PATIENT INFORMATION CIRCLE DATE OF BIRTH ____/____/____

NAME: _____ MALE FEMALE SOCIAL SECURITY _____-____-_____
LAST FIRST MI

ADDRESS:_____ HOME PHONE (____)_____

_____ WORK PHONE (____)_____
CITY STATE ZIP OR Cell

PLEASE CIRCLE: MARITAL STATUS: SINGLE MARRIED DIVORCED OTHER

REFERRED BY: FRIEND YELLOW PAGES REFERRAL PROGRAM WALK IN OTHER PHYSICIAN_____

EMERGENCY CONTACT (LIVING AT ANOTHER LOCATION)

NAME:_____ RELATIONSHIP_____

DAY PHONE (____)_____ NIGHT PHONE (____)_____

GUARANTOR INFORMATION (WHO IS RESPONSIBLE FOR THIS ACCOUNT-USUALLY, THE PERSON COMPLETING THE FORM)

NAME: _____ SOCIAL SECURITY # _____-_____-_____ DOB _____/_____/_____
LAST FIRST MI

ADDRESS:_____ HOME (____)_____

_____ WORK (____)_____
CITY STATE ZIP

RELATIONSHIP TO PATIENT : SELF FATHER MOTHER GRANDPARENT OTHER_____

EMPLOYER_____ WORK PHONE (____)_____

ADDRESS_____ EXTENSION #_____

_____ DRIVERS LICENSE #_____
CITY STATE ZIP

INSURANCE INFORMATION- Our facility will only file insurance for certain health plans. Please verify whether or not your plan is eligible upon return of this form.

PRIMARY INSURANCE_____ PHONE# (____)_____

ADDRESS_____ POLICY #_____

_____ GROUP #_____
CITY STATE ZIP

NAME OF INSURED_____ INSURED DATE OF BIRTH _____/____/_____

INSURED SOCIAL SECURITY_____-_____-_____ EMPLOYER_____

SECONDARY INSURANCE_____ POLICY #_____

ADDRESS_____ GROUP #_____

_____ PHONE # (____)_____
CITY STATE ZIP

NAME OF INSURED_____

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE PATIENT INDICATED ON THIS FORM. AUTHORIZATION IS HEREBY GRANTED TO RELEASE INFORMATION AS MAY BE NECESSARY TO PROCESS AND COMPLETE MY CLAIM. AUTHORIZATION IS GRANTED TO RELEASE MEDICAL INFORMATION TO ANY PHYSICIANS OR ENTITIES I MAY BE REFERRED TO.

_____ _____
SIGNATURE DATE

I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THIS FACILITY. I UNDERSTAND THE POLICY OF THIS FACILITY IS TO PAY FOR SERVICES AT THE TIME OF SERVICE. IN THE EVENT MY HEALTH INSURANCE IS FILED BY THIS FACILITY, I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE PAID DIRECTLY TO THE ATTENDING PHYSICIAN FOR SERVICES RENDERED.

_____ _____
SIGNATURE DATE

Email:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on _____ *and remains in effect until we replace it.*

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. YOUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

HIPAA Privacy Authorization Form

****Authorization for Use or Disclosure of Protected Health Information**

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

****1. Authorization****

I authorize Dr. L. Alvarado **(healthcare provider) to use and disclose the protected health information described below to** _____ **(individual seeking the information).**

****2. Effective Period****

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ **to** _____.

****OR****

b. ☐ all past, present, and future periods.

****3. Extent of Authorization****

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

b. ☐ I authorize the release of my complete health record with the exception of the following information:

- **☐ Mental health records**
- **☐ Communicable diseases (including HIV and AIDS)**
- **☐ Alcohol/drug abuse treatment**
- **☐ Other (please specify):** _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

---

Date

Medicine Sheet

Pharmacy_____

Patient's Name_____ **Allergies**_____

_____

Medications	**Strength**	**Dosage**

Integrated Medical Care
Luis M. Alvarado, MD.,FACP
Board Certified in Internal Medicine

Medical History:

Name:_____

Why are you seeing this doctor:_____

How long have you had this condition?_____

Last PCP:_____

Medical Conditions or History: Circle yes or no (If yes write what year diagnosed)

High Blood Pressure	Yes___No___	Open Heart Surgery	Yes___No___
Diabetes (sugar)	Yes___No___	Lung Surgery	Yes___No___
High Cholesterol	Yes___No___	Thyroid Surgery	Yes___No___
Heart Blockage	Yes___No___	Brain Surgery	Yes___No___
Heart Attack	Yes___No___	Aortic Surgery	Yes___No___
Leaky Valve	Yes___No___	Stomach Surgery	Yes___No___
Carotid Artery Disease	Yes___No___	Gall Bladder Surgery	Yes___No___
Leg Arterial Blockage	Yes___No___	Colon Surgery	Yes___No___
Stroke	Yes___No___	Prostate Surgery	Yes___No___
Thyroid Disease	Yes___No___	Hysterectomy	Yes___No___
Emphysema or COPD	Yes___No___	Ovarian Surgery	Yes___No___
Asthma	Yes___No___	Tubal Ligation	Yes___No___
Lung Disease	Yes___No___	Bone Surgery	Yes___No___
Arthritis	Yes___No___		
Lupus	Yes___No___	**Cancer and Type**	Yes___No___
Gout	Yes___No___	_____	
Stomach Ulcers	Yes___No___	**Allergies:**_____	
Acid Reflux	Yes___No___	_____	
Duodenal Ulcer	Yes___No___	_____	
Hepatitis B or C	Yes___No___		
Pancreatitis	Yes___No___	**Advanced Directives:**	
Kidney Stones	Yes___No___	Living Will?	Yes___No___
Kidney Disease	Yes___No___	Organ Donor?	Yes___No___
Aneurysm (AAA)	Yes___No___	Power of Attorney?	Yes___No___
		Can We Resuscitate?	Yes___No___

Any other Medical Problems:_____

Other Surgeries:_____

Social History: Type of work:_____Or Retired/Disabled?

Alcohol Yes___No___

Smoking Yes___No___ If yes how many yrs?_____

How many packs a day?_____

Illicit Drugs Yes___No___

Do you drink coffee? Yes___No___ If yes how many cups?_____

Diet Yes___No___

Exercise Yes___No___How and how often? _____

Family History: (Circle)

Father is Alive/Dead Cause:_____Age:___

Mother is Alive/Dead Cause:_____Age:___

Brothers: Yes___No___How many____

Sisters: Yes___No___How many____