Beach Family Doctors Medical Group

714-845-5900

Welcome to our practice!

Office Hours / After Hours

Office hours are 8:30am-5:00pm Monday through Friday. Phone hours are 9:00am-12:00pm and 2:00pm-5:00pm. We are closed all major holidays.

For urgent medical issues after regular office hours that can't wait until the next business day, please call our office and leave a message with our service so they can page the doctor. For all other issues, please call us during our regular phone hours.

Same Day/ Urgent Appointments

We understand that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please call the office if you feel you have an urgent matter that needs same day attention. If your doctor is unavailable, we have a Nurse Practitioner and a Physician Assistant who are able to assist you. For our GNP HMO members, Urgent Care is not authorized during business hours. Call 9-1-1 for emergencies.

Medication Refills

We don't want you to run out of your medications. We recommend that you notify the pharmacist to send us a "refill request" and allow us at least 48 hours to process your routine refill. If you prefer to call us, please do so during our regular phone hours and allow 3-4 business days for us to refill your medications.

Canceling Appointments and No-Shows

We require a 24 hours advance notice if you are unable to make it to your scheduled appointment.
We charge a $50.00 no show fee if you fail to keep your scheduled appointment or are more than 15 minutes late for your scheduled appointment time.

Communication

We believe in having good communication between our staff and our patients. We encourage you to express any question or concerns so we may better serve you. We ask that you treat our staff in a polite manner for they are here to help you.

Our online patient portal, NextMD allows you to communicate with our office, request appointments and view and print lab/radiology orders and results. Please ask the office staff to sign you up with your email address.

Treatment without an Office Visit

If you are sick and treated over the phone, there may be a $25.00 fee for services rendered without an office visit.

Co-pays and Deductibles/New Patients/Returned Checks

Co-pays and deductibles are due at time of service. We will only accept cash or credit for a new patient's first visit. There will be a $25.00 service charge for returned checks.

I have read and understand these policies including the NO SHOW FEE POLICY.

X Print name: ___________________________________ Date: ___________________________

X Signature: ____________________________________

BEACH FAMILY DOCTORS
9131 Adams Ave.
Huntington Beach, CA 92646
714-845-5900 Office
714-845-5922 Fax

PATIENT INFORMATION

Name (Last, First, Middle)			Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐
Street address:	City, State Zip	DOB:	Sex: M☐ F☐
SSN#	Home Phone:	Cell Phone:	Email Address:
Student Status: ☐Full-Time ☐Part-Time	Smoker: ☐Yes ☐No	Veteran: ☐Yes ☐No	**Emergency Contact Name:**
Emergency Contact Number:			

Primary Employer:		Secondary Employer (if Applicable)	
Address:		Address:	
City, State Zip	Work Phone:	City, State Zip	Work Phone:

RESPONSIBLE PARTY INFORMATION (if Different than above)

Name (Last, First, Middle)	SSN#	DOB:	Sex: M☐ F☐
Street address:	City, State Zip	Phone:	
Relationship To Patient:			

PRIMARY INSURANCE

Name of Insurance Company:		Policy #:
Name of Insured:	DOB:	Group #:
Address of Insurance Company:		Relationship to Patient:

SECONDARY INSURANCE

Name of Insurance Company:	Policy #:
Name of Insured:	Group #:
Address of Insurance Company:	Relationship to Patient:

I hereby assign my insurance benefits to be made directly to my physician or assisting physicians, for services rendered. I attest that the above information is accurate. I understand that I am responsible for knowing my benefits/coverage and will be financially responsible for all charges not covered by my insurance company. I authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I agree that a photocopy of this agreement shall be as valid as the original. All charges are the direct responsibility of the patient. I understand that services cannot be rendered on the assumption that charges will be paid by the insurance company. If there are problems collecting payment, attorney's fees, collection agency costs and any related fees will be added to my bill. I acknowledge that I have read, understand and agree to give consent to assess, treat, test.

_______________________________ _______________

Signature of Patient/Guardian *Date*

Health Questionnaire 7-18 years

Name:____ DOB:____________ Age:____ Date: __________

PARENTS/GUARDIANS

Mother_________________________________ Occupation____________________ Phone__________________

Father _________________________________ Occupation____________________ Phone__________________

Allergies to Medications____

Current Medications ____

Vaccinations up to date? Y N (Please provide records)

____

____

PAST MEDICAL HISTORY: Has the child had any of the following? **Circle Y for Yes and N for No**

Asthma	Y	N	Anemia	Y	N	Kidney Infections	Y	N
Chicken Pox	Y	N	Dehydration	Y	N	Heart Murmur	Y	N
Ear Infections	Y	N	Seizures	Y	N	Eczema	Y	N
History of Molestation or Abuse			……………………………..	Y	N			

Has the child ever been hospitalized? If yes, please explain:

____

____

Has the child been under a doctor's care for any continuing illness or condition? If yes, please explain:

____

____

Has there been any surgery or major injury? If yes, please explain:

____

____

FAMILY HISTORY

Has any Blood Relative ever had:

Cancer	Y	N	Diabetes	Y	N	Heart Trouble	Y	N
Stroke	Y	N	High Blood Pressure	Y	N	Seizures	Y	N
Mental Illness	Y	N	Alcohol or Drug Abuse	Y	N	Bleeding Problem	Y	N
Asthma	Y	N	Bleeding Tendencies	Y	N	Arthritis	Y	N
Any other illnesses run in the family?..............................				Y	N	Hereditary Disease	Y	N

Please list the general health and list any illnesses for each family member:

Father ____

Mother ____

Brothers/Sisters ____

Maternal Grandparents ____

Paternal Grandparents ____

SOCIAL HISTORY

Circle one: Are parents Single Married Separated Divorced Widowed Other

Any smokers in the house? Y N

Do you have pets? Y N

Brothers/Sisters and ages ____

Extracurricular activities/hobbies (sports, arts, etc.) ____

____

DIET HISTORY	Servings/day		Servings/day
Dairy	________________	Meat	______________
Fruit	________________	Caffeine	______________
Vegetables	________________	Junk Food	______________
Juice	________________	Other	______________

REVIEW OF CURRENT HEALTH

Name:____ DOB:____________ Age:____ Date: __________

General:

Fever	Y	N
Chills	Y	N
Night Sweats	Y	N
Weight loss	Y	N
Weakness or fatigue	Y	N

School:

Homework Problems	Y	N
Behavior Problems	Y	N
School Problems	Y	N
Attention Problems	Y	N
Hyperactivity	Y	N

Other _______________________

Skin:

Hives, eczema or rash	Y	N
Frequent infections	Y	N
New or changing moles	Y	N
Change in hair or nails	Y	N
Abnormal pigment	Y	N
Itching	Y	N

Head, Eyes, Ears, Nose & Throat

Wear glasses	Y	N
Headaches	Y	N
Sneezing/runny nose	Y	N
Sinus problems	Y	N
Nosebleeds	Y	N
Decreased hearing	Y	N
Dental problems	Y	N
Ear problems or disease	Y	N

Gastrointestinal:

Nausea or vomiting	Y	N
Heartburn or indigestion	Y	N
Diarrhea	Y	N
Constipation	Y	N
Blood w/ bowel movements	Y	N
Pain w/ bowel movements	Y	N
Abdominal pain or cramping	Y	N

Nerves & Mental Health:

Numbness or tingling	Y	N
Dizziness or vertigo	Y	N
Fainting spells	Y	N
Depression (feeling sad often)	Y	N
Anxiety (afraid often)	Y	N
Unusual eating habits	Y	N

Urinary:

Loss of urine	Y	N
Urinates more frequently	Y	N
Night time urination	Y	N
Painful or burning urination	Y	N

Musculoskeletal:

Painful joints (including back)	Y	N
Leg pain w/ walking	Y	N
Weakness of muscles or joints	Y	N
Hand and feet swelling	Y	N

Respiratory:

Cough	Y	N
Shortness of breath	Y	N
Upper respiratory infection	Y	N
Wheezing or asthma	Y	N

Blood System:

Any bleeding problems	Y	N
Easy bruising	Y	N
Bleeding gums	Y	N

Cardiovascular:

Chest pain or pressure	Y	N
Irregular or rapid heartbeat	Y	N
Heart murmur	Y	N

Neck:

Thyroid problems or goiter	Y	N
Swollen or enlarged glands	Y	N

Allergies:

Hay fever	Y	N

Other _________________________

Gynecological:

Period started	Y	N
Are they regular?	Y	N

Social:

Dating	Y	N
Ever had intercourse	Y	N
Currently sexually active	Y	N
Ever smoked	Y	N
Ever done drugs	Y	N
Ever drank alcohol	Y	N

Any other concerns you want to tell the doctor?

____

____

____

Person completing this form: ___________________________________ Relationship: ______________________

Signature: ____ Date: ____________________________

Request for Medical Information

1. **Authorization :** I authorize disclosure of information and health records as described below:
   Name of Patient: ____ Date of Birth: ___________
   Telephone: ___________________________

2. **Record Holder:** ____
   Address: ____
   Phone: ______________________________________ Fax: _________________________________

3. **Records May Be Released To:**
   Beach Family Doctors Medical Group
   9131 Adams Ave.
   Huntington Beach, CA 92646
   Phone: 714-845-5900
   Fax: 949-999-8113

4. **Type of Information:** This authorization is limited to the following types of information -

   ___All Records ___Discharge Summary ___Progress Notes
   ___Operative/Procedure ___History/Physical Exam ___Treatment for Alcohol/Drug Abuse
   ___Consultation Reports ___HIV Test Results ___Emergency Department Reports
   ___Psychiatric Records ___Laboratory Reports ___Billing Information
   ___Radiology/Nuclear Medicine Reports
   ___Other_________________________________

5. **Dates of Service:** All ___ or From _______ To _______

6. **Use if Information:** The individual or entity identified above is permitted to use my information for the following purposes: **Please check all that apply.**

   ___Continuing Medical Care ___Second Opinion ___Personal
   ___Insurance ___Legal
   ___Other (please specify) ___________________

7. **Duration:** This authorization is valid for 90 days from the date next to my signature, unless otherwise noted here: ____

8. **Signature:**
   Print Name: ____
   Signature: ____
   Date: _________________________________
   If signed by other than patient, indicate your relationship to the patient: ___________________
   Witness Signature: ____
   Date: _________________________________

HIPAA Notice of Privacy Practices - Acknowledgement of Receipt

Beach Family Doctors Medical Group

9131 Adams Ave.

Huntington Beach, CA 92646

Phone: 714-845-5900 Fax: 714-845-5922

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our office.

X__________________________________ __________________________________ ___________

Signature Print Name Date

If not signed by the patient, please indicate relationship:

☐Parent of minor ☐Guardian of minor ☐Conservator of an incompetent patient

<u>Communication:</u>

Our general office policy is that no information may be left with anyone but the patient. We realize that many patients may find multiple methods of communication acceptable, even though total confidentiality cannot be guaranteed.
Below is a list of communication options. Please place a check mark next to the methods that are acceptable means of communicating information regarding your healthcare, **<u>and write the corresponding information on the line provided</u>**. Please understand that by checking a box you are granting us permission to COMMUNICATE ANY AND ALL INFORMATION TO YOU IN THIS MANNER. Again, a check mark means that we can leave information in that manner. If in doubt, we recommend NOT checking a box.

Home Answering Machine or Voice Mail: ____ Acceptable ☐

Office Voice Mail: ____Acceptable ☐

Cell Phone Voice Mail: ____ Acceptable ☐

E-Mail Address: ____Acceptable ☐

Message with Spouse: ____ Acceptable ☐

Message with Other: ____ Acceptable ☐

X__________________________________ __________________________________ ___________

Signature Print Name Date

AUTHORIZATION FOR OTHER ADULT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize

____ (an adult into whose care the minor(s) has been entrusted)

to consent to 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 surgeon 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

BEACH FAMILY DOCTORS
9131 Adams Ave.
Huntington Beach, CA 92646
www.Beachfamilydoctors.net

Release of Medical Information

I authorize disclosure of medical information and health records as described below:

Name of Patient: ____

Date of Birth: ____

Any and All Records May Be Released to:

Another Physician, Hospital, Laboratory or other Medical Entity Involved in my Medical care.

Signature: ____

Print Name: ____________________________________ Date: _______________

If signed by Guardian, indicate relationship to patient.

____