Ocean Breeze Medical Group, Inc.

Registration Form

By initialing next to the phone number(s) below, I authorize Ocean Breeze Medical Group, Inc, its physicians and staff to provide to me detailed messages on my voicemail regarding medical information such as: test results, medications, referrals, authorization determination, etc. for my benefit of receiving the information in a timely manner.

Name:	Date of birth:	Sex: M/F	Social Security Number:

Address:	City:	State:	Zip Code:

Marital Status:	Spouse Name:	Home Phone Number: **INITIAL:**	Cell Phone Number: **INITIAL:**

Occupation:	Employer:	Employer Phone #:

Address:	City:	State	Zip Code:

In case of emergency, name and phone number of person we may contact (not living with you):

Pharmacy Name: **City:** **Phone #:**

Email Address:

I the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Ocean Breeze Medical, Inc, Dr. Davalos, and/or Dr.Ebrahimzadeh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

Ocean Breeze Medical Group, Inc.

Notice Of Privacy Practices Acknowledgement

Privacy Official: Ricardo Davalos, M.D.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signature: _____ Date:_____

Patient Name: _____

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Print Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

Please list those individuals and their relationships to you with whom we can communicate via phone and/ or in person **your medical information which may include: test results, diagnosis, plan of care, referrals, medications prescribed, personal discussions, etc.**

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Ocean Breeze Medical Group, Inc. Staff signature/ Witness: _____

Ocean Breeze Medical Group, Inc.

Practice Policies

Welcome to Ocean Breeze Medical Group, Inc. The physicians greatly appreciate you selecting them as your family physician. Our office is committed to offering you state of the art care in a stress-free atmosphere. In order for us to fulfill this commitment to you, we ask that you play a key role and extend the following courtesies:

My Signature below acknowledges my understanding of the following:

Article 1: I understand that my insurance contract is between my insurance company and me. It is the responsibility of the patient to know and understand their medical insurance benefits. I agree that I am required to provide Ocean Breeze Medical Group, Inc. with the most correct and updated information about my insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. I also agree I am responsible for any charges my insurance may not cover. I understand that failure to pay my account or make suitable financial agreements may result in my account being placed in a state of delinquency. If this becomes necessary, I agree to pay all collection fees, which include but are not limited to collection fees, court fees, attorney fees and any other fees for the collection of my account balance.

Article 2: Ocean Breeze Medical Group, Inc. accepts cash, checks, and Visa/ MasterCard payments. I understand that I am required to pay my co-payment or co-insurance at the time of the service. Any other arrangement must be made prior to the appointment. There will be a fee of $25.00 for a returned check. I agree that full payment and returned check fee will be paid in ten days to avoid dismissal from practice. All outstanding balances greater than $100 or balances in collection must be paid and brought current prior to any appointment.

Article 3: OCEAN BREEZE MEDICAL GROUP, INC. REQUIRES A 24 HOUR CANCELLATION NOTICE. IF CANCELLED WITHIN 24 HOURS OR "NO SHOW" FOR YOUR APPOINTMENT THERE IS A $150.00 MISSED FEE FOR EITHER IN OFFICE OR TELEHEALTH VISITS. A $200 FEE WILL INCUR FOR MISSED PHYSICAL EXAMS. REPETITIVE MISSED APPOINTMENTS WITHOUT NOTIFICATION WILL RESULT IN DISMISSAL FROM THE PRACTICE.

Article 4: Walk in patients will be accommodated but will not supersede those with appointments.

Article 5: Referrals will not be granted over the phone until an Ocean Breeze Medical Group, Inc. physician evaluates the patient. As your referral is processed, elements of your medical record may be forwarded to the specialist along with your referral. I authorize to provide the necessary information to the designated specialist.

Article 6: Ocean Breeze Medical Group, Inc. will phone in a prescription to the appropriate pharmacy only under special circumstances. It is the patients' responsibility to provide the pharmacy's name and phone number. Ocean Breeze Medical Group, Inc. will not refill prescriptions written by another physician. Ocean Breeze Medical Group, Inc. will provide you with enough refills to last until your next appointment. Approval of refill request in between appointments is at the discretion of the physician. Due to liability issues, no refills for controlled substances will be granted over the phone unless the patient is re-evaluated by an Ocean Breeze Medical Group, Inc. physician. Lost prescriptions for a controlled substance will not be refilled. Failure to comply with this policy will result in dismissal from the practice.

Article 7: At the discretion of Ocean Breeze Medical Group, Inc. treatments or consultations may be performed over the phone. A charge of $45.00 will be assessed to the caller, which may not be a covered insurance benefit.

Article 8: I allow Ocean Breeze Medical Group, Inc. to photograph my medical and or surgical condition and their treatments. These pictures may be added to my medical records. On rare occasion, once your identity is concealed, these pictures may be used in scientific, educational, or research purposes.

Article 9: I have been offered information on creating an advance directive and understand that information. If I already have an advance directive, I understand it is my responsibility to provide a copy to Ocean Breeze Medical Group, Inc.

Article 10: If you are a Medicare beneficiary: There are many items that are not covered under the Medicare program. To name a few: Pre-operative exams and associated lab work, and some screening tests. It is your responsibility to be aware of your covered benefits. Federal regulations require that we inform you of the above. Your signature on this form will indicate that you have been informed, and that you will be responsible for charges of this nature, should they occur during one of your visits.

Article 11: If you are a Medi-Cal Beneficiary: Be advised that Ocean Breeze Medical Group, Inc. does not participate with the California Medicaid program and cannot bill your services to the Medi-Cal plan.

Article 12: We may use and disclose medical information to contact and remind our patients about appointments.

Article 13: Ocean Breeze Medical Group, Inc. will not discuss results or other medical information with anyone other than the patient unless written consent is provided on **Notice of Privacy Practices Acknowledgement Form.**

_____	_____	_____
Print Patient Name	Responsible Party Name/Signature	DATE

Ocean Breeze
MEDICAL GROUP, INC.

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I DO Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within two weeks, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decisions to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature	Date	Physician Name

Patient Name (PRINT)

OCEANBREEZE MEDICAL GROUP, INC.
HEALTH QUESTIONAIRE

Name _____ Age _____ Date _____
SSN# _____

PAST MEDICAL HISTORY:

Measles……	NO	YES	Seizure……..	NO	YES	Peptic Ulcer……	NO	YES
Mumps……..	NO	YES	Heart Disease…….	NO	YES	Kidney Disease.	NO	YES
Chicken Pox……	NO	YES	Hypertension……..	NO	YES	Diabetes…….	NO	YES
Polio……..	NO	YES	Tuberculosis……..	NO	YES	Thyroid Disease.	NO	YES
Rheumatic Fever	NO	YES	Pneumonia…….	NO	YES	Venereal Disease..	NO	YES
Scarlet Fever…..	NO	YES	Asthma……	NO	YES	Anemia……..	NO	YES
Cancer……..	NO	YES	Hepatitis……..	NO	YES	Blood Clot……...	NO	YES
Stroke……..	NO	YES	Liver Disease…….	NO	YES	Gout……..	NO	YES

Past Hospitalizations:
Year _____ Illness _____
Year _____ Illness _____
Year _____ Illness _____
Year _____ Illness _____

Past Surgeries:
Year _____ Surgery_____
Year _____ Surgery_____
Year _____ Surgery_____
Year _____ Surgery_____

Allergies: (Medication & Food)
1.) _____ Reaction _____
2.) _____ Reaction _____
3.) _____ Reaction _____
4.) _____ Reaction _____

Current Prescription Medications:
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____

Non-Prescription Medications:
Name: _____ Dosage:_____
Name: _____ Dosage:_____
Name: _____ Dosage:_____
Name: _____ Dosage:_____

Immunizations:

Year	
	Influenza
	Tetanus
	Pneumococcol
	Other
	Childhood vaccine's
	Up to date? **Y N**

Social History:

Marital Status: S M Sep D W # of Children _____
Occupation:
Job Satisfaction: □ Yes □ No
Smoker: □ Yes □ No □ In the Past Packs per Day_____ Years___
Caffeine: □ Yes □ No Cups per Day _____
Alcohol: Type_____ Amount _____ Frequency _____
Recreational Drugs:
Advance Directive/Living Will: □ Yes □ No

Family History	**If Living:**		**If Deceased:**		**Has any blood relative Ever had:**	**Relationship**	**NO**	**YES**
	Age	**Health**	**Age**	**Cause**				
Father					Cancer:			
Mother					Type of Cancer:_____			
Husband/Wife					Type of Cancer: _____			
Son/Daughter					Type of Cancer: _____			
					Diabetes			
					Heart Trouble			
					High Blood Pressure			
					Stroke			
Brother/Sister					Convulsions			
					Suicide			
					Mental Illness			
					Bleeding Tendency			
					Gout or other arthritis			
					Hereditary Defects			

GENERAL

Do you eat a well balance diet? _____ NO YES
Approx. weight now ____ 1 yr ago _____
Maximum weight: _____
Exercise? Frequency / wk _____
Activities _____
Any sexual concerns? _____NO YES
Year of last complete physical _____
Headaches _____ NO YES
Glasses/contacts _____NO YES
Double Vision _____ NO YES
Eye disease or injury _____ NO YES
Year last checked for glaucoma _____
Itching eyes or nose/hay fever _____ NO YES
Septal deviation/polyps (circle) _____ NO YES
Nosebleeds _____ NO YES
Sinus trouble _____ NO YES
Ear disease _____ NO YES
Impaired hearing _____ NO YES
Ringing in ear _____ NO YES
Hoarseness _____ NO YES

NECK

Stiffness _____ NO YES
Enlarged glands _____ NO YES
Injury _____NO YES

RESPIRATORY

Coughing up blood _____ NO YES
Chronic cough (including Smoker's Cough) NO YES
Wheezing _____ NO YES
Shortness of breath _____NO YES
How many blocks can you walk without having to stop to catch your breath? _____
Night sweats _____NO YES
Skin test for tuberculosis _____ NO YES
If yes, year tested and results _____
Year of last chest x-ray _____

CARDIOVASCULAR

Chest pain or angina pectoris _____ NO YES
Shortness of breath when lying flat _____ NO YES
Pain in legs on walking, relieved by rest __ NO YES
Varicose veins _____ NO YES
Ankles often badly swollen _____NO YES
Heart murmur _____ NO YES
Rapid, hard or skipped heart beats _____ NO YES
Year of last EKG _____
Have you had a stress treadmill? Year ____ NO YES

GASTROINTESTINAL

Change in appetite _____ NO YES
Heartburn or indigestion _____NO YES
Sour taste in throat or mouth _____NO YES
Intolerance to spicy foods, coffee or alcohol NO YES
Ever vomited blood? _____NO YES
Do foods stick in throat _____NO YES
Gallbladder trouble/intol. to greasy foods NO YES
Intolerance to milk products _____ NO YES
Hiatal Hernia _____NO YES
Pancreatitis _____NO YES
Do you often vomit? _____ NO YES
Crampy abdominal pain _____NO YES
Chronic constipation _____ NO YES
Frequent diarrhea _____ NO YES
Change in bowel habits _____NO YES
Bloody or black bowel movements _____ NO YES
Hemorrhoids or piles _____ NO YES

GENITORURINARY

Loss of urine when cough or sneeze _____ NO YES
Kidney or bladder infection (circle) _____NO YES
Burning or frequent urination (circle) _____ NO YES
Feeling must go immediately? _____ NO YES
Do you have to get up at night to urinate? # NO YES
Blood in urine _____ NO YES
Kidney Stones _____ NO YES
Swelling of hands and feet _____ NO YES
Difficulty starting urination? _____ NO YES
Decrease in strength of stream _____ NO YES
Penile Discharge _____ NO YES
Date of last prostate exam _____

MUSCULOSKELETAL

Significant arthritis/joint pain _____NO YES
Low back pain _____NO YES
Muscle weakness or tenderness _____NO YES
Difficulty walking _____ NO YES
Fractures (list) _____NO YES

SKIN

Skin disorders (list) _____ NO YES

NEUROLGIC/ PSYCHIATRIC

Numbness/ paralysis (circle) _____ NO YES
Fainting spells _____ NO YES
Memory Loss _____ NO YES
Dizziness _____ NO YES
Do you have trouble sleeping? _____ NO YES
Are you often depressed? _____ NO YES
Are you often anxious or nervous? _____ NO YES
Do you ever wish you were dead and away from it all?
Do you often worry? _____ NO YES
Have you ever been under psychiatric care? NO YES

HEMATOLOGIC

Excessive bleeding or abnormal bruising __NO YES

ENDOCRINE

Crave large amounts of fluids _____ NO YES
Intolerance to slightly warm rooms _____ NO YES
Intolerance to slightly cool rooms _____ NO YES
Change in textures of hair or skin _____ NO YES
Change in voice (as an adult) _____ NO YES
Hair Loss _____ NO YES
Diminished sex drive _____ NO YES
Darkening of skin _____ NO YES

GYNECOLOGICAL (this section for women only)

Age when period started _____ Years old
Frequency: every _____ Days; Last period _____
Are they abnormal or irregular? _____NO YES
Menopausal _____ Age _____ NO YES
Number of pregnancies _____ C/sections _____
Term Deliveries _____ premature _____
Miscarriages _____ Abortions _____
Pelvic inflammatory disease _____NO YES
Pain with intercourse _____NO YES
Date of last cancer smear _____ Normal? NO YES
Breast masses, lumps, cyst (circle) _____NO YES
Nipple Discharge _____ NO YES
Skin Discoloration/ dimpling _____ NO YES
Family history of breast cancer? _____NO YES
Date of last mammogram _____NO YES
Did someone other than the patient help fill this out?

Patient Name : _____

Patient Signature: _____

Reviewing Physician: _____