

Beach Family Doctors Medical Group

Welcome to our practice!

Office Hours / After Hours

8:30am-5:00pm Monday through Friday; Closed for lunch; Closed all major holidays.

For urgent medical issues after regular office hours that can't wait until the next business day, please call our office and leave a message with our service so they can page the doctor. For all other issues, please call us during our regular office hours.

Same Day/ Urgent Appointments

We understand that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please let us know as soon as you can and we will try to accommodate you.

Emergencies

Call 911 for medical emergencies.

Medication Refills

We don't want you to run out of your medications. We recommend that you notify the pharmacist to send us a "refill request" when you are picking up your last refill. If you prefer to call us, please do so during our regular office hours and allow 3-4 business days for us to refill your medications.

Forms

Please schedule an appointment if you have any forms our doctors need to fill out. DMV physicals with forms will be \$50.00 and work/school physicals with forms are \$25.00.

Medical Care

In order for us to provide the best possible care for you, we will need your cooperation in keeping your scheduled appointments, making follow up appointments if required, scheduling annual physical exams, complete tests ordered for you and take medications prescribed to you if any.

Canceling Appointments and No-Shows

We ask that you notify our office 24 hours in advance if you are unable to come in for your scheduled appointment. This gives us a chance to schedule a patient at that time. If for any reason you are unable to give us 24 hours' notice, please call our office as soon as you can.

An accumulation of 3 missed appointments may result in a notice of non-compliance and denial of rescheduling appt.

Medical Records

If you are being treated by a specialist or have medical records with another doctor, we would like to send them a request for medical records. Please complete the medical records request in this package or ask the front office.

Communication

We believe in having good communication between our staff and our patients. We encourage you to express any question or concerns so we may better serve you. We ask you treat the staff in a polite manner for they are here to help.

Treatment without an Office Visit

If you are treated over the phone, there may be a \$25.00 fee for services rendered without an office visit.

Co-pays and Deductibles/New Patients/Returned Checks

Co-pays and deductibles are due at time of service. We will only accept cash or credit for new patient first time visits.

There will be a \$25.00 service charge for returned checks.

BEACH FAMILY DOCTORS

19582 Beach Blvd., Suite 218
 Huntington Beach, CA 92648
 714-845-5900 Office
 714-845-5922 Fax

PATIENT INFORMATION

Name (Last, First, Middle)				Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>			
Street address:			City, State Zip		DOB:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>
SSN#		Home Phone:		Cell Phone:		Email Address:	
Student Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact Name:		Emergency Contact Number:	
Primary Employer:				Secondary Employer (if Applicable)			
Address:				Address:			
City, State Zip		Work Phone:		City, State Zip		Work Phone:	

RESPONSIBLE PARTY INFORMATION (if Different than above)

Name (Last, First, Middle)			SSN#		DOB:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Street address:			City, State Zip		Phone:		
Relationship To Patient:							

PRIMARY INSURANCE

Name of Insurance Company:			Policy #:				
Name of Insured:			DOB:		Group #:		
Address of Insurance Company:				Relationship to Patient:			

SECONDARY INSURANCE

Name of Insurance Company:			Policy #:				
Name of Insured:			Group #:				
Address of Insurance Company:				Relationship to Patient:			

I hereby assign my insurance benefits to be made directly to my physician or assisting physicians, for services rendered. I attest that the above information is accurate. I understand that I am responsible for knowing my benefits/coverage and will be financially responsible for all charges not covered by my insurance company. I authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I agree that a photocopy of this agreement shall be as valid as the original. All charges are the direct responsibility of the patient. I understand that services cannot be rendered on the assumption that charges will be paid by the insurance company. If there are problems collecting payment, attorney's fees, collection agency costs and any related fees will be added to my bill. I acknowledge that I have read, understand and agree to give consent to assess, treat, test.

Signature of Patient/Guardian

Date

Health Questionnaire - Birth to 6 years

Name: _____ DOB: _____ Age: _____ Date: _____

PARENTS/GUARDIANS

Mother _____ Occupation _____ Phone _____

Father _____ Occupation _____ Phone _____

Marital Status _____

Allergies to Medications _____

Current Medications _____

Vaccinations up to date? Y N (Please provide records)

MEDICAL HISTORY

Birth History: (circle one) Vaginal Cesarean (reason why) _____

Birth weight _____ Days in Hospital _____

Any Complications? _____

Hospitalizations/Surgeries? _____

CHILDHOOD ILLNESSES: Has the child had any of the following? **Circle Y for Yes and N for No**

Asthma	Y N	Bronchitis	Y N	Allergies	Y N
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Chicken Pox	Y N	Strep Throat/Pharyngitis	Y N	Eczema	Y N
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Ear Infections	Y N	Seizures/Convulsions	Y N	Urinary Infections	Y N
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FAMILY HISTORY

Has a Blood Relative ever had:

Cancer	Y N	Heart Disease	Y N	Tuberculosis	Y N
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Diabetes	Y N	High Blood Pressure	Y N	Seizures	Y N
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Birth Defects	Y N	High Cholesterol	Y N	Asthma	Y N
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DEVELOPMENT

Roll over _____ months Crawled _____ months Walked _____ months

Mama/Dada _____ months Toilet trained _____ months

NUTRITIONAL HISTORY

Breast fed _____ months Milk _____ Servings/day Type _____

Fruit _____

Vegetables _____

SOCIAL HISTORY

Any smokers in the house? Y N Daycare _____

Brothers/Sisters and ages _____

Any other concerns you want to tell the doctor?

Person completing this form: _____ Relationship: _____

Date: _____

Signature: _____

Request for Medical Information

1. **Authorization** : I authorize disclosure of information and health records as described below:

Name of Patient: _____ Date of Birth: _____

Telephone: _____

2. **Record Holder:** _____

Address: _____

Phone: _____ Fax: _____

3. **Records May Be Released To:**

Beach Family Doctors Medical Group

19582 Beach Blvd., Suite 218

Huntington Beach, CA 92648

Phone: 714-845-5900

Fax: 949-999-8113

4. **Type of Information:** This authorization is limited to the following types of information -

<input type="checkbox"/> All Records	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Operative/Procedure	<input type="checkbox"/> History/Physical Exam	<input type="checkbox"/> Treatment for Alcohol/Drug Abuse
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> HIV Test Results	<input type="checkbox"/> Emergency Department Reports
<input type="checkbox"/> Psychiatric Records	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Billing Information
<input type="checkbox"/> Radiology/Nuclear Medicine Reports		
<input type="checkbox"/> Other _____		

5. **Dates of Service:** All or From _____ To _____

6. **Use if Information:** The individual or entity identified above is permitted to use my information for the following purposes: **Please check all that apply.**

<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Second Opinion	<input type="checkbox"/> Personal
<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	
<input type="checkbox"/> Other (please specify) _____		

7. **Duration:** This authorization is valid for 90 days from the date next to my signature, unless otherwise noted here: _____

8. **Signature:**

Print Name: _____

Signature: _____

Date: _____

If signed by other than patient, indicate your relationship to the patient: _____

Witness Signature: _____

Date: _____

HIPAA Notice of Privacy Practices - Acknowledgement of Receipt

Beach Family Doctors Medical Group
19582 Beach Blvd., Suite 218
Huntington Beach, CA 92648
Phone: 714-845-5900 Fax: 714-845-5922

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our office.

X _____
Signature Print Name Date

If not signed by the patient, please indicate relationship:

- Parent of minor Guardian of minor Conservator of an incompetent patient

Communication:

Our general office policy is that no information may be left with anyone but the patient. We realize that many patients may find multiple methods of communication acceptable, even though total confidentiality cannot be guaranteed. Below is a list of communication options. Please place a check mark next to the methods that are acceptable means of communicating information regarding your healthcare, and writing the corresponding information on the line provided. Please understand that by checking a box you are granting us permission to COMMUNICATE ANY AND ALL INFORMATION TO YOU IN THIS MANNER. Again, a check mark means that we can leave information in that manner. If in doubt, we recommend NOT checking a box.

- Home Answering Machine or Voice Mail: _____ Acceptable
- Office Voice Mail: _____ Acceptable
- Cell Phone Voice Mail: _____ Acceptable
- E-Mail Address: _____ Acceptable
- Message with Spouse: _____ Acceptable
- Message with Other: _____ Acceptable

X _____
Signature Print Name Date

Emergency Contact Information Form

Date: _____

Patient Name: _____

Date of Birth: _____

Name of Person to Contact: _____

Relationship to Patient: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Emergent and Urgent Care Policies

We have made a commitment to quickly respond to all urgent calls from patients. To meet urgent needs there are doctors in the office from 8:30 to 5:00 most days. We are capable of handling almost all of your urgent needs in our office and for this reason do not refer to urgent care centers during office hours.

Emergency Room visits are intended for conditions (possible heart attack, severe breathing problems and major injuries) that pose an immediate threat to your health. Injuries such as sprained ankles, possible fractures, fevers, diarrhea and skin lacerations are not usually considered emergent. Hoag Hospital is the site for emergency care for all of our patients. Only in circumstances where minutes may make the difference would it be appropriate to go to another local hospital.

If you have an urgent need after hours, call the office and follow the recorded instructions. Our service will take a message and contact the on-call doctor with your information so they can respond to your call in a timely manner. The doctor will ask appropriate questions and give advice based upon the circumstances.

This advice may include:

- Scheduling an appointment for the next business day
- Prescribing medication over the phone
- Giving advice over the phone
- Referral to an Urgent Care Facility
- Referral to an Emergency Room (usually Hoag Hospital)

If is extremely important for our HMO patients that whenever possible that a call be made to us prior to seeking care at an Emergency Room or Urgent Care facility. Failure to call for advice may result in the patient being responsible for all charges associated with the visit.

I have read and understand this policy

Signature: _____ Date: _____

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize

_____ (an adult into whose care the minor(s) has been entrusted)

to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of

_____ (name(s) and address of minor(s))

deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code §6910.

Signed: _____ Dated: _____

Print Name: _____

Please specify relationship to minor:

parent with legal custody

guardian with legal custody

MEDICATION LIST

Today's Date: _____

Last Name: _____ First Name: _____

Date of Birth: _____

Current Medications, Supplements, Vitamins, Herbs, etc:

Name of Medication	Dosage	Taken How Often Per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
19.		