

Date _____ Doctor _____ Appointment date _____
 Primary care physician _____ Have you ever been treated by one of our doctors: Yes No
 Referred by _____ (physician, attorney, other _____)

Patient Information

Name: Last _____ First _____ Middle _____
 Address (mailing) _____ City _____ State _____ Zip _____
 Street (if different than mailing) _____ City _____ State _____ Zip _____
 Cell phone # _____ Home phone # _____ E-mail _____
 Birth date _____ Age _____ Race _____ Male Female Language preference _____
 Marital status: Married Unmarried Separated Other _____ Social Security # _____
 Patient's employer _____ Occupation _____

Insurance Information

Primary Insurance _____ Policy # _____ ID # _____
 Address of Insurance Company _____
 Insured name _____ Birth date _____ Social Security # _____
 Spouse/Guardian's employer _____ Occupation _____
 Employer's address _____ Employer's phone _____
Secondary Insurance _____ Policy # _____ ID # _____
 Address of Insurance Company _____
 Insured name _____ Birth date _____ Social Security # _____
 Spouse/Guardian's address (if different from patient's) _____ Employer's phone _____

Injury Information

Injury: How did it happen? _____
 Where? _____ Date of Injury _____
Industrial: Did injury occur on-the-job? Yes No Date of Injury _____ Claim # _____
 Employer at time of injury _____
 Employer's Workmen's Compensation insurance carrier _____
 Address of compensation insurance carrier _____

Emergency Contact

In case of emergency, contact _____ Relationship _____
 Emergency contact address _____ Phone _____

Authorization to Release Information and Insurance Benefits: My signature below indicates that I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I authorize my insurance benefits be paid directly and authorize Coon Joint Replacement Institute or insurance company to release any information required to process my claims. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I understand that various portions of my treatment may also be provided by a physician assistant or nurse. Also if patient is a minor, I authorize treatment.

DATE _____ TIME _____ SIGNED _____
(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship _____

Name _____ Date of birth _____ Social Security # _____

Height _____ (required) Weight _____ (required) Handed: Right Left Ambidextrous

Why are you seeing the doctor today? _____

Current problem is the result of a(n): _____

REVIEW OF SYSTEMS

Are you currently having or have you had problems with: (check your response and describe all YES answers)

- | | | | | | |
|--------------------------|-----------------------------|------------------------------------|--------------------------|-----------------------------|------------------------------------|
| Tiredness | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Pain down back of legs | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Weakness | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Digestion | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Weight Loss/Gain | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Heartburn | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Chills | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Bowel movement | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Stool blood red/black | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Night sweats | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Bladder problem/Prostate | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Teeth/Gum problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Urinary tract infections | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Eyes/Glaucoma | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Ears, Nose, Throat | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | High blood pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Nosebleeds | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Bleeding problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Lungs/Breathing | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Paralysis/Weak limbs | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Wheezing | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Loss of sensation | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Loss of balance | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Heart problems/Pacemaker | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Loss of coordination | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Chest pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Numbness/Tingling | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Stroke/TIA | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Skin rash | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Short of breath | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Change of skin color | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Resting/Exertion | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Nail changes | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Joint problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Skin ulcer | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Swelling | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Blackout/Fainting | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Redness | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Depression/Anxiety | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Stiffness | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | AIDS | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Deformities | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Varicose vein | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Polio | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Discoloration | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | TB | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Muscle pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Epilepsy | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Back pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Hepatitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

A B C
(check one)

DATE _____ TIME _____ VIEWED BY _____ MD
 DATE _____ TIME _____ VIEWED BY _____ MD
 DATE _____ TIME _____ VIEWED BY _____ MD

OVER

Name _____ Date of birth _____ Social Security # _____

MEDICATION ALLERGIES

Side effects _____

Side effects _____

Are all immunizations up to date? Yes No, indicate which immunizations are due _____

PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Treating/Doctor	Year	Complications

Have you ever had general anesthesia? No Yes

Have any problems with anesthesia? No Yes, explain _____

FAMILY HISTORY

Member	Alive (A)	Deceased (D)	Age	Health Status of Cause of Death
Grandmother (mom's)	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____
Grandfather (mom's)	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____
Grandmother (dad's)	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____
Grandfather (dad's)	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____
Mother	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____
Father	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____
Sister/Brother	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____
Sister/Brother	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____
Sister/Brother	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____
Sister/Brother	<input type="checkbox"/> A	<input type="checkbox"/> D	_____	_____

SOCIAL HISTORY

Work in the home Employed (occupation) _____

Student Daycare Retired Single Married Divorced Separated Widowed

Children? No Yes, # _____ Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never Type of exercise _____

History of substance abuse:

Smoke currently? No Yes, _____ packs per day for _____ years

Quit smoking: this year over one year over five years over ten years

Previously smoked _____ packs per day for _____ years

Drink alcohol? No Yes: Daily 1-2 times per week 1-2 times per month 1-2 times per year

DATE _____ TIME _____ SIGNED _____ Patient

Our number one goal is to provide you with a safe and high-quality care experience. Our physicians and staff are dedicated to meeting your care needs. You can help assure your safety by partnering with your care team in the following ways:

HAND HYGIENE

Washing/cleansing your hands is one of the easiest ways to avoid spreading an infection.

Our staff will wash their hands (or use a hand sanitizer) each time before and after they care for you. Don't be afraid to ask your care giver if he or she has washed their hands. Ask your family to cleanse their hands as well. Avoid touching wounds or bandages.

RESPIRATORY HYGIENE

Here are some simple steps you can take to keep you and others safe if you have a respiratory (breathing) problem:

- Let your care giver know if you are coughing up any sputum.
- Cough or sneeze into tissue or into your elbow rather than directly into the air or you hands.
- If you are asked to wear a protective mask, please do so.
- Depending on your illness, staff may need to wear a mask as well.

OTHER WAYS TO KEEP YOU SAFE

Your care team works to provide you with safe care. Here are some ways in which you can help:

- **Identification:** Staff will use two methods of identifying you (perhaps your name and date of birth) when performing tests, giving medications, obtaining specimens, ect. This is done for your protection.

- **Medication:** Let your physician and staff know of any medications you are taking, any allergies, and any past difficulties you have had in taking medication. Ask your care giver about medications you are not familiar with taking.
- **Ask Questions:** Please ask questions about the care you are receiving. You have the right to receive the information you need to make an informed care decision. If you do not understand what is being explained or wish further information, do not hesitate to say so.
- **Fall Prevention:** If you feel unsteady on your feet or need assistance walking, let your care giver know. We will assist you to prevent you from falling.

REPORTING A SAFETY CONCERN

If at any time you feel there is an unsafe situation, or believe your care is not as safe as it could be, you or your family may alert us immediately. Report safety concerns to your care giver or unit manager/director or patient advocate.

If you still feel that your concern has not been addressed to your satisfaction, please ask to speak with a patient advocate at St. Helena Hospital who can assist you in reporting your concern to the appropriate external regulatory and/or accrediting agency.

My signature below indicates that I understand the above information and have received a copy of this form.

DATE _____ TIME _____ SIGNED _____ Patient

COPIES: White - Chart; Yellow - Patient

St. Helena Hospital Clinic, St. Helena, CA

**PARTNERING FOR SAFETY
WHAT YOU CAN DO TO HELP**

Clinics

Patient Identification



Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to treatment.

All charges incurred for services in the office will be due and payable at the time service is rendered.

Exceptions: Medicare, Medi-Cal, Health Maintenance Organizations, Preferred Provider Organizations and any AHCMG group contracts. However, all co-pays, deductibles and other appropriate payment responsibility per contract will be collected at the time of service.

Co-Pays: All co-pays are due and payable at the time of service in accordance with the legal requirements prohibiting writing off patient responsibility amounts. You have agreed to be responsible for your co-pay and all will be paid at the time of service or your appointment may be rescheduled.

Proof of Insurance: You are responsible for providing the physician office with correct and accurate insurance information so that we may bill your insurance company and receive payment in a timely fashion. You must bring your insurance card with you at each visit. At each visit you will be asked to review the insurance information in our data bank and will be asked to sign as evidence that the information is correct. We will bill your insurance company for you, however, you are responsible for the payment and the amount is due at the time of service with the exceptions noted above.

Second Insurance: We will bill your secondary insurance once. However, you are responsible for the balance, and the balance owed after payment received from primary carrier will be transferred to you.

Payment Methods: We have a variety of payment methods available including cash, check and credit card.

Worker's Compensation: We will provide treatment for work-related injuries. Any charges incurred for this treatment are ultimately the responsibility of the patient. We will need proof of worker's compensation coverage from your employer and until we receive the appropriate information and approval from the employer, you will be responsible for payment.

Usual and Customary Rates: We are committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates, with the exceptions noted above.

Medicare and Medi-Cal Noncovered Procedures: You are responsible for any noncovered services they request and will be asked to sign a waiver indicating responsibility for payment.

Refunds: If your account becomes over-paid, we will promptly refund the over-payment due.

Non-sufficient Funds Check: All checks received for payment of services and returned by the bank marked "non-sufficient funds" will be charged to you and a non-sufficient check processing charge of \$25 will be charged.

No Show Appointments: We understand that occasionally you will be unable to make scheduled appointments due to emergencies. However, it is expected that you will notify the physician's office within 24 hours of appointment and reschedule the appointment. If you fail to notify the office of a cancellation within 24 hours of your scheduled appointment, a charge of \$25 may be added to your account.

Receipts: We wish to ensure that all patient payments are credited appropriately. Our staff will provide you a receipt for your payment. If the staff should fail to provide you a receipt, please ask for one.

Insurance Coverage: Please be aware that insurance coverage varies with each plan. It is your responsibility to be familiar with your plan. It is your responsibility to know if annual gyn exams are a covered benefit. If you are being seen for contraceptive reasons, it is your responsibility to know what your insurance covers and for payment of the fees for such services.

Laboratory Services: I understand that it is my responsibility to inform this office of any specific laboratory or hospital designated for pap smears, cultures, or any specimen that is collected in the office and sent.

I have read the financial policy and I understand and agree to the financial policy.

DATE _____ SIGNED _____

Patient/Parent/Guardian

COPIES: White - Clinic; Yellow - Billing

Patient name _____

Date of birth _____

I understand that as part of my health care, this organization creates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- basis for planning my care and treatment
- means of communication among the health professionals who contribute to my care
- source of information for applying my diagnosis and clinical information to my bill
- means by which a third-party payer (e.g. insurance carrier) can verify that services billed were actually provided
- and a tool for routine health care operations such as assessing quality and outcomes

I have been provided with a Notice of Privacy Practices that provides a more complete description of information and uses and disclosures.

DATE _____ TIME _____ SIGNED _____
(Patient/Parent/Guardian)

If signed by other than patient, indicate relationship _____

WITNESS _____

Office Use Only

Medical Record Number _____

Acknowledgment of Receipt of Notice of Privacy Practices was not signed as noted below:

- Patient Refused to Sign
- Patient was Unable to Sign

The following attempts were made to obtain signature:

Date	Time	Explanation/Reason	Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10 Woodland Road
 St. Helena, CA 94574

**Acknowledgment of
 Receipt of Notice of Privacy Practices**

Patient Identification

Client name _____

Medical Record # _____