

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS			
CITY, STATE		ZIP	HOME PHONE	CELL PHONE	
PATIENT DATE OF BIRTH	PATIENT SSN	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
PATIENT EMPLOYER NAME		PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)			EMPLOYER PHONE

HOW DID YOU HEAR ABOUT CENTRAL VALLEY MEDICAL GROUP?

- Friend/Family Member
- Insurance Provider List
- Search Engine (Google, Yahoo, Bing)
- Social Media (Yelp, Facebook)
- Other _____

INSURED/RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT: spouse parent guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)			PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)			PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	

PRIMARY DOCTOR/FAMILY DOCTOR		REFERRING DOCTOR			
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP		PHONE NUMBER	

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE
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Authorization to release health information to:

Name(s)		ADDRESS			
CITY, STATE		ZIP	HOME PHONE	DAYTIME PHONE	
DATES OF SERVICE		AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)			
FROM:	TO:	<input type="checkbox"/> NEVER DATE:			
Release the following information:					
<input type="checkbox"/> All Records	<input type="checkbox"/> Chart Notes	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> History & Physicals	

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the

Federal Privacy Rule 45 CFR (164.524).

- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date
Person Completing Form <i>(if patient needs help)</i>	<input type="checkbox"/> Family Member <input type="checkbox"/> Other <i>(Specify)</i>	<input type="checkbox"/> Friend	Need help with form? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter?
 Yes No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.					Need Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Clinic Use Only:</i>					Nutrition
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	Safety
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: <input type="checkbox"/> (men) 5 or more alcohol drinks in one day? <input type="checkbox"/> (women) 4 or more alcohol drinks in one day?	No	Yes	Skip	Sexual Issues
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Other Questions
27	Do you have other questions or concerns about your health?	No	Yes	Skip	

If yes, please describe:

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined the SHA
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature:		Print Name:		Date:	
SHA ANNUAL REVIEW					
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	

Date of Last

Complete Physical Exam

Blood Work

Colonoscopy

Tetanus Shot

For Females

Date of Last Menstrual Period

Date of Last Pap Smear

History of Abnormal Pap?

Date of Last Mammogram

DEXA

Number of Pregnancies

Miscarriages

Terminations

Living Children

Method of Contraception

Pharmacy

Pharmacy Name

Pharmacy #

Pharmacy Address

Pharmacy City/State

Pharmacy Name

Pharmacy #

Pharmacy Address

Pharmacy City/State