O.C. RHEUMATOLOGY

**GAYLE KOOKOOTSEDES, M.D.**
25411 Cabot Rd., Suite 109
Laguna Hills, CA 92653

# REGISTRATION FORM

Today's Date: [Date] | PCP:

**PATIENT INFORMATION**

Patient's Last name: | First: | Middle | Marital status: ❍ M ❍ S ❍ D ❍ W

Is this your legal name? ❍ Yes ❍ No | If not, what is your legal name? | Driver's License #: | Birth date: | Age: | Sex: ❍ M ❍ F

**Race:** ❍ White ❍ Asian ❍ Black/African American ❍ Native Hawaiian or Other Pacific Islander ❍ American Indian-Alaskan Native ❍ Other Race

**Ethnicity:** ❍ Hispanic or Latino ❍ Non-Hispanic or Latino **Preferred Language:** ❍ English ❍ Other ___________________________________

Address: [Address/ P.O. Box, City, ST ZIP Code]

| Social Security no.: | Home phone no.: | Cell phone no.: |
|---|---|---|
| Occupation: | Employer: | Employer phone no.: |

Chose clinic because/referred to clinic by (Please choose one option): ❍ [Doctor's Name] ❍ [Internet] ❍ [Word of Mouth] ❍ [Insurance Plan] ❍ [Other]

Other family members seen here:

**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist at the time of check in.)

| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: |
|---|---|---|---|

Is this person a patient here? ❍ Yes ❍ No | Is this patient covered by insurance? ❍ Yes ❍ No

| Occupation: | Employer: | Employer address: | Employer phone no.: |
|---|---|---|---|

Please indicate primary insurance:

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber:

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber:

**IN CASE OF EMERGENCY**

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize O.C. Rheumatology or insurance company to release any information required to process my claims.

______________________________ Patient/Guardian signature

______________________________ Date

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# NEW PATIENT HEALTH QUESTIONNAIRE FORM

PATIENT'S NAME: ____________________________________________ DATE: _______________

REASON FOR YOUR VISIT TODAY (symptoms, onset, duration): ______________________________________

______________________________________________________________________________________

## PAST MEDICAL HISTORY - List current medical problems with year of diagnosis & any hospitalizations

| CURRENT MEDICAL PROBLEMS: | YEAR | CURRENT MEDICAL PROBLEMS: | YEAR |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

ANY PREVIOUS FRACTURES? ❍ YES ❍ NO IF YES, PLEASE DESCRIBE:

ANY OTHER SERIOUS INJURIES? ❍ YES ❍ NO IF YES, PLEASE DESCRIBE:

| LIST SIGNIFICANT SURGERIES: | YEAR | LIST SIGNIFICANT SURGERIES: | YEAR |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

## SOCIAL HISTORY

| Do you smoke? ❍ Yes ❍ No | Number of packs per day? | How many years? |
|---|---|---|
| Do you drink alcohol? ❍ Yes ❍ No | How often? | |

Do you use any substances/drugs that are not medical? ❍ Yes ❍ No

If yes, please list & how often:

## FAMILY HISTORY – Please check & indicate which family member in the space provided

| | | | |
|---|---|---|---|
| ❍ Cancer | ❍ Heart Disease | ❍ Autoimmune Disease | ❍ Tuberculosis |
| ❍ High Blood Pressure | ❍ Epilepsy | ❍ Diabetes | ❍ Arthritis |
| ❍ Asthma | ❍ Alcoholism | ❍ Stroke | ❍ Other |



POS Reorder # 1500820

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DRUG ALLERGIES ❍ YES ❍ NONE KNOWN

IF YES, what medication & type of reaction

MEDICATIONS - Please list all current medications including prescription, over-the-counter & vitamins

| NAME OF MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

REVIEW OF SYSTEMS - Please check Y (Yes) or N (No) & fill in the blanks where appropriate

**CONSTITUTIONAL**

Y N Tired all the time
Y N Feel weak all over
Y N Recent Weight Loss
Y N Recurring Fever

**ENDOCRINE**

Y N Heat/Cold Intolerance
Y N Change in Hat Size
Y N Change in Ring Size

**EYES**

Y N Frequent Red Eyes
Y N Frequent Eye Pain
Y N Chronic Eye Dryness
Y N Recent Vision Changes

**HEENT**

Y N Hair Loss or Bald Spots
Y N Vertigo
Y N Recent Hearing Loss
Y N Recent Sinusitis
Y N Chronic Mouth Dryness
Y N Frequent Mouth Ulcers
Y N Food feels like it sticks in your throat
Y N Throat hurts when you swallow food or liquid
Y N Hoarseness

**RESPIRATORY**

Y N Chest hurts with a deep breath
Y N Frequently short of breath
Y N Frequent Coughing
Y N Frequent Wheezing
Y N Snoring
Y N Asthma

**CARDIOVASCULAR**

Y N Chest pain with exertion
Y N Feel short of breath with mild exertion
Y N Recent Fainting
Y N Frequent Ankle Swelling

**GASTROINTESTINAL**

Y N Frequent Abdominal Pain
Y N Frequent Vomiting
Y N Frequent Nausea
Y N Frequent Diarrhea
Y N Frequent Constipation
Y N Blood in stool or black/tarry stool

**MUSCULOSKELETAL**

Y N Joint Pains. Which Ones?___________________________
Y N Muscle Pains. Location(s)? _________________________
Y N Body stiffness upon awakening. How long?___________
Y N Joint swelling. Which ones? ________________________
Y N Fingers or toes swell up like hot dogs

**SKIN**

Y N Pigment Changes
Y N Psoriasis
Y N Recurring Rashes. Where? _________________________
Y N Frequent itching
Y N Brief sun exposure causes skin rash
Y N Recent finger or toe nail changes
Y N All color drains out of fingers when it's cold

**HEMATOLOGIC**

Y N Frequent Swollen Glands
Y N Treated for a blood clot. Body part? ________________
Y N Excessive Bleeding
Y N Frequent Nosebleeds
Y N Excessive Bruising

**NEUROLOGIC**

Y N Headaches
Y N Seizures
Y N Numbness. Body part(s): _________________________
Y N Burning Sensation. Body part(s): ____________________
Y N Pins-and-needle sensation. Body part(s): ____________
Y N Recent weakness of a body part: ___________________

Number of times pregnant: _______________________________________
Number of live births:___________________________________________
Number of miscarriages:_________________________________________
Number of abortions: ___________________________________________
Method of contraception:_________________________________________

**PSYCHIATRIC**

Y N Depression
Y N Anxiety
Y N Confusion
Y N Sleep Problems: Falling Asleep Staying Asleep

PATIENT SIGNATURE ______________________________________________ DATE ________________

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# ASSIGNMENT OF INSURANCE BENEFITS, AUTHORIZATION OF PAY BENEFITS AND RELEASE OF INFORMATION TO INSURANCE COMPANIES

Please Initial & Sign at the Bottom:

______ I hereby authorize payment to Dr. Gayle Kookootsedes & OC Rheumatology all benefits now due or becoming due under my group policy and I hereby direct my insurance carrier to pay such benefits.

______ I hereby authorize said assignee to release information to the insurance carrier related to these services rendered and in reference to the settlement of claims.

______ I understand that in the event that my insurance coverage is not effective, I will be billed and held financially responsible for all services rendered.

## Medicare Patients Certification, Authorization to Release Information and Payment Request

______ I request that payment of authorized Medicare benefits be made either to me or on my behalf to OC Rheumatology for any services rendered to me. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine the benefits payable for related services. I understand that my signature directs that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on item 9 of the HCFA-1500 claim form or elsewhere, my signature authorizes release of the information to the insurer or agency shown.

I have read the above and understand my possible financial responsibility to OC Rheumatology and hereby affixed by signature as acknowledgment of this understanding.

__________________________________________ ________________
Signature (Patient, Parent, or Guardian) Date

**NOTICE TO CONSUMERS**

Medical doctors are licensed and regulated by the Medical Board of California

800-633-2322 www.mbc.ca.gov

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## CONSENT TO ACCESS PRESCRIPTION HISTORY

Our office uses a computerized medical record that allows us to electronically send prescriptions directly to pharmacies. Our system allows us to access a list of prescriptions filled by our patients within the past 2 years. Reviewing this list helps to assure patient safety and avoid duplication of prescriptions and also alerts us to possible drug interactions with medications that may be prescribed by others. Please select one of the following options and sign below:

❍ YES. I grant Dr. Gayle Kookootsedes & OC Rheumatology and staff permission to access my prescription history from external sources.

❍ NO. I do not wish to grant Dr. Gayle Kookootsedes & OC Rheumatology staff permission to access my prescription history from external sources.

____________________________ Printed Patient Name
____________________________ Patient Signature
____________ Date

## MESSAGE AUTHORIZATION

You may leave appointment reminders on:

❍ My home phone number
❍ My mobile phone number
❍ With a member of my household
❍ My email address
❍ None of the above

You have authorization to leave test results on:

❍ My home phone number
❍ My mobile phone number
❍ With a member of my household
❍ My email address
❍ None of the above

____________________________ Printed Patient Name
____________________________ Patient Signature
____________ Date

## DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS & OTHER CAREGIVERS

I agree that Dr. Gayle Kookootsedes & OC Rheumatology and staff may disclose certain aspects of my health information to a family member, close personal friend, or other caregiver since such a person may be involved with my health care or payment related to my health care. It is understood that we will disclose only information that is directly relevant to the person's involvement with my health or payment related to my health care. I understand that I am not required to list anyone, and that I may change this list at any time in writing. I authorize disclosure of my health information to:

| Name | Relationship | Phone |
|---|---|---|
| | | |
| | | |

____________________________ Printed Patient Name
____________________________ Patient Signature
____________ Date

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# OFFICE FINANCIAL POLICY

OC Rheumatology strives to provide the best possible care for our patients. Advising you of our office policies in advance allows for improved communication to achieve the best possible physician-patient relationship. Please review this policy carefully and if you have any questions, please ask a member of our staff.

- Upon arrival, please sign in at the front desk. If this is your first visit, or if your insurance has changed since your last visit, please present your insurance card(s).
- Federal law requires that our office review and document photo identification for our patients. A driver's license is usually used for this purpose. Photo identification also helps to ensure patients' safety by verifying that all records, medications, diagnostic tests, etc. are associated with the correct person.
- You are responsible for any and all co-payments, deductibles and co-insurance as specified by your insurance plan.
- *Co-payments are due at the time of service.*
- Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 calendar days of receipt of your bill.
- Accounts with balances over 90 days past due may be turned over to a collection agency.
- If your account is in bad debt or is assigned to a collection agency, no future appointments will be scheduled. Failure to address accounts seriously past due may be grounds for dismissal from the practice and referral to another provider.
- A $25 penalty plus any bank fees incurred will be charged for any checks returned for insufficient funds or stop payment.
- Although we understand that a change in appointment time or day may be necessary, we reserve the right to charge $50 for failure to reschedule or cancel within 24 hours.

I have read & understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

______________________________ Printed Patient Name

______________________________ Patient Signature

__________ Date

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## ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE RECEIPT

Name: ________________________________________________________________

Address: ______________________________________________________________

City: ____________________________________ State: ________________________

ZIP: __________________ Telephone: __________________________________

### I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

________________________________________________ ____________
Signature of Patient or Authorized Person Date

________________________________________________
Self/Relationship to Individual