Dignity Health Medical Group
Ventura County
A Service of Dignity Health Medical Foundation

PATIENT INFORMATION

Do you need an Interpreter?			What is your primary language?		
Last Name	First Name	M.I.	Sex (M/F)	Date of Birth	Social Security Number
Patient's Address		City	State		Zip Code
Patient's Home telephone	Work Phone		Message Phone		Martial Status (S, M, D, or W)
Patient's Employer	Employer's Street Address		City, State, Zip Code		Telephone

GUARANTOR INFORMATION (COMPLETE ONLY IF PATIENT IS A MINOR OR A FULL-TIME STUDENT)

Father's Name (Last, First, MI)	Father's Address (If different from the Patient's)	
Father's Employer	Employer's Street Address	City, State, Zip Code
Father's Social Security Number	Date of Birth	Business Phone
Mother's Name (Last, First, MI)	Mother's Address (If different from the Patient's)	
Mother's Employer	Employer's Street Address	City, State, Zip Code
Mother's Social Security Number	Date of Birth	Business Phone

SPOUSE OR EMERGENCY INFORMATION

Last Name	First Name	Relationship	Telephone

INSURANCE INFORMATION

Prim ary Insurance Co.	Policy Number	Group Number	Plan Code
Subscriber Name	Date of Birth	SS#	Employer
Secondary Insurance Co.	Policy Number	Group Number	Plan Code
Subscriber Name	Date of Birth	SS#	Employer

DOES THE PATIENT HAVE ANY OTHER MEDICAL INSURANCE? IF YES, PLEASE COMPLETE BELOW:

Insurance Co.	Subscriber	Policy Number

NEAREST RELATIVE (NOT LIVING WITH YOU)

Relatives Name	Street Address	Phone Number

How did you hear about our clinic?
Please check boxes and indicate which

☐ Newspaper ☐ Radio ☐ Television
☐ Family, Friend ☐ Postcard Mailing ☐ Insurance Co.
☐ Website ☐ Physical Referral ☐ Other (please specify) _____

My signature below authorizes the above named insurance company(s) to pay for all medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance company. I authorize release of medical information to said insurance company. Additionally, my signature provides willing consent to the procedures which may be preformed, including emergency treatment or services, and which may include but is not limited to, laboratory procedure, x-ray exams, medical or surgical treatment or procedures, anesthesia, or services rendered to the patient under the general and special instructions of the patient's physician or his designate.

_____ _____
Signature If Not Patient, Relationship

_____
Date

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Patient Intake Form

Last Name: _____ **First Name:** _____

Preferred Name: _____ **DOB:** _____

Preferred Phone # (____) _____ **(circle one: cell home work)**

Preferred Pharmacy _____

Occupation: _____

Medical History: (circle any that apply)

Diabetes High Blood Pressure High Cholesterol Heart Disease Cancer

Other/explain: _____

Tobacco use? No Yes If yes, type of tobacco and # of years: _____

If a former tobacco user, when did you quit and how long did you use?

Alcohol use? No Yes If yes, type frequency and amount: _____

Current Medications: (including over the counter)

Allergies: (medications, foods, and explain reaction)

Surgical History and/or Hospitalization: _____

Family Medical History: (father, mother, and siblings, etc..) (circle any that apply)

Diabetes High Blood Pressure High Cholesterol Heart Disease Cancer

Other/explain: _____

Desired outcome for this visit: _____

Patient Signature: _____ Date: _____

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ADVANCE DIRECTIVE STATUS

I have been informed of my right to formulate an Advance Directive, and I have been provided with information regarding the execution of an Advance Directive. (Check one):

- ☐ I have previously completed an Advance Directive and have provided a copy for inclusion in my medical record.
- ☐ I will provide a copy of my previously executed Advance Directive to Dignity Health Medical Group - Ventura for inclusion in my medical record.
- ☐ A copy of my Advance Directive is on file with _____
  Name of Provider or Health Care Facility
- ☐ I have not executed an Advance Directive and I am not interested in any further information.
- ☐ I am interested in formulating and Advance Directive and will discuss my options with my primary care physician.

_____ _____
Patient Signature Date

_____
Patient Name (Please Print)

Comments (include steps taken to obtain a copy of Advance Directive):

_____

_____

_____

☐ A copy of the Advance Directive has been requested.

_____ _____
Signature of Group Representative Date

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Joint Notice of Privacy Practices for Health Information (NPP) Acknowledgment Form

Effective April 14, 2003, the law requires that Dignity Health Medical Group - Ventura County give to a patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care.

Patient Name: _____ Medical Record #: _____

Acknowledgment Signature: _____ Date: _____

Print Name: _____ Relationship to patient: _____
(if signed by someone other than patient)

For Official Use

I provided a copy of the NPP to the patient (or personal representative) but was unable to obtain his or her written acknowledgment of receipt of such for the following reasons:

_____

_____

I have attempted to provide to the patient (or personal representative) a copy of the NPP, but was unable to do so for the following reasons:

_____

_____

Signature of Hospital Representative: _____ Date: _____

Print Name: _____ Department: _____

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CONSENT TO TREATMENT

Name of Patient: _____ **Date:** _____

Birth Date: _____

1. **Consent to Treatment:** The undersigned consents to health care encompassing routine diagnostic procedures and other health services rendered to the patient by Dignity Health Medical Group - Ventura County, and its duly authorized agents and personnel.

2. **No Guarantees:** It is understood that the practice of medicine and surgery and the rendering of health care is not an exact science and that no guarantees have been made as to the results of treatments, examinations or other health services rendered by Dignity Health Medical Group - Ventura County.

3. **Release of Information:** The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Dignity Health Medical Group - Ventura County may disclose portions of the patient's records, including his/her medical records, to any person or entity which is or may be liable, for all or any portion of Dignity Health Medical Group - Ventura County's reimbursement for charges. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.

4. **Assignment of Benefits:** The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Dignity Health Medical Group - Ventura County or any insurance benefits otherwise payable to or on behalf of the undersigned for treatment and health care services rendered by the patient's health plan, at a rate not to exceed Dignity Health Medical Group - Ventura County's regular charges. It is agreed that payment to Dignity Health Medical Group - Ventura County, 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 that he/she is financially responsible for charges not covered by this assignment pursuant to Paragraph 5 below.

5. **Financial Agreement:** If the patient is not a member of an HMO at the time of services rendered, the undersigned agrees, whether he/she signs as an agent or as patient that he/she hereby individually obligates himself/herself to pay the account to Dignity Health Medical Group - Ventura County; in accordance with the regular rates and terms of Dignity Health Medical Group - Ventura County. Should the account be referred to an attorney or collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at a legal rate.

6. **Certification:** The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or duly authorized by the patient as the patient's general agent to execute this Agreement and to accept its term.

_____ **Signature:** _____
Date and Time of Signing — Patient/Parent/Guardian/Conservator/Other

_____ _____
Witness — If signed by other than patient, indicate relationship

Financial responsibility Agreement by Person Other Than the Patient or the Patient's Legal Representative, I agree to accept financial responsibility for services rendered to patient and to accept the terms of the Financial Agreement and Assignment of Insurance Benefits Provisions above.

_____ **Signature:** _____
Date and Time of Signing — Financially Responsible Party

Driver's License Number/Identification Card Number/Social Security Number: _____

_____
Witness

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TB Screening Questionnaire

Today's Date _____

Name: _____ Date of Birth: _____

1. Have you ever had a skin test for tuberculosis (PPD)? Yes ____ No ____
   If yes, when was your most recent test? Date _____
   What was the result? Negative ____ Positive ____
2. If your TB test result was Positive, what is the date of your most recent Chest X-Ray?
   Date: _____ What was the result? _____.
3. Have you ever been treated for a positive TB test result? Yes ____ No ____
   If yes, what medication were you given? _____.
   When were you treated? From: _____ to _____.
4. Have you ever been exposed to anyone with active Tuberculosis? Yes ____ No ____
5. Have you ever lived or worked in a medical clinic or hospital, a homes shelter, drug or alcohol detox facility, or jail where you may have had direct contact with anyone infected with Tuberculosis? Yes ____ No ____
6. Have you ever lived or traveled in Africa, Asia, Central America, Mexico or South America? Yes ____ No ____
7. Do you have any medical illnesses of your immune system: Cancer, HIV (AIDS), alcohol and/or drug addiction? Yes ____ No ____
8. Have you had any treatment with chemotherapy or prednisone (cortisone)? Yes ____ No ____
9. Have you ever received the BCG vaccine?
   If yes, Date (approximate):

REVIEWED BY MD: TB Risk _____ High _____ Low MD Initial: _____

This part to be completed by the medical technician. Test placed by _____

Date of Test: _____ dose: _____ Site: _____

Manufacturer _____ Lot #: _____ Expiration Date: _____

Date Read: _____ Read by _____ Result: Induration: _____ x _____ mm

Interpretation: Positive _____ Negative _____

Action taken: _____

(The form below may be completed, removed and given to the patient for their records)

Name: _____ Date: _____

TB Test (PPD) results: Positive ____ Negative ____ Date of test: _____ Date read: _____

Signature of person reading test: _____

Name of Provider or Medical Clinic: _____

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Consent to Release Protected Health Information

Patient Name _____ MRN _____

In the event we need to contact you regarding lab / test results or other sensitive information, may we leave a detailed message on your voicemail?

☐ Yes Phone Number(s): Cell: _____ Home: _____

☐ No

Signature of Patient: _____ Date: _____

Would you like our office to mail your test results to your home?

☐ Yes Mailing Address: _____

☐ No

Signature of Patient: _____ Date: _____

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The state of California mandates that medical information may be shared only with the patient, or the patient's legal representative. In accordance with this law, every employee of Dignity Health Medical Group of Ventura County is required to sign a Confidentiality Statement on an annual basis, indicating they will keep the medical information of every patient in the strictest confidence.

The staff and / or physicians cannot release medical information to family members of patients without permission from the patient or the patient's legal representative.

If you wish to give permission for the staff and / or physicians to verbally release general medical information to family members, list the name(s) and relationship of those individuals in the space provided below. General medical information excludes the discussion of psychiatric services, drug and alcohol counseling, sexually transmitted diseases, HIV testing, and pregnancy or termination of pregnancy.

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

I authorize that the above individual(s) may have access to information regarding my general medical condition. I will notify Dignity Health Medical Group of Ventura County in writing if I wish to add or delete individuals who may have access to my medical information.

Signature of Patient: _____ Date: _____

Witness: _____

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Please answer the following Demographic Questions:

Which **race** would you classify yourself as?

- African American
- American Indian/Alaska Native
- Asian
- Native Hawaiian/Other Pacific Islander
- White
- Other
- Declined to state

Which **ethnicity** would you classify yourself as?

- Hispanic, Latino or Spanish Origin
- Not Hispanic, Latino or Spanish Origin
- Declined to state

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Message to our Patients

Appointment Cancellations

Please give at least 24 hours notice if you need to cancel your appointment.

Failure to Keep Appointments Without 24-Hour Notice

While we don't charge for missed appointments, if you miss three appointments without providing notice to our office, you may be discharged from the practice.

Late Arrivals

Although being late is sometimes unavoidable, please be aware that others who are on time may be delayed because you are late. Therefore, in consideration for all of our patients, if you know you are going to be at least 15 minutes late, please contact our office immediately so we can reschedule your appointment. If you arrive 15 minutes past your appointment time, you will be asked to reschedule for another day/time. *Tip: Plan to arrive ten minutes early to your appointment to take care of paperwork and copayments.*

Signature _____ Date _____