychiatric care?

HEMATOLOGIC

Excessive bleeding or abnormal bruising

ENDOCRINE

Crave large amounts of fluids
Intolerance to slightly warm rooms
Intolerance to slightly cool rooms
Change in textures of hair or skin
Change in voice (as an adult)
Hair Loss
Diminished sex drive
Darkening of skin

GYNECOLOGICAL (this section for women only)

Age when period started _____ Years old
Frequency: every ____ Days; Last period ____
Are they abnormal or irregular?
Menopausal _____ Age _____
Number of pregnancies _____ C/sections _____
Term Deliveries _____ premature _____
Miscarriages _____ Abortions _____
Pelvic inflammatory disease
Pain with intercourse
Date of last cancer smear ____ Normal?
Breast masses, lumps, cyst
Nipple Discharge
Skin Discoloration/ dimpling
Family history of breast cancer?
Date of last mammogram
Did someone other than the patient help fill this out?
Patient Name :

NO YES

Patient Signature:

Reviewing Physician:

