

# 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 <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>		
Street address:		City, State Zip		DOB:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
SSN#	Home Phone:	Cell Phone:		Email Address:	
Student Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Emergency Contact Name:</b>		<b>Emergency Contact Number:</b>
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 <input type="checkbox"/> F <input type="checkbox"/>	
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*

## Adult Health Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**PAST MEDICAL HISTORY:** Had you ever had any of the following? **Circle Y for Yes and N for No**

Measles	Y	N	Heart Disease	Y	N	Lung Disease	Y	N
Chicken Pox	Y	N	High Blood Pressure	Y	N	Liver Disease	Y	N
Tuberculosis	Y	N	Thyroid Disease	Y	N	Anemia	Y	N
Alcoholism	Y	N	Venereal Disease	Y	N	Asthma	Y	N
Drug Abuse	Y	N	Intestinal Problems	Y	N	Seizures	Y	N
Depression	Y	N	Stroke	Y	N	Ulcers	Y	N
Eating Disorder	Y	N	Diabetes	Y	N	Cancer	Y	N
History of Molestation or Abuse	.....			Y	N			
Have you ever thought about suicide?.....				Y	N			

**ALLERGIES TO MEDICATIONS:** Penicillin / Aspirin / Morphine / Codeine / Sulfa / Iodine Dye/ Adhesive  
Egg / Tetanus / Vaccine / Flu Vaccine / Other Medications

**CURRENT MEDICATIONS**

**PAST HOSPITALIZATIONS**

**SURGERIES**

	Reason	Year	Type	Year
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Vitamins/herbs/nonprescription \_\_\_\_\_

Describe any chronic illness or disease: \_\_\_\_\_

**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 -	Y	N
Asthma	Y	N	Bleeding Tendencies	Y	N	Tendencies		
Any other illnesses run in the family?.....				Y	N			

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

Father \_\_\_\_\_  
 Mother \_\_\_\_\_  
 Brothers/Sisters \_\_\_\_\_  
 Grandparents \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status:	Dependents:	Do you exercise?	Y	N	Sexual History:	
Single _____	_____	Days per week	_____	_____		
Married _____	_____	Do you use Tobacco?	Y	N	Is your sex life	
Divorced _____	_____	Pack per week	_____	_____	satisfactory?	Y N
Separated _____	_____	Do you drink Alcohol?	Y	N	Do you use	
Widowed _____	_____	Drinks per week	_____	_____	contraception?	Y N
		Any Street Drugs like			What type?	_____
		Marijuana or Cocaine?	Y	N		

What is your current profession? \_\_\_\_\_ Any exposure to fumes, dust or chemicals? Y N

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE ENTER THE LAST DATE OF YOUR LAST		<b>GYNECOLOGY</b>	
<b>Immunization</b>		<b>Screening Tests</b>	
Tetanus	_____	Pap	_____
Pneumonia	_____	Mammo	_____
Hepatitis B	_____	Prostate	_____
MMR	_____	Cholesterol	_____
Hepatitis A	_____	Colon Cancer	_____
Chickenpox	_____	Bone Density	_____
		Number of Pregnancies	_____
		Miscarriages	_____
		Living Children	_____
		Periods every _____ days	
		Painful Periods	Y N
		Heavy Periods	Y N
		Last Period	_____
		Abnormal Pap Smear	Y N

**Please review the following list of symptoms. Circle Y if you are CURRENTLY HAVING or if you FREQUENTLY HAVE the symptom listed.**

<b>GENERAL</b>		<b>RESPIRATORY</b>		<b>HEART CIRCULATION</b>	
Fevers	Y N	Cough	Y N	Chest pain	Y N
Chills	Y N	Shortness of Breath	Y N	Chest Pressure	Y N
Night Sweats	Y N	Infections	Y N	Shortness of Breath w/ walking	Y N
Weight Loss	Y N	Wheezing	Y N	Shortness of Breath w/ Laying Down	Y N
Weakness	Y N	Asthma	Y N	Irregular Heartbeat	Y N
Fatigue	Y N	Coughing up Blood	Y N	Rapid Heartbeat	Y N
Snoring	Y N	<b>HEAD EARS NOSE THROAT</b>		Feeling Smothered at Night	Y N
Insomnia	Y N	Headache	Y N	Bleeding Problems	Y N
<b>SKIN</b>		Ringing Ears	Y N	Easy Bruising	Y N
Hives	Y N	Ear Problems	Y N	Bleeding Gums	Y N
Eczema	Y N	Sneezing	Y N	<b>MUSCLES AND JOINTS</b>	
Changing skin lesion	Y N	Runny Nose	Y N	Painful Joints	Y N
Change in Hair	Y N	Sinus Problems	Y N	Back Pain	Y N
Change in Nails	Y N	Hay Fever	Y N	Walking Leg Pain	Y N
Abnormal Pigment	Y N	Allergies	Y N	Weakness	Y N
Itching	Y N	Nose Bleeds	Y N	Swelling Joints	Y N
<b>GASTROINTESTINAL</b>		Hearing Loss	Y N	<b>NERVES MENTAL HEALTH</b>	
Nausea	Y N	Dizziness	Y N	Numbness	Y N
Vomiting	Y N	Dental Problems	Y N	Tingling	Y N
Heartburn	Y N	<b>URINARY TRACT</b>		Dizziness/Vertigo	Y N
Indigestion	Y N	Loss of Urine	Y N	Fainting Spells	Y N
Diarrhea	Y N	Frequent Urination	Y N	Nerve Problems	Y N
Constipation	Y N	Nighttime Urination	Y N	Depression	Y N
Gal Bladder Prob.	Y N	Painful Urination	Y N	Anxiety	Y N
Hemorrhoids	Y N	Kidney Stones	Y N	Panic	Y N
Blood in Stool	Y N	Blood in Urine	Y N	Other Mental Prob.	Y N
Pain w/ Stool	Y N	Frequent Infections	Y N	<b>ENDOCRINE</b>	
Change in Bowel Habits	Y N	Weakened Stream	Y N	Thyroid	Y N
Abdominal Pain	Y N	Difficulty Starting	Y N	Hormone Therapy	Y N
Tarry or Dark Stool	Y N	Prostate Trouble	Y N	Hot Flashes	Y N
Food Sticking in Throat	Y N				

**SPECIAL QUESTIONS FOR THE DOCTOR:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# 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 -

<input type="checkbox"/> All Records	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Operative/Procedure	<input type="checkbox"/> History/Physical Exam	<input type="checkbox"/> Treatment for Alcohol/Drug Abuse
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> HIV Test Results	<input type="checkbox"/> Emergency Department Reports
<input type="checkbox"/> Psychiatric Records	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Billing Information
<input type="checkbox"/> Radiology/Nuclear Medicine Reports		
<input type="checkbox"/> 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.**

<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Second Opinion	<input type="checkbox"/> Personal
<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	
<input type="checkbox"/> 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

**Communication:**

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, **and write the corresponding information on the line provided**. 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



# 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.

\_\_\_\_\_