***** ALL MEDICAL RECORDS ARE SAFEGUARDED AND CONFIDENTIAL *****

Name: _____ Age: _____ Date: _____

Family History	If Living		If Deceased		Please Circle
	Age	Health	Age at Death	Cause	Has any blood relative had: Who	no or yes
Father					Cancer	no or yes
Mother					Tuberculosis	no or yes
Brother or Sister 1.					Diabetes	no or yes
2.					Heart Trouble	no or yes
3.					High Blood Pressure	no or yes
4.					Stroke	no or yes
5.					Epilepsy	no or yes
Husband or Wife					Mental Illness	no or yes
Son or Daughter 1.					Suicide	no or yes
2.					Congenital Deformities	no or yes
3.					List any previous surgeries:	
4.						
5.						
6.						

Personal History

Illnesses You Have Had

Measles or German Measles	No or Yes
Chickenpox or Mumps	No or Yes
Whooping Cough	No or Yes
Scarlet Fever or Scarlatina	No or Yes
Pneumonia or Pleurisy	No or Yes
Diphtheria or Smallpox	No or Yes
Influenza	No or Yes
Rheumatic Fever/Heart Disease	No or Yes
Arthritis or Rheumatism	No or Yes
Any bone or joint disease	No or Yes
Neuritis or Neuralgia	No or Yes
Bursitis, Sciatica, Lumbago	No or Yes
Polio or Meningitis	No or Yes
Bright's Disease or Kidney INF	No or Yes
Gonorrhea or Syphilis	No or Yes
Anemia or Jaundice	No or Yes
Epilepsy	No or Yes
Migraine Headaches	No or Yes
Tuberculosis	No or Yes
Diabetes or Cancer	No or Yes
High or Low Blood Pressure	No or Yes
Nervous Breakdown	No or Yes
Food, Chemical, Drug Poisoning	No or Yes
Hay Fever or Asthma	No or Yes
Hives or Eczema	No or Yes
Frequent Colds/Sore Throats	No or Yes
Frequent Infections/Boils	No or Yes
Any other Disease	No or Yes

Allergies: Are You Allergic To

Penicillin or Sulfa	No or Yes
Aspirin, Codeine or Morphine	No or Yes
Mycins or Other Antibiotics	No or Yes
Merthiolate or Mercurochrome	No or Yes
Any other Drugs	No or Yes
Any Foods	No or Yes
Adhesive Tap	No or Yes
Nail Polish or other Cosmetics	No or Yes
Tetanus, Antitoxin or Serums	No or Yes

Injuries: Have You Had Any

Broken bones	No or Yes
Sprains or Dislocations	No or Yes
Lacerations (Extensive)	No or Yes
Concussion or Head Injury	No or Yes
Ever been knocked out	No or Yes

Transfusions: Have You Ever Had

Blood or Plasma Transfusion	No or Yes

Weight

Current_____ One year ago_____
Maximum _____ When_____

Habits: Do You

Sleep Well?	No or Yes
Use Alcoholic Bev?	No or Yes
If yes, Everyday?	No or Yes
Smoke?	No or Yes
If yes, How much?	_____
Exercise Enough?	No or Yes
Diet well balanced?	No or Yes

List Any Drugs or Medications You Take Regularly or Frequently

_____
_____
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- Eye Disease
- Eye Injury
- Impaired Sight
- Ear Disease
- Ear Injury
- Impaired Hearing
- Trouble w/ Nose
- Trouble w/ Sinuses
- Trouble w/ Mouth
- Trouble w/ Throat
- Fainting Spells
- Loss of Consciousness
- Convulsions
- Paralysis
- Frequent/Severe Headaches
- Dizziness
- Depression
- Anxiety
- Hallucinations
- Enlarged Glands
- Goiter or Enlarged Thyroid
- Skin Disease
- Swelling of hands, Feet or Ankles
- Varicose Veins
- Extreme Tiredness or Weakness
- Chronic or Frequent Cough
- Chest Pain or Angina Pectoris

- Spitting up of Blood
- Night Sweats
- Shortness of Breath
- Palpitations or Fluttering Heart
- Kidney Disease or Stones
- Bladder Disease
- Albumin, Sugar, Pus, etc in Urine
- Difficulty Urinating
- Stomach Trouble or Ulcers
- Indigestion
- Liver or Gallbladder Disease
- Colitis or other Disease
- Appendicitis
- Hemorrhoids or Rectal Bleeding
- Constipation or Diarrhea
- Recent Change in Bowel Action or Stools
- Recent Changes in Appetite or Eating Habits

Women Only: Menstrual History

Age At Onset_____

- Regular
- Irregular
- Heavy Flow

Cycle: _____ Days (From Start to Finish)
Usual Duration _____Days
Pain or Cramps No or Yes
Date of Last Period _____
Number of Pregnancies? _____
Children Born Alive? _____
Stillbirths?_____

Citrus Valley Medical Associates, Inc.

Consent for purposes of Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health, history, symptoms, examinations, test results, diagnoses, 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 tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization 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 to reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____

_____ _____

Signature or Patient/Legal Representative Date Relationship to Patient

_____ _____

Print Name of Patient Medical Group Representative Date

Please list all dependents, relationship and date of birth (NO SPOUSE)

Name	Relationship	Date of Birth

Office Use Only: **Accepted** **Denied**

_____ _____

Authorized Signature Date

Citrus Valley Medical Associates, Inc.

Eligibility Guarantee Form
(One Form per Member)

I, _____, understand that I am eligible for Health Plan benefits with
(Subscriber's Name)

_____ as of _____ through
(Name of Health Plan) (Month) (Day) (Year)

_____. I have selected Citrus Valley Medical as my medical group
(Name of Employer)

and Dr. _____ as my Primary Care Physician. I understand that if the above is
(Name of Physician/Provider)

not true, or if I am not eligible under the terms of my health plan and/or employer groups Medical and Hospital subscriber agreement, I am financially responsible for all charges for services rendered. Additionally, and assuming my eligibility for benefits is not established as set forth above, I agree to pay for all services within 60 days of receiving a bill from the physician listed above.

_____ _____

Signature of Patient (Parent or guardian if under 18) Date

_____ _____

Witness Date

Office Use Only

Patients Name: _____ DOB: _____

Member ID or Subscriber SSN: _____

Eligibility Verified by: _____

Member Service Rep: _____

Confirmation#: _____

Member Verified? Yes No Employer Group Verified? Yes No

ADVANCE HEALTH CARE DIRECTIVE

Dear Patient,

As your physician, we are requested to ask any patient over the age of 18, if they have an existing Advance Health Care Directive, so that we can incorporate the information into your medical records. You are not required to give us this information, but we are required to ask. Please complete this form and return to the receptionist.

Thank you

Patient Name: _____ Social Security#: _____

Patient Signature: _____ Date: _____

- ❖ Do you have an Advanced Health Care Directive? ( ) Yes ( ) No
- ❖ If yes, please indicate which type of Directive?
  - Durable Power of Attorney for Health Care ( )
  - California Natural Death Act ( )
  - Living Health Care Will ( )
  - Other: _____ ( )
- ❖ Will you bring us a copy of your Directive? ( ) Yes ( ) No
- ❖ I decline to answer these questions ( ) Yes ( ) No

INTERNAL OFFICE USE ONLY

Type of Health Care Directive Received:	**Date Received**
Durable Power of Attorney for Health Care	_____
California Natural Death Act	_____
Living Health Care Will	_____
Other: _____	_____

A Message To Our Patients About Arbitration

Our goal is to provide medical care to our patients in a way that will avoid disputes. We know that most problems occur as a result of miscommunication. So, if you have concerns about your medical care, please discuss them with us.

Please read the attached contract entitled Physician-Patient Arbitration Agreement. By signing the contract, we are agreeing that any dispute arising out of the medical services you receive will be resolved in binding arbitration before an arbitration panel instead of by a lawsuit in a court of law.

Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

We believe that the method of resolving disputes in arbitration spares the parties some of the rigors of a court trial and the publicity which may accompany judicial proceedings.

Thank you

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved in arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relation to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of the arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVIN UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: *Citrus Valley Medical Associates and Affiliated Providers*
Physician's or Authorized Representative's Signature

By: Citrus Valley Medical Associates and Affiliated Providers
Print Name of Physician, Medical Group, or Association Name

Date: _____

By: _____
Patient's or Patient Representative's Signature

By: _____
Print Patient's Name

Date: _____

_____
(If Representative Print Name/Relationship to Patient)

Citrus Valley Medical Associates, Inc.
Patient Registration and Billing Information

Patient Name_____ DOB_____ Sex: F M

Marital Status: Married Divorced Separated Widowed Single Primary Physician_____

Preferred Language: English Spanish Other_____ Email: _____

Is Visit Due to an Accident? _____ Work Injury? _____

Patient Information

Street_____
City_____ State & Zip _____
Home #_____Cell#_____
SSN_____Drivers License#_____
Employer Name_____
Street_____
City_____ State & Zip_____
Work Phone No_____
Emergency Contact_____
Street_____
City_____ State & Zip_____
Phone_____
Relationship_____

Guarantor Information (If Patient is a Minor)

Name_____
Street_____
City_____ State & Zip_____
Home _____Cell#_____
SSN_____Drivers License_____
Date of Birth_____
Relationship to Patient_____
Employer Name_____
Street_____
City_____ State & Zip_____
Work Phone No_____

For Office Use Only

Date Received____/____/____ By_____

Insurance # 1 (Please Provide Card to Receptionist)

Insurance Company_____
Subscriber_____
Relationship_____
Address_____
City_____ State & Zip_____
Subscriber's Employer_____
Employer's Address_____
City_____ State & Zip_____
Policy No/Certification No_____
Group No & Plan_____
Subscriber's Date of Birth_____

Insurance # 2 (Please Provide Card to Receptionist)

Insurance Company_____
Subscriber_____
Relationship_____
Address_____
City_____ State & Zip_____
Subscriber's Employer_____
Employer's Address_____
City_____ State & Zip_____
Policy No/Certification No_____
Group No & Plan_____
Subscriber's Date of Birth_____

- I authorize and give consent to Citrus Valley Family Practice for general medical treatment.
- I authorize Citrus Valley Family Practice to furnish information concerning my care to my insurance company to process this claims.
- I understand that I will be billed for any uncovered services and for any co-payment or deductible that is not paid by my insurance company.

Signed_____Date_____