GATEWAY MEDICAL CENTER

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***Anaheim Clinic**
710 N Euclid St Suites 101/301, Anaheim, CA 92801

***Anaheim Hills Clinic**
500 S Anaheim Hills Rd Ste 230, Anaheim Hills, CA 92807

***Santa Ana Clinic**
801 N Tustin Ave Ste 602 Santa Ana, CA 92705

PATIENT INFORMATION - CONFIDENTIAL

Last Name:		First Name:			Middle Initial:
❑ Mr. ❑ Mrs.	❑Miss ❑ Ms.	Marital status (circle one): **Single/Mar/Div/Sep/Wid**	Sex: ❑ M ❑ F	E-mail address:	
Social Security #:	Driver License #:	Date of Birth:	Age:		
Home Address:					
City:		State:	Zip:		
Preferred method of contact: ❑ Home Phone ❑ Work Phone ❑Cell Phone					
Home Phone:	Work Phone:	Cell Phone:			
Ethnicity: ❑ Latino/Hispanic ❑ Non-Hispanic ❑ Other ❑ Not Reported/Refused					
Race: ❑ Caucasian/White ❑ Black ❑ Hispanic ❑ Asian ❑ Native American ❑ Asian Pacific ❑ American ❑ Pacific Islander ❑ Other_____					
Primary Care Physician:		Physician's Phone:			
Employer:		Employer's Phone:			
Emergency Contact:		Emergency Contact's Phone:			
Pharmacy Name:		Cross Streets (Pharmacy):			
Reason for Visit:					

PRIMARY INSURANCE			**SECONDARY INSURANCE**		
❑ I certify that patient has NO insurance coverage. Patient/Responsible party: _____					
Insurance Name:			Insurance Name:		
Insured Name:			Insured Name:		
Date of Birth:	ID#:		Date of Birth:	ID#:	
City:	State:	Zip:	City:	State:	Zip:
Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other:_____			Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other:_____		

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PATIENT ELIGIBILITY WAIVER

I hereby assign all benefits to Gateway Medical Center for services rendered to me or said patient. I authorize any holder of medical information about me or said patient to release to my Insurance Company any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to Gateway Medical Center and I authorize the release of medical information necessary to pay the claim. I have given all my insurance information for billing purposes and understand the billing procedures. I understand that I am responsible for all charges not covered by my insurance policy including, but not limited to, co-payments, deductibles and non-covered services. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability for all charges if my insurance company does not remit payment on my behalf.

COMMUNICATION CONSENT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or his/her PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (Please check all that apply):

❑ Home Telephone _____
- ❑ Leave message with detailed information
- ❑ Leave message with call back number only

❑ Written Communication
- ❑ Mail to my home address
- ❑ Mail to my work/office address

❑ Work Telephone _____
- ❑ Leave message with detailed information
- ❑ Leave message with call back number only

❑ Cell Phone _____
- ❑ Leave message with detailed information
- ❑ Leave message with call back number only

Please add any special instructions regarding the release of your medical information (i.e., specific family member or representative):_____

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of Gateway Medical Center'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 visit.

Patient Signature: _____ Date: _____

If other than patient please state relationship_____

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We strive every day to provide you with the highest quality of care you expect and deserve. Providing you with the **best possible care** requires a "partnership" between you and your physician. To embark on this "partnership in your health" we ask you to help us and will need your agreement for the following. This is not an exhaustive list but highlights a few key areas. By signing you agree to:

1. The Importance of follow-up as advised by the medical providers at Gateway Medical Center

I understand the importance of follow-up as advised by the physicians and medical providers at Gateway Medical Center. This include the need of office visits, annual physical examinations, follow up, receiving care with recommended specialist and completing labs/tests. During these visits, my physician might order tests, review my plan of care, prescribe medication, or even discover and treat a serious health condition. If I don't show up to my appointment, or miss my appointment and fail to reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition.

2. Contact the Physician's 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 or his/her office staff within a reasonable period of time, I will call the office for my test results.

3. Inform My Physician if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my physician may make certain recommendations based on what he or she feels is best for my health taking into consideration my requests and preferences. This might include prescribing medication, performing testing or procedures, referring me to other specialists, and ordering labs and tests. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my physician 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 decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be fully informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. We are here to help you get better and lead active healthy and productive lives. We want you to consider us a trusted partner in your health.

Thank you,

The Physicians and Staff at Gateway Medical Center

_____ _____

Patient Name (Print) Date

_____

Patient Signature

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PATIENT (SELF) HEALTH QUESTIONNAIRE (CONFIDENTIAL)

Last Name:	First Name:	Date of Birth:	Phone:	Sex: ❑ M ❑ F

Medication (List all medications that you take on a regular basis including non-prescription medications)

Medication Name:	Dosing:	Medication Name:	Dosing:

_____Initial: I consent/allow Gateway Medical Center to review, send and receive my prescription history from external sources

_____Initial: I DO NOT consent/allow Gateway Medical Center to review, send and received my prescription history from external sources

List Allergies (medications and/or foods, etc.) _____ ☐ No Known Allergies

Medical History: Do you have or have you had any of the following:

Illness/Conditions		**Surgical Procedure**	**Year**	**Surgical Procedures**	**Year**
❑ Anemia	❑ High Blood Pressure	❑ None		**Men Only**	
❑ Anxiety	❑ High Cholesterol	Angioplasty	_____	Prostate Biopsy	_____
❑ Arthritis	❑ Kidney Diseases	Appendectomy	_____	TURP	_____
❑ Asthma	❑ Liver Disease/Hepatitis	Arthroscopy	_____	Vasectomy	_____
❑ Birth Defect	❑ Migraine Headaches	Back Surgery	_____	**Women Only**	
❑ Colitis	❑ Osteoporosis	CABG (heart bypass)	_____	Bilateral Tubal Ligation	_____
❑ Concussion	❑ Pneumonia	Carpal Tunnel Release	_____	Breast Biopsy	_____
❑ Depression	❑ Seizure Disorder	Cataract Extraction	_____	D&C	_____
❑ Diabetes	❑ HIV/AIDS	Cholecystectomy	_____	C-section	_____
❑ Eczema/ Psoriasis	❑ Stroke/TIA	Colectomy	_____	Hysterectomy	_____
❑ Gallbladder Diseases	❑ Thyroid Diseases	Gastric Bypass	_____	Mastectomy	_____
❑ GERD/ Heartburn	❑ Cancer: Type_____	Hernia Repair	_____		
❑ Ulcer	❑ Any other disease_____	Hip Replacement	_____		
❑ Heart Attack/ Heart Disease		Pacemaker	_____		
		Thyroidectomy	_____		
		Tonsillectomy	_____		
		Other	_____		

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Gynecology History (women only)

Are you Pregnant? ❑ Yes ❑ No

Are you breastfeeding? ❑ Yes ❑ No

Last Menstrual Period? _____

History of Abnormal PAP ❑ Yes ❑ No Type: _____

Number of pregnancies, if any_____ How many children do you have _____

Family History (Please check if any family member has had any of the following conditions. If other, please list relationship)

❑ Adopted **Mother** ❑ Alive ❑ Deceased **Father** ❑ Alive ❑ Deceased

Diagnosis	Mother	Father	Sister	Brother	Other
Diabetes					
High Blood Pressure					
Heart Disease					
Stroke					
Cancer/Type					
Other					

❑ Y ❑ N Are you Ashkenazi Jewish descendent?_____

Health Maintenance
When, if ever, have you had the following?

Colonoscopy _____ Pap Smear/ GYN Exam _____ Prostate Exam _____

Influenza Vaccine _____ Pneumococcal Vaccine _____ Shingles Vaccine _____

Tetanus Vaccine _____ Mammogram _____

Social History

Are you Employed? ❑ Yes ❑ No If yes, occupation _____

Tobacco Use ❑ Yes ❑ No Former, year quit _____

Alcohol Use ❑ Yes ❑ No Drinks per week _____

Street Drug Use ❑ Yes ❑ No Type of drug _____

Caffeine Use ❑ Yes ❑ No

How many days a week do you exercise? _____

What is your highest level of education?_____

_____ _____

Signature of Patient (*or legal/personal representative*) Relationship (*if other than patient)*

_____ _____

Patient Name (Print) Date

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize ❑ **Gateway Medical Center** ❑ **Other:**_____to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____
Name
_____
Address
_____ _____ _____
City State Zip Code

❑ **Gateway Medical Center**- 710 N Euclid St, Anaheim, CA 92801

The medical information/records will be used for the following purpose: _____

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse	_____ (initial)	Tests for Antibodies to HIV	_____ (initial)
Psychiatric/Mental Health	_____ (initial)	HIV Diagnosis/Treatment	_____ (initial)
Genetic Information	_____ (initial)		

DURATION This authorization shall be effective immediately and remain in effect until_____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of Patient (*or legal/personal representative)*	Relationship (*if other than patient)*
Patient Name (Print)	Date
Patient Social Security Number	Patient Date of Birth
Witness Name (Print)	Witness Signature