ImpactMD
Filer Tab: Administrative
Filer Button: Registration Form

BRISTOL PARK
MEDICAL GROUP

MRN: _______________

PATIENT REGISTRATION

NAME: ____
Last First Middle

DATE OF BIRTH: ____________ SOCIAL SECURITY NUMBER: ________________ SEX: ________

MARITAL STATUS: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated ❒ Domestic Partner

ADDRESS: ____
Street City State Zip

DAYTIME PHONE: ( ) ____________________ EVENING PHONE: ( ) ____

EMAIL ADDRESS: ____________________ DRIVER'S LICENSE #: ____________________

EMPLOYER: ____________________ PHONE: ( ) ____________

WORK ADDRESS: ____

RESPONSIBLE PARTY (Parent or Legal Guardian who Resides with Patient)

NAME: ____
Last First Middle

DATE OF BIRTH: ____________ SOCIAL SECURITY NUMBER: ________________ SEX: ________

MARITAL STATUS: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated ❒ Domestic Partner

ADDRESS: ____

DAYTIME PHONE: ( ) __________ EVENING PHONE: ( ) __________ DRIVER'S LICENSE #: ________

EMPLOYER: ____________________ EMPLOYER PHONE: ( ) ________

EMERGENCY CONTACT (If Different than Responsible Party)

NAME: ____
Last First Middle

DAYTIME PHONE: ( ) __________ EVENING PHONE: ( ) __________ RELATIONSHIP: ____________

PLEASE SIGN AND RETURN TO RECEPTIONIST:

I/we do hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of Bristol Park Medical Group, Inc. which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage, excluding only authorized covered services provided under a valid prepaid HMO contract.

I furthermore agree to pay legal interest, collection expense, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Bristol Park Medical Group, Inc. to release information requested by insurance company and/or its representative.

______ (initial) I fully understand this agreement and consent will continue until cancelled by me in writing.

______ (initial) I authorize Bristol Park Medical Group, Inc. to render necessary medical or surgical treatment to the above-named minor of whom I am the parent or legal guardian.

SIGNATURE: ____________________________ DATE: ____________________

NAME (Please print): ____________________ RELATIONSHIP: ____________________

---------- **FOR OFFICE USE ONLY** ----------

Location: ______________ Date: ______________ By: ____________________

BRISTOL PARK
MEDICAL GROUP

HEALTH QUESTIONNAIRE

NAME ________________ AGE ________ DATE ________

HISTORY OF PAST ILLNESS/INJURIES (HAVE YOU HAD?):

MEDICAL RECORD # ________

	YES	NO	UNSURE
MEASLES	❑	❑	❑
MUMPS	❑	❑	❑
CHICKEN POX	❑	❑	❑
DIABETES	❑	❑	❑
STROKES	❑	❑	❑
CANCER	❑	❑	❑
RHEUMATIC FEVER OR HEART DISEASE	❑	❑	❑
TUBERCULOSIS	❑	❑	❑
SEXUALLY TRANSMITTED DISEASE	❑	❑	❑
CONGENITAL ABNORMALITIES	❑	❑	❑
OTHER SERIOUS DISEASES	❑	❑	❑

LIST ________________

	YES	NO
HAVE YOU EVER BEEN HOSPITALIZED OR BEEN UNDER MEDICAL CARE FOR VERY LONG?	❑	❑

IF YES, FOR WHAT REASON? ________________

	YES	NO
HAVE YOU HAD ANY HEAD INJURIES?	❑	❑
HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS?	❑	❑

OPERATIONS:

	YES	NO
HAVE YOU HAD ANY SURGERY?	❑	❑

PLEASE DESCRIBE ________________

FAMILY HISTORY	IF LIVING:		IF DECEASED:	
	AGE	HEALTH	AGE	CAUSE
FATHER				
MOTHER				
BROTHER / SISTER				
HUSBAND / WIFE				
SON / DAUGHTER				

HAS ANY BLOOD RELATIVE EVER HAD?	YES	NO
CANCER		
TUBERCULOSIS		
DIABETES		
HEART TROUBLE		
HIGH BLOOD PRESSURE		
STROKE		
CONVULSIONS		
SUICIDE OR SEVERE DEPRESSION		
MENTAL ILLNESS		
BLEEDING TENDENCY		
GOUT OR OTHER ARTHRITIS		
ALCOHOL OR DRUG PROBLEMS		

SOCIAL HISTORY: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

	YES	NO
DO YOU LIVE ALONE?	❑	❑
DO YOU HAVE DEPENDENTS AT HOME?	❑	❑
DO YOU EXERCISE REGULARLY?	❑	❑
DO YOU SMOKE?	❑	❑

HOW MUCH? ________________

	YES	NO
HAVE YOU ***EVER*** SMOKED?	❑	❑
HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING?	❑	❑
HAVE PEOPLE EVER ANNOYED YOU BY CRITICIZING YOUR DRINKING?	❑	❑

ARE YOU CURRENTLY EMPLOYED?
❑ FULL TIME ❑ PART TIME ❑ NOT EMPLOYED

WHAT IS YOUR JOB? ________________

YEARS OF EDUCATION COMPLETED?: ________________

HOW MUCH *WORK TIME HAVE YOU LOST DUE TO YOUR HEALTH?*

PAST SIX MONTHS: ________________

PAST ONE YEAR: ________________

PAST FIVE YEARS: ________________

SYSTEMIC REVIEW (DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?):

GENERAL:	YES	NO
RECENT WEIGHT CHANGE?	❑	❑
SKIN:	YES	NO
JAUNDICE?	❑	❑
HIVES, ECZEMA OR RASH?	❑	❑
FREQUENT INFECTION OR BOILS?	❑	❑
ABNORMAL PIGMENTATION?	❑	❑
HEAD-EYES-EARS-NOSE-THROAT:	YES	NO
EYE DISEASE OR INJURY	❑	❑
DO YOU WEAR GLASSES/CONTACTS?	❑	❑
DOUBLE VISION	❑	❑
HEADACHES	❑	❑
GLAUCOMA	❑	❑
HEAD-EYES-NOSE-THROAT: (cont´d)	YES	NO
SNEEZING OR RUNNY NOSE	❑	❑
NOSE BLEEDS	❑	❑
CHRONIC SINUS TROUBLE	❑	❑
EAR DISEASE	❑	❑
IMPAIRED HEARING	❑	❑
ITCHING EYES OR NOSE	❑	❑
TRANSIENT EPISODES OR UNCONSCIOUSNESS	❑	❑
DIZZINESS	❑	❑
NECK:	YES	NO
STIFFNESS	❑	❑
THYROID TROUBLE	❑	❑
ENLARGED GLANDS	❑	❑

(OVER PLEASE)

NAME ______________________ MRN ______________ DATE ______________

SYSTEMIC REVIEW (Cont'd):

RESPIRATORY:	YES	NO
SPITTING UP BLOOD?	❑	❑
CHRONIC OR FREQUENT COUGH	❑	❑
ASTHMA/WHEEZING OR DIFFICULTY BREATHING	❑	❑
PLEURISY OR PNEUMONIA	❑	❑

CARDIOVASCULAR:	YES	NO
CHEST PAIN/ANGINA PECTORIS OR HEART ATTACK		
SHORTNESS OF BREATH WALKING OR LYING DOWN	❑	❑
HIGH BLOOD PRESSURE	❑	❑
SWELLING OF HANDS, FEET OR ANKLES	❑	❑
AWAKENING IN THE NIGHT SMOTHERING	❑	❑
HEART MURMUR/PALPITATIONS	❑	❑

GASTROINTESTINAL:	YES	NO
PEPTIC ULCER (STOMACH/DUODENAL)	❑	❑
HEARTBURN/INDIGESTION	❑	❑
VOMITING BLOOD OR FOOD	❑	❑
GALLBLADDER DISEASE	❑	❑
LIVER TROUBLE/HEPATITIS	❑	❑
PAINFUL/BLOODY BOWEL MOVEMENTS	❑	❑
HEMORRHOIDS/PILES OR BLACK STOOLS	❑	❑
CHANGE IN BOWEL HABITS (DIARRHEA, ETC.)	❑	❑
CRAMPING OR PAIN IN THE ABDOMEN	❑	❑
DOES FOOD STICK IN THROAT?	❑	❑

GYNECOLOGICAL (FEMALE ONLY):

AGE PERIODS STARTED ______________

HOW LONG PERIODS LAST ______________ DAYS

FREQUENCY OF PERIODS ______________ DAYS

NUMBER OF PREGNANCIES ______________

NUMBER OF MISCARRIAGES/ABORTIONS ______________

DATE OF LAST PAP SMEAR ________ RESULTS ________

DATE OF LAST MAMMOGRAM ________ RESULTS ________

GENITOURINARY:	YES	NO
LOSS OF URINE	❑	❑
FREQUENT URINATION (DAY OR NIGHT)	❑	❑
BURNING OR PAINFUL URINATION	❑	❑
BLOOD IN URINE	❑	❑
KIDNEY TROUBLE (STONES, ETC.)	❑	❑

LOCOMOTOR-MUSCULOSKELETAL:	YES	NO
VARICOSE VEINS	❑	❑
ANY DIFFICULTY IN WALKING	❑	❑
ANY PAIN IN CALVES OR BUTTOCKS ON WALKING, RELIEVED BY REST	❑	❑

NEUROLOGIC:	YES	NO
HAVE YOU HAD FAINTING SPELLS?	❑	❑
CONVULSIONS	❑	❑
PARALYSIS	❑	❑

HEMATOLOGIC:	YES	NO
ARE YOU SLOW TO HEAL AFTER CUTS?	❑	❑
BLOOD DISEASE	❑	❑
ANEMIA	❑	❑
PHLEBITIS	❑	❑
EXCESSIVE BLEEDING OR ABNORMAL BRUISING?	❑	❑

ENDOCRINE:	YES	NO
THYROID DISEASE	❑	❑
HORMONE THERAPY	❑	❑
ANY CHANGE IN HAT OR GLOVE SIZE	❑	❑
ANY CHANGE IN HAIR GROWTH	❑	❑
HAVE YOU BECOME COLDER THAN BEFORE, OR SKIN BECOME DRYER?	❑	❑

PSYCHIATRY:	YES	NO
HAVE YOU EVER BEEN ADVISED TO SEEK OR HAVE YOU SOUGHT TREATMENT FOR:		
DEPRESSION	❑	❑
ANXIETY AND/OR PANIC	❑	❑
SEVERE STRESS	❑	❑
ALCOHOL AND/OR DRUG ABUSE	❑	❑

PLEASE LIST ALL KNOWN ALLERGIES (DRUGS, FOOD, ANIMALS, ETC.):

____

____

____

SIGNATURE OF PATIENT: ______________________ DATE ______________

QUESTIONNAIRE REVIEWED BY: ______________________ DATE ______________

(MEDICAL PROVIDER)

BRISTOL PARK
MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical records:

FROM:	**TO:**
______________________________	______________________________
(Name of Physician, Medical Group or Hospital)	(Name of Physician, Medical Group or Hospital)
______________________________	______________________________
(Address)	(Address)
______________________________	______________________________
(City, State, Zip) (Telephone)	(City, State, Zip) (Telephone)

I understand that I have the right to limit the type of information released from my medical records as in the case of HIV test results, mental health information and alcohol and drug abuse information. The following information is to be released:

I have no limitations on the information to be released from my medical record including any information concerning AIDS or results of HIV testing, psychological or psychiatric treatment, and/or alcohol or drug abuse.

The information to be released from my medical records **shall be limited** to**:**

____

The reason for requesting that my medical records be copied is:

Changed Insurance	Second Opinion	Personal Use
Changed Doctor	Legal Case	Unhappy with Care/Service
Moved Out of Area	Accident/Third Party Liability	Other ___________________

I agree to pay a reasonable charge to cover the cost of clerical costs incurred in making the records available for inspection. In addition, I understand I will be charged a copying fee of up to twenty-five cents ($0.25) per page for standard documents, and the cost of postage.

I understand that I may receive a copy of this authorization. This authorization is effective now and will remain in effect for six (6) months from the date signed or __________. I understand that requestor may not further use or disclose the medical information unless another authorization is obtained from me unless such use or disclosure is specifically required or permitted by law.

Patient Name: ____________________________________ Date of Birth: _______________________

Address: ____ Soc. Sec. No.: ______________________

City:__________________________________ State:______ Zip:_______ Phone: ________________

Signed: ____ Date: ____________________

(Signature of Patient/Parent/Patient's Legal Representative*)

Relationship to Patient: ____

* Authorized representative must submit copies of legal documents supporting assignment of this authority.

This authorization for use of disclosure of medical information is being requested to you to comply with the terms of the confidentiality of Medical Information Act of 1981, Section 56, et. sec., California Civil Code. Effective January 1, 1983, California law guarantees patients access to their medical care and specifies available procedures. Health & Safety Code 1795 et. sec. Declares that "every person having ultimate responsibility for decisions respecting his/her own health care also possesses a concomitant right of access to complete information respecting his/her condition and care provided." In compliance with California's Health and Safety Code 1795.12, it is our policy to allow current and former adult patients, parents of minor patients (with exceptions), patient guardians or conservators, and deceased patient's beneficiaries or personal representatives to inspect the patient's medical record within five working days alter receiving a written request or to ensure that copies are transmitted within five days after receipt of the written request and payment of reasonable clerical costs.

BRISTOL PARK
MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form you acknowledge receipt of the Notice of Privacy Practices of Bristol Park Medical Group, Inc. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice from any of our offices, or by accessing our web site at *www.bristolparkmed.com*.

I acknowledge receipt of the *Notice of Privacy Practices* of Bristol Park Medical Group, Inc.

Signature: ____________________________________ Date: ___________________
(patient/parent/guardian/conservator)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained.

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgement was not obtained.

Signature of provider representative: ______________________ Date: _____________

BRISTOL PARK
MEDICAL GROUP

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice applies to all records of your care generated and maintained by Bristol Park Medical Group, Inc. and/or Bristol Park Medical Management, L.P. (collectively referred to in this Privacy Notice as "Bristol Park Medical Group"). Your hospital or non-Bristol Park Medical Group providers may have different policies or notices about the use and disclosure of information in their possession.

We are required by law to: 1) make sure that medical information that identifies you is kept private; 2) make available to you this Notice of our legal and privacy practices with respect to medical information about you; and 3) follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

- We may disclose medical information about you to doctors, nurses, medical students, or other Bristol Park Medical Group personnel involved in taking care of you. We may also disclose medical information to people outside the medical group, such as family members, specialists or others who are involved in providing services that are part of your care.
- We may use or disclose medical information about you so that the treatment and services you receive at Bristol Park Medical Group may be billed to and payment may be collected from you, an insurance company or a third party.
- We may use or disclose medical information about you for Bristol Park Medical Group operations. These may include use of information to evaluate the performance of our staff, effectiveness of programs, and ways to improve care and services we offer. These uses and disclosures are necessary to ensure that all of our patients receive quality care.
- We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or care at Bristol Park Medical Group.
- We may use or disclose medical information to tell you about or recommend possible treatment options or alternatives, and about health-related benefits and services that may be of interest to you.
- We may disclose medical information about you to other healthcare providers in the event you need emergency care.
- We will disclose medical information about you as required by federal, state or local law.
- We may use or disclose medical information to a public health organization or federal organization when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- We may use or disclose medical information about you in special situations such as for workers' compensation programs, as required by military command authorities or the Department of Veterans Affairs, in response to a court or administrative order, or for public health activities.
- Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may later revoke this permission in writing, at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- You have the right to review and receive a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes. You must submit a written request to review and copy your medical information. We may charge a fee for the costs of supplying a copy of the records.
- You have the right to ask us to amend medical information that you feel is incorrect or incomplete. Your request for an amendment must be submitted in writing and must provide a reason that supports your request.

  We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information: 1) was not created by us; 2) is not part of the medical information kept by or for Bristol Park Medical Group; 3) is not part of the information which you are permitted to inspect and copy; or 4) is accurate and complete.
- You have the right to request an "accounting of disclosures." This is a list of disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and include: 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosures to you. You must submit a written request. The request must state a time period that may not be longer than six years and may not include dates before April 14, 2003, when current federal health privacy laws become effective for Bristol Park Medical Group.
- You have the right to request restrictions or limitations on the use or disclosure of medical information about you. You must submit a written request for restriction that specifies: 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply. Bristol Park Medical Group reserves the right to refuse your restriction if it is in conflict of providing you quality healthcare or in an emergency situation.
- You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as only at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contacted. We will accommodate reasonable requests.
- You have the right to possess a copy of this Privacy Notice upon request. You may receive a paper copy of this notice, or you can also obtain a copy of this Notice at our website, www.bristolparkmed.com.
- You have the right to file a complaint with Bristol Park Medical Group if you believe your rights to privacy have been violated. All complaints must be submitted in writing to the Quality Management Department at the address noted at the end of this Notice. All complaints will be investigated. *No personal issue will be raised for filing a complaint.*

CHANGES TO THIS NOTICE

Bristol Park Medical Group reserves the right to change this Notice at any time. We will post a copy of the current notice in our clinical sites and on our website.

If you have any questions about this Privacy Notice, please contact:

Attn: Chief Privacy Officer
Bristol Park Medical Group, Inc.
2501 S. Pullman St.
Santa Ana, CA 92705
Tel: (949) 437-9000