Stewart MEDICAL GROUP

Patient Name: _____
Date of Birth: _____

PATIENT INFORMATION:			
First Name:	Last Name:	M.I.	Date of Birth:
Street Address:	City:	State	Zip code:
*Check Primary Phone ☐ Home Phone	☐ Work phone	☐ Cell Phone	
Alternate name (if different from above):	Email address:		
Gender: ☐ Male ☐ Female	SSN:	Preferred Language:	Driver's License #:
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Life Partner ☐ Divorced ☐ Separated	Preferred Contact: ☐ Mail ☐ Home Phone ☐ Work Phone ☐ Cell Phone	Race: ☐ American Indian ☐ Hispanic/Latino ☐ Asian ☐ White ☐ Pacific Islander ☐ African American ☐ Other:_____	
Referred By:			
Employment Status: ☐ Unemployed ☐ Full time ☐ Retired ☐ Student ○ Full time ○ Part time			
Patient's Employer:	Patient's occupation:		
Spouse's Employment Status: ☐ Unemployed ☐ Full time ☐ Retired ☐ Student ○ Full time ○ Part time			
Spouse's Employer:	Spouse's occupation:		

RESPONSIBLE PARTY: (GUARANTOR) ☐ SAME AS PATIENT		Relationship to patient:	
First Name:	Last Name:	M.I.	Date of Birth:
Street Address:	City:	State	Zip code:
*Check Primary Phone ☐ Home Phone	☐ Work phone	☐ Cell Phone	
Gender: ☐ Male ☐ Female	SSN:	Preferred Language:	Driver's License #:

EMERGENCY CONTACT (FOR MINOR, THIS SECTION MAY BE USED FOR OTHER PARENT)			
1. Name: (first, last)	Relationship to patient:	Date of Birth:	
Street Address:	City:	State	Zip code:
*Check Primary Phone ☐ Home Phone	☐ Work phone	☐ Cell Phone	
2. Name: (first, last)	Relationship to patient:	Date of Birth:	
Street Address:	City:	State	Zip code:

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*Check Primary Phone	☐ Home Phone	☐ Work phone	☐ Cell Phone

Insurance information:

1. Primary Insurance Carrier:	Primary Insurance Carrier Address:	Relationship to Policy Holder: ☐ self ☐ spouse ☐ parent
Primary Insurance Phone #	Policy and/or Subscriber ID #	Group #
2. Secondary Insurance Carrier:	Secondary Insurance Carrier Address:	Relationship to Policy Holder: ☐ self ☐ spouse ☐ parent
Secondary Insurance Phone #:	Policy and/or Subscriber ID #	Group #

Work or Auto Injury ☐ yes ☐ no	Do you have an attorney ☐ yes ☐ no	If yes, list attorney and/or W/C adjustor's name and phone #

ADVANCED DIRECTIVES

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐Living Will ☐HC Proxy

Date Reviewed: _____

MEDICATIONS – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Medication Name

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medical History – check all that apply, include year onset

Condition	Year	Condition	Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Syndrome	
☐ Asthma		☐ Liver Disease	

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☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer – Type:_____		☐ Osteoporosis	

Medical History (continued) – check all that apply, include year onset

Condition	Year	Condition	Year
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Other: _____	
☐ Diabetes		☐ Other: _____	

Surgical History – Check all that apply, include year performed

Surgical Procedure	Year	Surgical Procedure	Year
☐ None		**Male Only**	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/ Stent		☐ TURP	
☐ Appendectomy		(Trans-urethral resection of prostate)	
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other:_____	
☐ CABG (heart bypass)			
☐ Carpal Tunnel Release		**Female Only**	Year
☐ Cataract Extraction		☐ Augmentation Mammoplasty	
☐ Cholecystectomy		☐ Bilateral Tubal Ligation	
☐ Colectomy		☐ Breast Biopsy	
☐ Colostomy		☐ Cesarean Section	
☐ Gastric Bypass		☐ D and C	
☐ Hernia Repair		☐ Hysterectomy	
☐ Hip Replacement		☐ Mastectomy	
☐ Knee Replacement		☐ Myomectomy	
☐ LASIK eye surgery		☐ Reduction Mammoplasty	
☐ Liver Biopsy		☐ TAH/BSO	
☐ Pacemaker		☐ Vaginal Hysterectomy	
☐ Small Bowel Resection		☐ Other:_____	
☐ Thyroidectomy			
☐ Tonsillectomy		☐ Other surgery:_____	

Family History – check if any family member(s) has had any of the following conditions

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other
Alcoholism	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐

Family History - continued

Diagnosis	Mother	Father	Brother	Sister	Other
Alzheimer's Disease	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐

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Cancer – Type:	☐	☐	☐	☐	☐
CVA (stroke)	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
PVD	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐
Other: (specify)	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

Social History For Adult Patient

Do you have Children? ☐ Yes ☐ No	How many?	Female(s)	Male(s)
Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit:	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:	
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:_____	
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:	Sleep patterns: ☐ changes ☐ no changes	
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets Other: _____	

For Pediatric Patient

Patient lives with:	☐ Mother	☐ Father	☐ Both Parents	☐ Other:

Mother's Occupation:	Father's Occupation:
Parents Relationship: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	Childcare: ☐ Mother ☐ Grandparent ☐ Father ☐ Nanny ☐ Sibling ☐ Daycare
Tobacco Exposure: ☐ Yes ☐ No Smokers at home: ☐ Yes ☐ No	Patient is current smoker: ☐ Yes ☐ No

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Payment Policy

CONSENT TO CARE:

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Stewart Medical Group in regard to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I also hereby authorize Stewart Medical Group to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

_____
Initial

PATIENT RESPONSIBILITY:

· You are responsible for all charges resulting from treatment provided by Stewart Medical Group We bill most insurance carriers; however, primary responsibility for the account is yours. Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made.

· **Your co-payment is always due at the time of service.** You are responsible for knowing what the amount of your co-pay is, and for assuring that it is collected at each visit. The fee will be assessed for any co-pay that your insurance assesses you that was not paid at the time of service.

· If we find it necessary to send your account to collections, you will be required to make a payment at the time of each of your next visits with us or you may be released as a payment.

· Minor: Patients under 18 years of age will be the responsibility of the custodial parent(s)

_____
Initial

INSURANCE BILLING:

· Please bring your current medical card with you to each appointment as we require a copy of your insurance card to be on file with our office. This is to ensure accuracy.

· It is your responsibility to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information immediately so that we may insure all of your charges are billed to the correct insurance company. if your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges in full.

_____
Initial

NOTIFICATION OF RELEASE FOR PAYMENT:

Stewart
MEDICAL GROUP

Patient Name: _____
Date of Birth: _____

I understand that Stewart Medical Group will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions.

I hereby instruct and direct that _____ Insurance Company pay by check made out to STEWART MEDICAL GROUP, 1024 S. Garfield Ave. Alhambra, CA 91801-4762, or if my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it to STEWART MEDICAL GROUP at the address above, for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS and BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment. _____ Initial

RETURNED CHECKS:

It is our office policy to charge a $25.00 fee for checks that are returned regardless of the reason. _____ Initial

AUTHORIZATION TO RELEASE INFORMATION:

· In obtaining payment for services, I authorize Stewart Medical Group to furnish information from my medical record to any company that may be responsible for payment of all or part of my charges

· If I have been referred by, or am being referred to another healthcare provider, I authorize Stewart Medical Group release my medical information to this provider for continuing care.

· I also assign Stewart Medical Group all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. _____ Initial

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE STATEMENTS ABOVE. I HAVE RECEIVED A COPY OF THIS INFORMATION.

_____ _____ _____

Patient Name (Please Print) Date

IF PATIENT IS UNDER THE AGE OF 18 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is _____ year(s) of age is unable to sign because: _____

_____ _____ _____

Patient Name: _____
Date of Birth: _____

Signature Relationship to Patient Date

Sign Below if Disclosure of Information is NOT Authorized:

Therefore, I agree to pay for costs of all treatment and services personally.

_____ _____ _____

Patient Name (Please Print) Date

HIPAA and NOTICE of PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of Stewart Medical Group Notice of Privacy Practices. This Notice describes how Stewart Medical Group may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____ _____

Signature of Patient or Personal Representative Date Relationship to Patient