NEW PATIENT REGISTRATION

EDINGER MEDICAL GROUP

Please complete the following forms if you are registering a new patient. Please be sure to verify that we accept your insurance prior to filling out this form and have your insurance card accessible. Fields marked with a red asterisk * must be completed.

Patient Information

Patient Name * _____ Patient DOB * _____

SSN * _____

Address * _____

City * _____ State * _____

ZIP Code * _____

Email Address * _____

Preferred Phone Number * _____ Preferred Phone Number Type *

○ Cell ○ Work ○ Home

Cell Phone Number _____ Home Phone Number _____

Work Phone Number _____

Sexual Orientation & Gender Identity

Sex (Assigned at Birth) *

○ Male ○ Female ○ Unknown

Pronouns

○ he/him/his/himself ○ they/them/their/theirs/themselves ○ xie/hir ("here")/hir/hirs/hirself ○ en/en/ens/ens/enself

○ yo/yo/yos/yos/yoself ○ She/her/her/hers/herself ○ ze/zir/zir/zirs/zirself ○ co/co/cos/cos/cos ○ ey/em/eir/eirs/emself

○ ve/vis/ver/ver/verself ○ Other

Sexual Orientation

○ Lesbian, gay or homosexual ○ Straight or heterosexual ○ Bisexual ○ Do not know ○ Choose not to disclose ○ Other

Gender Identity

○ Male ○ Female ○ Female-to-Male (FTM)/ Transgender Male/Trans Man

○ Male-to-Female (MTF)/ Transgender Female/Trans Woman ○ Genderqueer, neither exclusively male nor female

○ Choose not to disclose ○ Other

Demographics

Marital Status *

○ Single ○ Married ○ Divorced ○ Widowed ○ Legally Separated

Employment Status * **Employer** _____ **Occupation**_____

○ Full time ○ Part time ○ Unemployed ○ Retired

Insurance Information

Do you have medical insurance? Yes No

Policy Holder Name _____ DOB: _____

Insurance Company _____

Subscriber ID # * _____ **Group Plan #** * _____

Do you have secondary insurance? * Yes No

Secondary Policy Holder Name _____ **Secondary Insurance Company** _____

DOB: _____

Secondary Subscriber ID # _____ **Secondary Group Plan #** _____

In Case of Emergency: Please provide contact information of a family member, friend or relative. This is not your physician. If you wish to add additional emergency contact, please let us know at your next appointment.

In case of emergency, whom should we contact? * _____

Emergency Contact's Relationship to Patient * _____

City * _____ **State** * _____

ZIP Code * _____

Emergency Contact's Phone Number * _____ **Emergency Contact's Number Type** *

Cell Home Work

Insurance Assignment and Authorization

I hereby authorize Edinger Medical Group to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments for medical services rendered to my dependents or myself to Edinger Medical Group. I understand that I am responsible for any amount not covered by insurance.

Insurance Assignment and Authorization

☐ By checking this box, I acknowledge that I have read and hereby agree with the terms and conditions in the insurance Assignment and Authorization

Pharmacy History Authorization

I hereby authorize the physicians of Edinger Medical Group to review my medication history as prescribed by other physicians.

Pharmacy History and Authorization

☐ By checking this box, I acknowledge that I have read and hereby agree with the terms and conditions in the Pharmacy History and Authorization

Signature *

Signer's Name * _____

Name: _____

DOB: _____

Primary Language *

○ English ○ Spanish ○ Arabic ○ Chinese ○ Vietnamese ○ Other

Ethnicity *

○ Hispanic or Latino ○ Not Hispanic or Latino ○ Refused to Respond

Race *

○ White ○ Hispanic ○ Asian Black or African American Native Hawaiian ○ Other Pacific Islander

○ Refused to Report ○ Other

Pharmacy Information

Primary Pharmacy Name * _____ Primary Pharmacy Phone Number * _____

Primary Pharmacy Address * _____

City * _____ State * _____

ZIP Code * _____ Do you have a secondary or mail-in pharmacy *

○ Yes ○ No

Secondary/Mail-In Pharmacy Name Secondary/Mail-In Pharmacy Phone Number

City * _____ State * _____

ZIP Code * _____

How did you hear about us? *

○ Health Plan Website/Directory Advertisement Landmark ○ Google ○ Other Website

○ Social Media ○ Other ○ Family/Friend

Advertisement

○ OC Register ○ Seacliff Living ○ HB Living ○ BeLocal ○ FV Living ○ Yelp ○ Landmark Newsletter

○ Social media ○ Other

Current and Past Medical History

Please check the box of any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when an illness started, enter an approximate year.

- ☐ Allergies or Hay Fever
- ☐ Anemia
- ☐ Anxiety/Panic Attack
- ☐ Arthritis
- ☐ Asthma
- ☐ Benign Tumor
- ☐ Bleeding Tendency
- ☐ Breast Lumps or Fibrocystic Dis.
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Convulsions, Seizures
- ☐ Deafness or Decreased Hearing
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Emphysema
- ☐ Gallbladder Trouble
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Hemorrhoids
- ☐ Hepatitis/Jaundice
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Kidney Stones
- ☐ Life Threatening Allergies
- ☐ Liver Trouble
- ☐ Lung Problems
- ☐ Pneumonia
- ☐ Prostate Problems (male only)
- ☐ Sexually Transmitted Disease Skin
- ☐ Problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Tuberculosis
- ☐ Ulcerative Colitis or Chron's Disease

Prior Hospitalization and Surgeries

Surgery (1) _____ **Surgery Date (1)** _____

Results/Complications (1) _____

Surgery (2) _____ **Surgery Date (2)** _____

Results/Complications (2) _____

Surgery (3) _____ **Surgery Date (3)** _____

Results/Complications (3) _____

Reason for Hospitalization 1 _____ **Hospitalization Date 1** _____

Reason for Hospitalization 2_____ Hospitalization Date 2_____

Reason for Hospitalization 3_____ Hospitalization Date 3_____

Current Medications

Name of Medication (1)_____ Dose (1)_____ Strength (1)_____

Name of Medication (2)_____ Dose (2)_____ Strength (2)_____

Name of Medication (3)_____ Dose (3)_____ Strength (3)_____

Allergic Reaction to Medication

Medication (1)_____ Type of Reaction (1)_____

Medication (2)_____ Type of Reaction (2)_____

Medication (3)_____ Type of Reaction (3)_____

Include any additional medication allergies and reactions

Menstrual History

Only complete if "Female" was selected for "Sex (Assigned at Birth)" on Page 1.

Date of Last Period	Regular?	# of Pregnancies	# of Live Children	# of Miscarriages	# of Abortions
	○ Yes ○ No				

Family History

If any blood relative has suffered any of the following - please check the box and indicate which relative.

- ☐ Epilepsy
- ☐ Migraines
- ☐ Mental Illness
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Depression
- ☐ Asthma
- ☐ Hay Fever
- ☐ Stroke
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Other
- ☐ Cancer

Health Risk Factors

Do you smoke?

○ Yes ○ No

For how many years?

How many packs per day?

If you've quit, what year?

Do you consume alcohol?

○ Yes ○ No

What type of alcohol?

How many drinks per week?

How many drinks per day?

Other Health Risk Factors (Check all that apply)

☐ Drug Use ☐ Significantly Increased Body Weight

☐ HIV Risk Factor Blood Transfusions, Hemophilia, History of IV Drug Usage, High Risk Sexual Behavior) ☐ Sedentary Lifestyle

☐ Other

Other

If not currently in a mutually monogamous relationship, do you routinely use condoms?

○ Yes ○ No

Do you examine your breasts monthly?

○ Yes ○ No

If you are sexually active and not planning a pregnancy, do you use a form of contraception?

○ Yes ○ No

Do you routinely wear a seatbelt?

○ Yes ○ No

Provider Signature*

Patient Name *_____

Today's Date *_____

Electronic Communication Consent

Edinger Medical Group communicates with patients via text message and email about non-sensitive and non-urgent issues relating to your healthcare. By providing your cell phone number and email address on this form, you agree to receive these notifications. Your email address will also be used to enroll you in the MyEMGChart Patient Portal. Please note, you may contact our office to opt-out or unsubscribe from these services at any time.

☐ **Please check here to acknowledge that you have read and understand these terms** *

Patient Financial Policy and Agreement

Edinger Medical Group EMG is committed to serving your healthcare needs. Please understand that payment of your bill is considered part of your healthcare relationship with our medical group and providers. This document is Edinger Medical Group's Patient Financial Policy. EMG requires that you read, sign, and agree to this policy prior to receiving treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

INSURANCE BILLING

Your insurance policy is a contract between you and your health insurance company. It is your responsibility to know your benefits and how they will apply to the treatment you receive. All patients are responsible for their co-payment, co-insurance, unmet deductible, and cost of non-covered services at the time of the visit.

Depending on whether you are an HMO, PPO or CASH patient, you will initial next to the statement below that applies to you. *

- ◯ I am an HMO patient.
- ◯ I am a PPO patient.
- ◯ I am a CASH patient.

CONTRACTED HMO PLANS: All copays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. *

CONTRACTED PPO PLANS: We bill your insurance company as a courtesy. All co-pays, co-insurance unmet deductible, and cost of non-covered services will be collected at the time of the visit. Any remaining balances due after contract adjustments and health plan payments are your responsibility. You will receive a statement for this remaining financial responsibility. All patient balances are due within 30 days of our statement date. *

CASH PATIENTS: All services must be paid in full at the time of the visit/treatment. Our offices will provide you with an estimate of the cost of treatment before the visit. *

OUT OF NETWORK PLANS

For patients with plans with which we are Out of Network, our offices will provide you with an estimate of the cost of treatment before the visit.

PAST DUE ACCOUNT BALANCES

Patients with an outstanding balance deemed past due (90 days) must speak with an account representative prior to future appointments.

REPORTING OF DELIQUENT ACCOUNTS TO CREDIT AGENCIES

If a patient account balance becomes delinquent and the patient account is suspended, that delinquent balance will be reported to national credit agencies. This may affect your current and long-term credit status adversely. These delinquent balances will remain in effect with credit bureaus indefinitely in the future until your overdue balance is paid.

RETURNED CHECKS
A $25.00 fee will be charged for any returned check.

OPEN PAYMENTS
The Open Payments database is a federal tool used to search for payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

To acknowledge that you have read and understood the statements above, initial here: *

Patient Financial Policy Agreement

| have read the above EMG Patient Financial Policy, agree to abide by it, and have provided EMG with true and correct insurance information. I will notify EMG of any change in my health insurance coverage. I assign any payment and/or benefit from my insurance carrier for these services to EMG. I further authorize the release of any medical records necessary for REPORTING OF DELIQUENT ACCOUNTS TO CREDIT AGENCIES If a patient account balance becomes delinquent and the patient account is suspended, that delinquent balance will be reported to national credit agencies. This may affect your current and long-term credit status adversely. These delinquent balances will remain in effect with credit bureaus indefinitely in the future until your overdue balance is paid. RETURNED CHECKS A $25.00 fee will be charged for any returned check. OPEN PAYMENTS The Open Payments database is a federal tool used to search for payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

To acknowledge that you have read and understood the statements above, initial here: * the adjudication and payment of claims or any authorizations for services or procedures rendered or to be rendered.

Signature *

Signer's Name * _____

Print Responsible Party Name

(If different from patient)

_____

Today's Date * _____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, * _____

Name

, understand that as part of my health care, Edinger Medical Group originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and will be provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Edinger Medical Group is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I wish to have the following restrictions to the use or disclosure of my health information:

I wish to share my electronic medical records in efforts to assist me with current or future care needs:
I understand that I have the right to revoke this privilege in writing.

Name
Email Address

Relationship
Phone Number

Patient Consent and Authorization *

- ○ I fully understand and ACCEPT the terms of this consent.
- ○ I fully understand and DECLINE the terms of this consent.

Signature *

Signer's Name *

Today's Date *

Name: _____

DOB: _____

Phone Number: _____

Address: _____

Medical Records Release Form

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Would you like you Edinger Medical Group to retrieve your medical records from a previous physician's office? *

○ Yes ○ No

I (the patient) authorize Edinger Medical Group to retrieve my medical records from the following physician/facility:

Outside Physician's Information

Name of Physician/Facility * _____ **Fax Number** * _____

Address 1 * _____

Address 2 _____

City * _____ **State** * _____

ZIP Code * _____

Health Information Release Authorization

Date Range of Health Information * _____

Part A: Health Information to be Released *

☐ Billing Records ☐ Lab Reports ☐ Specific Visit ☐ X-Ray Reports ☐ Immunization Records ☐ OB/GYN Records
☐ X-Ray Films ☐ Other

Part B: In compliance with California Statutes, which require special permission to release otherwise privileged information, please INITIAL next to the records that you want released: (separate specific authorization required)

Mental Health	Drug Abuse	Alcohol Abuse	HIV/AIDS Testing

Health Information Release Authorization

By initialing here, I (the patient) hereby authorize the use and/or disclosure of my health information as described in Part A and/or Part B. *

Information Regarding Release of Health Information

Edinger Medical Group recognizes the patient's right of confidentiality of their health information under federal privacy regulations and California law. The patient should be aware of the following information when requesting or releasing health information.

Right to Refuse to Sign this Authorization: This authorization is voluntary. Refusal to sign will not affect the patient's ability to receive treatment or payment of claims.

Right to Inspect or Receive a Copy of Health Information to be Used or Disclosed: A patient has the right to inspect or obtain a copy of the health information they have authorized to be used or disclosed by signing this Authorization form.

Right to Receive a Copy of this Authorization: A patient has the right to revoke his authorization at any time by giving written notice of revocation to the Privacy Officer. Revocation of this authorization WILL NOT affect any action taken in reliance of this authorization before receipt of the written notice of revocation.

Multiple Releases of Information: A patient may request multiple releases of the information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release of information for care provided after the date of the patient's signature, UNLESS the authorization specifically states that SPECIFIC RECORDS that will be generated in the future may be released, for example, "future records of a specific test" or "future records of specific clinic appointment."

Who May Sign this Authorization

1. Generally, all patients 18 years of age and older must sign for release of their own health information unless the following conditions apply:
   - The patient is incompetent.
   - The patient is disabled and cannot sign the form.
   - The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If there is no surviving spouse or representative, then an adult member of the immediate family may sign.)
   - IMPORTANT: With very few exceptions, if the patient is age 18 or older, parents' signatures ARE NOT acceptable.

2. All persons signing for release of health information on behalf of the patient must state their relationship to the patient and provide legal proof of legal authority of their capacity to act for the patient.

3. Minors: Patients less than 18 years of age must sign for release of health information in the following cases:Alcohol or other drug-related abuse treatment:
   - Alcohol or drug-related abuse treatment: age 12 or older.
   - Mental health treatment: age 12 or older may consent to release of records without parental consent.
   - HIV test results: age 12 or older.
   - Emancipate minors who are married or in the military.

Fees for Records: Copies of a patient's medical record sent directly to another physician or medical facility will be made generally at no charge; however, if many requests are made, a copying fee may be applied as allowed by California law.

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be disclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Edinger Medical Group | Medical Records
Email: medicalrecords@edingermedicalgroup.com
Fax: 714-965-2595

Acknowledgement

This authorization will expire on the date below. If I (the patient) do not indicate a date, this authorization will expire one (1) year from the date of my signature.

Signer's Name *

Signature *

Was this signed by someone other than the patient? *

◯ Yes ◯ No

If yes, please state your legal relationship to the patient

Today's Date *