NAME: ______________________________ DATE: _____________ AGE: ________ DATE OF BIRTH: ___________________

Primary Care Physician: ______________________________ Referring (Physician): ______________________________

Other physicians you see regularly: ____

Preferred Pharmacies (Name, cross streets or phone number): ____

What brings you in to see us today?

____

____

Do you have any ***ALLERGIES?*** *(Please use the back of this sheet if you need more space.)* ☐ *NO*

Allergic to:	*What kind of reaction do you get:*

What ***MEDICATIONS*** *do you currently take? (Please use the back of this sheet if you need more space.)* ☐ *NONE*

Name of Medication	*Dosage*	*Times per day*	*Reason for taking*

PAST MEDICAL HISTORY: ☐ *NONE*

☐ Anemia
☐ Anesthesia complications
☐ Anxiety disorder
☐ Bleeding disorder / Blood clots
☐ Breast problems
☐ Cancer (specify)
☐ Depression
☐ Diabetes (type I or II)
☐ GI problems (specify)
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Kidney problems (specify)
☐ Lung disease
☐ Melanoma
☐ Osteoporosis
☐ Seizure disorder
☐ Skin cancer (non melanoma)
☐ Stroke / Mini stroke
☐ Thyroid disease
☐ Other: __________________

PAST SURGICAL HISTORY (list month/year or estimated date): ☐ *NONE*

☐ Abdominal surgery (specify)
☐ Back surgery (specify)
☐ Breast surgery (specify)
☐ Caesarean section
☐ Cancer surgery (specify)
☐ Eye surgery (specify)
☐ GYN surgery (specify)
☐ Heart surgery (specify)
☐ Ears/Nose/Throat surgery (specify)
☐ Orthopedic /Joint replacement
☐ Pacemaker
☐ Plastic surgery (specify)
☐ Stents
☐ Other: __________________

FAMILY HISTORY: ☐ *NONE*

Family member	Anesthesia problems	Autoimmune disease	Bleeding or clotting disorder	Cancer (specify type)	Diabetes	Heart disease	High cholesterol	Hypertension	Kidney disease
MOTHER									
FATHER									
SIBLINGS:									

Family member	Liver disease	Lung disease	Neurologic disorders	Osteoporosis	Psychiatric disorders	Stroke	Thyroid disease	Other (specify)
MOTHER								
FATHER								
SIBLINGS:								

PREGNANCY HISTORY:		***GYN HISTORY:***		***SOCIAL HISTORY:*** *(Please circle or check where applicable.)*
# Total		Age (yrs.) at menopause (if applicable)		Occupation:
# Living		Date (year) of last Mammogram		Marital status: Married / Single / Divorced / Separated / Widowed / Domestic Partner
# Full term		Age at first period (menarche)		Smoking: Never / Former / Some days / Every day / How much per day/week?
# Pre term		Age at first child (if applicable)		Alcohol: None / Occasional / Moderate / Heavy
# Miscarriage (Ab.S.)				Other drugs: ☐YES ☐ NO
# Abortion (Ab.I.)				Caffeine intake: None / Occasional / Moderate / Heavy
# Ectopic				Do you live: ☐ alone ☐ with others:
# Multiple births				

PLEASE CONTINUE ON TO NEXT PAGE

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NAME: ________________________________ DATE: ________________ AGE: _______ DATE OF BIRTH: _______________

<u>REVIEW OF SYSTEMS</u>—Have you experienced any of the following conditions in the <u>past month</u>? Please circle ALL that apply.

01. CONSTITUTIONAL	NONE	weight loss ___#, weight gain ___#, fever/chills, fatigue, loss of appetite, headache
02. EYES	NONE	glaucoma, macular degeneration, vision changes, glasses/contacts, blurred vision, double vision, cataracts
03. ENT/MOUTH	NONE	hearing loss, sinusitis, nose bleeds, sore throat/difficulty swallowing, mouth ulcer/canker sores, bleeding gums
04. ENDOCRINE	NONE	increased thirst, hair loss, increased hair growth, cold intolerance
05. RESPIRATORY	NONE	shortness of breath, chronic cough, sputum/productive cough, spitting up blood, wheezing
06. CARDIOVASCULAR	NONE	chest pain. palpitations, shortness of breath when lying flat, edema
07. GASTROINTESTINAL	NONE	heartburn, nausea, vomiting, diarrhea, constipation, flatulence, bloody stools, jaundice
08. GENITOURINARY	NONE	blood in the urine, flank pain/kidney stones, incontinence with coughing/sneezing/laughing, incomplete emptying, prior history of sexually transmitted diseases
09. MUSCULOSKELETAL	NONE	muscle aches, muscle weakness, joint pain, joint stiffness, joint swelling, difficulty walking, cold extremities, gout, fracture, back pain
10. SKIN	NONE	abnormal moles, rash
11. NEUROLOGICAL	NONE	headache, dizziness, loss of consciousness, weakness, numbness, seizures
12. PSYCHOLOGIC	NONE	depression, alcoholism, sleep disturbances

ADDITIONAL SPACE if necessary:

FINANCIAL AGREEMENT

PLEASE READ CAREFULLY

Georgeanna J. Huang M.D. Professional Corporation agrees to provide professional services by the physician and its employees to each patient and reserves the right to select the physician to perform the services required when she is not present to perform the services.

I hereby authorize Georgeanna J. Huang M.D. to furnish information to insurance carriers concerning my diagnosis and treatment and I hereby assign to the physician all payments for services rendered to myself or my dependents. I understand that all professional services rendered are charged to the patient. As a courtesy, necessary forms will be completed to expedite insurance payments. **I understand that I am responsible for any amount not covered by insurance.** Dr. Georgeanna J. Huang is a contracted provider for Medicare, Aetna, Anthem Blue Cross, Blue Shield of CA, UnitedHealthcare and most other major insurance companies. Due to the number of different insurance companies and their own numerous policies, we cannot be responsible to know the terms of your individual policy, even if we are a provider. **It is your responsibility as the patient to know your insurance policy's requirements** for prior authorization for office visits, X-rays, laboratory, and the amount of your deductible and co-payments. Furthermore, it is also necessary for you to know which laboratory, X-ray facility, and hospital you are required by your insurance to use for any necessary test and procedures.

We always welcome your questions and are available to help you understand your medical insurance as best as we can.

By signing below you acknowledge that you have read, understood, and accept the above.

The best medical service is based on a friendly mutual understanding between doctor and patient.

Authorized Signature: ______________________________ Date: __________

Printed Name: ______________________________

Witness: ______________________________ Date: __________

GEORGEANNA J. HUANG, MD 1000 NEWBURY ROAD, SUITE 165, THOUSAND OAKS, CA 91320 OFFICE (805)496-9976 FAX (805)496-9970

PATIENT PRIVACY & HEALTH DATA EXCHANGE CONSENT

1. A copy of The Health Information Privacy Act (HIPAA) has been provided to me.

______ I have read and understand my rights under HIPAA.

(INITIALS)

MEDICAL AND MEDICATION HISTORY AUTHORIZATION

2. Our office uses a certified electronic health record through Eclinicalworks, Inc. to maintain your records and compliance with federal regulations. As part of your record, your prescription medicine history can be downloaded from your pharmacy in order to increase accuracy. Your medical history from participating providers and hospitals is imported as well to improve your care. You have the option to OPT OUT of this information exchange, but we do not recommend this as it could delay your care. However, choosing to OPT OUT only prohibits this office from viewing your medical information – it does not remove your information from any other health record.

____ I choose to OPT OUT of medical history sharing.

____ I choose to OPT OUT of medication history sharing.

CONSENT TO CALL

3. As part of our electronic health record, you will receive automated phone calls from our practice to remind you of upcoming appointments, test results and more.

I **authorize** Eclinicalworks to contact me via ☐mobile phone ☐home phone. (Check one)

If I do not want Eclinicalworks to contact me via phone, I understand it is my responsibility to log into my portal and modify the mode of communication to email, portal, or text.

Print Name: ____

Signature: ______________________________________Date: __________

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