

**New Patient Information**

Today's Date:      /      /     

**Please complete the front and back side of this form. Thank you.**

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB:      /      /      M  F   
MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_  
Cell Phone (    ) \_\_\_\_\_

**Primary Insurance** ( PLEASE PROVIDE INSURANCE CARD )

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Contact Information** (Names of two people NOT living with you)

Full Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Full Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**Where did you hear about us? (specify which one)**

Another physician \_\_\_\_\_  
Website \_\_\_\_\_  
Hospital \_\_\_\_\_

**Medications/Vitamins/Supplements:**

<u>Name</u>	<u>Dose</u>	<u># of Times Taken Per Day</u>
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____
8 _____	_____	_____
9 _____	_____	_____

**List Any Medical Conditions Here:**

1 _____	6 _____
2 _____	7 _____
3 _____	8 _____
4 _____	9 _____
5 _____	10 _____

**Allergies:**

Medication/Food/Material/Etc.

Reaction

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

How many people currently live with you?

**Any** nicotine use in your life? (circle all that apply)

None    Cigarettes    Chewing Tobacco

**Any** alcoholic drinks in the last month?

Y / N

**Family History:** (List any conditions you know about on the line next to a type of relative)

Father \_\_\_\_\_  
Mother \_\_\_\_\_  
Brother/Sister \_\_\_\_\_  
Father's Parents \_\_\_\_\_  
Mother's Parents \_\_\_\_\_

**Health Maintenance:**

Last Check for Colon Cancer (if greater than 50 years) \_\_\_\_\_ / \_\_\_\_\_ (circle one) colonoscopy/stool cards

Last Pap Smear? \_\_\_\_\_ / \_\_\_\_\_

When was your last Tetanus vaccination? \_\_\_\_\_ / \_\_\_\_\_

Last Flu Shot? \_\_\_\_\_ / \_\_\_\_\_

**Miscellaneous Office Policies**

The following are office policies with which patients should be familiar.

Please arrive fifteen (15) minutes prior to scheduled appointment time to allow our office for check-in, to verify insurance information, and update contact information. Please update contact information each visit as needed.

All payments under \$30 must be paid in cash. All payments/co-payments must be made PRIOR to services.

Please bring your medications or an updated list of medications to each visit. Medicines include any vitamins or herbal supplements taken.

Please allow 24-48 hours for any referrals or prior authorizations to be submitted.

Please call if you have any problems with the medications or treatments provided prior to discontinuing or canceling any appointment.

Other specific office policies available on request.

I have read and understand the above information. A photocopy of this authorization shall be as valid as the original.

\_\_\_\_\_  
Signature of Patient or Parent / Legal Guardian of minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Parent / Legal Guardian

**Consent for purposes of treatment, payment, information release, and health care operations**

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Del Mar Family Medicine and its physicians, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of this office. I hereby authorize any physician, hospital, medical service organization, insurance company, or other organization to release to each other information acquired, including benefits paid or payable, concerning my protected health information as deemed necessary .

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Del Mar Family Medicine is not required to agree to the restrictions that I may request. However, if Del Mar Family Medicine agrees to the restrictions that I request, the restriction is binding on Del Mar Family Medicine and the signee will be notified.

The Notice of Privacy Practices describes my rights and the types of uses and disclosures of my protected health information during my treatment, payment of my bills, or in the performance of health care operations. The Notice also describes the duties of Del Mar Family Medicine and its’ physicians with respect to my protected health information. Del Mar Family Medicine also reserves the rights to change the privacy practices as modified by state and federal laws. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mailing or asking for one at the time of my next appointment. I have reviewed Del Mar Family Medicine Notice of Privacy Practices prior to signing this document.

I have the right to revoke this consent, in writing, at any time, except to the extent that Del Mar Family Medicine has taken action in reliance on this consent.

I consent to the examination, diagnosis, ancillary tests, and treatment of me or my dependents deemed necessary by the physicians of Del Mar Family Medicine, as evidenced by my signature, until revoked in writing.

I hereby authorize payment of benefits directly to Nirav Patel MD, Inc, otherwise payable to me under the terms and conditions of the funds. By signing this authorization, I understand that I am financially responsible to the providers of service for the charges not covered by my insurance company. If the account goes to collections, there will be a collection fee (30% of the delinquent balance due plus interest of 1.5% per month) added on to the balance of the account. If any check is returned due to insufficient funds or account closed, there will be a \$25.00 charge added to the amount of the check. If the check is not satisfied within 30 (thirty) days after notification, it will be subject to 3 times the amount of check, no less than \$100.00 or more than \$500.00 plus the amount of the check. (CA Civil Code Sec 1719).

I also agree that an outstanding balance of greater than \$250.00 will require me to place a deposit on future insurance payments to Del Mar Family Medicine or require me to pay ½ of the amount owed which will be returned to me once my insurance fulfills its obligation to Del Mar Family Medicine.

A photocopy of this authorization shall be as valid as the original. I hereby certify the statements hereon and those attached are true and correct to the best of my knowledge. I understand that it is fraudulent to fill out this form with information I know to be false or to omit important facts, and that criminal and/or civil penalties can result.

I authorize release of my health information to the following people (list individually separated by commas)

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Parent / Legal Guardian of minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient or Parent / Legal Guardian

\_\_\_\_\_

**Would you like to receive lab results and other information through your email?**

Y/N

If No, this form is complete.

You should be aware that the Internet is a very public space, where many people and business can read e-mail that is transmitted across the Internet. This office does not encrypt e-mail.

Do not list an e-mail address if you are uncomfortable having your personal and/or confidential medical information travel across the Internet, where it may be accessible to unknown businesses and individuals. We will use e-mail to notify you of laboratory results and remind you of follow up or appointments as the physician sees appropriate. Some results will not be sent over e-mail to protect confidentiality.

**The e-mail address used will be: [main@delmarfamilymed.com](mailto:main@delmarfamilymed.com)**

**We agree not to use your e-mail address to solicit personal information, sell products, address billing issues, nor will we share your e-mail address with other parties outside of Del Mar Family Medicine.**

To protect you from a delay in care, inappropriate care or a breach of your privacy, we cannot answer any questions including but not limited to medical, procedure related, medication related and those pertaining to family members through e-mail. We will not read or respond to medical information sent over e-mail as we cannot verify the source. Please call with any questions or refill requests. Any e-mails sent by the above patient or any family member will be discarded by our computer system.

I agree \_\_\_\_\_ (initial here)

Signature: \_\_\_\_\_

date: \_\_\_\_\_

email address: \_\_\_\_\_

You may revoke this agreement at any time by informing a member of our office staff.