Bear Valley Primary Care

12186 Hesperia Rd. Victorville, CA 92395

Ph: (760)381-8848 Fx:(760)381-8810

Last name: _____ **First Name:** _____ **DOB**_____ **M / F**

Reason for visit: _____ **How many days/weeks**: _____

Is this a work related problem? Yes / No

Medical History:

High blood pressure	Y / N	Thyroid Problem	Y / N
Diabetes	Y / N	Asthma	Y / N
Ulcers	Y / N	C.O.P.D	Y / N
Heart murmur/ valve disorder	Y / N	Alcohol abuse	Y / N
Stroke	Y / N	Smoker and if so packs per day _____	
Heart attack	Y / N	Depression	Y / N
Cancer	Y / N	Anxiety	Y / N
Gallstones	Y / N	High Cholesterol	Y / N
Kidney stones	Y / N	Other (please list):_____	
Blood Transfusión	Y / N		
Immunological Disorder	Y / N		
Diverticulosis	Y / N		

Family History: Please indicate health status or cause of death, diseases related to presenting problem &/or hereditary or high risk diseases. **NONE**

Mother: _____ Children: _____

Father: _____ Siblings: _____

Operations/Surgeries **NONE**

Name of Operation/surgery Year Complications

1._____

2._____

3._____

Medications Dosage/Frequency **NONE**

1. _____

2._____

3. _____

Medications Dosage/Frequency **NONE**

4._____

5._____

6._____

Allergies to Medication: **NONE**

Name:	Reaction	Name:	Reaction:

Patient signature:_____ **Date:**_____

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PATIENT REGISTRATION

Patient Name:_____ **Gender**: _____ **Date**:_____

Mailing address: _____ **Apt :** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Date of Birth: _____ **Social Security:** _____

Race: White Black Asian Middle Eastern **Other:** _____ **Ethnicity:** _____

Primary language: _____ **Do you need a translator: [ ] Yes [ ] No**

Marital Status: Single Married Divorce Widow **Email Address**:_____

Employer: _____ Occupation: _____

Address: _____ Suite/Unit/Apt: _____

City: _____ State:_____ Work Phone: _____

Primary Care Provider: _____ **Phone:** _____

Emergency contact: _____**Phone**:_____ **Relationship:**_____

Emergency contact is required by your insurance, if you REFUSE to provide one please initial here: _____

What Pharmacy would you like to use? _____ **City/Street:**_____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Phone:_____

Subscriber Name: _____ DOB: _____

Subscriber ID Number: _____Patient relationship to subscriber: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Carrier: _____ Phone:_____

Subscriber Name: _____ DOB: _____

Social Security: _____ Patient relationship to subscriber: _____

Subscriber ID Number: _____ Group Number:_____

Do you have an Advanced Directive? [ ] Yes [ ] No

Would you like more information about how to obtain an Advanced Directive? [ ] Yes [ ] No

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PATIENT NAME: _____ **DOB:**_____

CONSENT TO MEDICAL SERVICE: The undersigned consent to the procedures which may be performed, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, medical treatment or procedures, services rendered to the patient under the general and special instructions of the patient's physician, and to participate in the patient and employee protection program.

PRESCRIBE: The undersigned authorizes bear valley urgent care to request and use patient's prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

RELEASE OF INFORMATION: The urgent care may disclosure all or any part of the patient's record to any person, company or corporation which is or may be liable under a contract to the urgent care or to the patient or to a family member or employer of the patient for all or part of the urgent care charge, including but not limited to hospital or medical service companies, insurance companies, workman's compensation, or welfare funds. The patient's record may be forwarded to the primary care physicians or to another facility in the event of transfer.

ASSIGNMENT OF BENEFITS: Insurance is billed as a courtesy to the patient and is not an obligation. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment of any insurance benefits otherwise payable to or on behalf of the urgent care, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment and any applicable co-payments, co-insurances or deductible amounts.

FINANCIAL RESPONSIBILITY: In the event that the patient was evaluated by a physician, physician assistant and/or nurse practitioner at **Bear Valley Urgent Care**, and was advised to go to another facility or physician for further treatment and evaluation, the undersigned agrees that they are responsible for any applicable co-payments, co-insurances or deductible amounts.

Relationship to Patient: Self Mother Father Other**:** _____

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the assignment of insurance benefits.

Date _____ **Responsible Party** _____

(Sign Here)

Only sign below if you are a person who is given the authority to stand in the place of another. An authorized representative is an individual or organization that is selected by the patient to represent his/her interest in all aspects of their medical care. By: _____ _____

It's duly authorize representative signature Patient Agent or Representative (Print Name)

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Medical Record Request

Patient Name: _____ DOB:_____ Date: _____

[ ] Requesting records **to be sent** to Bear Valley Primary Care from the following…

Name: _____
Attention:_____
Address: _____
Phone: _____
Fax: _____

Please send the medical records from the following date from: _____ to: _____

- ☐ **Labs** **Other: _____**
- ☐ **Progress notes**
- ☐ **History and physical**
- ☐ **Consultation notes**

Purpose of requested use or disclosure

- ☐ **Continuing care** **Other: _____**
- ☐ **Patient request**
- ☐ **Insurance**
- ☐ **Legal**

I specifically authorize release of the following information **(check and initial as appropriate)**

- ☐ **Mental health treatment information** **initials_____**
- ☐ **HIV test results** **initials_____**
- ☐ **Alcohol / drug treatment information** **initials_____**

*if not checked and initialed the records containing such information can ***NOT*** be released.

Duration: this authorization expires: _____

*if no Date is given; this authorization will expire 6 months from the signature date.

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to the address specified in the "requesting records from" section above. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some case not protected by federal confidentiality law (HIPPAA)

Conditioning: I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law; my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. **This authorization is being requested of you to comply with the terms of the confidentiality of the medical information Act of I98I, civil code section 56 et seq. and the health insurance portability and accountability act (HIPAA) OF 2003.**

Patient/Legal Representative Signature: _____Date: _____