PATIENT REGISTRATION FORM
(Please fill out completely)

Patient Information:
First Name:______________________ MI:___ Last Name:____________________
Address:____
City:__________________ State:_____ Zip:________ Date Of Birth: ___/___/____
Home Phone: (____)_______________ Cell Number:(____)_____________________
Social Security Number:_______________ Sex:_____ Marital Status:__________
Email Address: ____
Race:______________________ Ethnicity: ___________________________________
Religion:___________________ Preferred Language:___________________________
Preferred Pharmacy:____

Employment:
Employer:_________________________ Occupation:____________________________
Employer Address: ____
City:_______________ State:____ Zip:_________ Work Phone: (____)__________

In Case of Emergency:
Please Contact:____
Phone Number: (____)__________________ Relationship:______________________

Responsible Party: (If same as patient, please skip)
First Name:____________________ MI:___ Last Name:_________________________
Relation to Patient: ____

Referral:
Who Referred You to this Office:____

Insurance:

Please present your insurance card to the front desk at every appointment.

I hereby assign my insurance benefits to be paid directly to the physician. I am financially responsible for non-covered services. I authorize this office to release my insurance carrier's information necessary for this claim.

Signature (Patient or parent of minor):_________________________ Date:__________________

PERIODIC HISTORY & PHYSICAL
(To Be Completed By Patient)

NAME________________________________ DOB__________ AGE________

REASON FOR VISIT:____

____

ALLERGIES TO MEDICATIONS: TYPE OF REACTION:

____

____

REACTIONS TO ANESTHESIA (Self and Family History) _______________

PLEASE DESCRIBE ANY PREVIOUS SURGERIES (With approximate dates):

____

____

____

LIST ALL SERIOUS ILLNESSESS (And any MEDICAL DIAGNOSIS' GIVEN IN THE PAST ie: Diabetes, Angina, Thyroid Problems, etc.)

____

____

____

LIST CURRENT MEDICATIONS (Include Over the Counter, Herbal, Vitamins and Birth Control)____

____

____

____

SOCIAL HISTORY: Please answer these questions if this is your first physical with us.

Married_______ Divorced_______ Separated_______ Widowed_______ Single_______

Occupation____

Hobbies/Interests_________________________________ Retired__________

Travel Outside of California?_______ Where? ______________________

Exposure to environmental agents?_________________________________

Race:_____________________________ Ethnicity:_____________________

Primary language spoken at home:__________________________________

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DO YOU:

Exercise Regularly? No______ Yes______
Smoke? No___ Yes___ Cigarettes___ Pipe___ Cigar___ Chew Tob___ (__packs/day)
Past Smoker? No___ Yes___ (___packs/day), How many years did you smoke? _____,
Year you quit? ____
Drink Alcohol? No_____ Yes_____ If yes, amount ______________________________
If no, Did you ever drink in the past?____, Amount_________, How many years?_____,
Year quit?______
Take in Caffeine? No_______ Yes_______ (_____cups/day)
Use of Recreational Drugs? No_______ Yes_______

IMMUNIZATIONS: Please list the year the last shot was given.
Pneumonia _________ Tetanus _________ Flu _________ Hepatitis B _________
Last skin test for TB _______

Do you have a: Living Will? NO/YES Durable Power of Attorney? NO/YES
If yes, please bring a copy for your chart. If no, would you like to fill one out? NO/YES

FAMILY HISTORY - Please list any illnesses of deaths in the family.

	Medical History	Current Age & Condition (if alive)	Age at Death & Reason
Grandfathers			
Grandmothers			
Father			
Mother			
Brothers/Sisters			
Children			
Other			

PLEASE LIST THE LAST TIME YOU HAD:

a) An Eye Exam **Month_________/Year_________** **Normal/Abnormal**
b) For Females
1) a pap/pelvic exam **Month______/Year______** **Normal/Abnormal**
2) a breast exam **Month______/Year______** **Normal/Abnormal**
3) a mammogram **Month______/Year______** **Normal/Abnormal**
c) Date of last physical exam________________ **Date of last lab tests______________**

<u>PROBLEM UPDATE</u>: Please circle anything in the list below that may have <u>changed</u> since your last full medical exam of <u>that you want to discuss with the doctor</u>. If this is your first exam with us, please circle all that apply to your medical history.

1.HEENT: Trauma, Head Injuries, Headaches, Visual Changes, Glaucoma, Cataracts, Hearing Changes, Ringing in ears. Vertigo, Frequent Ear Aches or Infections, Sinus Congestion, Frequent Sinus Infections, Nose Bleed, Snoring, Itchy, Runny Nose, Frequent Strep Throat or Hoarseness, Dental/Oral Problems.

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2. NECK: Stiffness or Pain, Swollen Glands, Goiter or an abnormal neck enlargement, Lumps.

3. RESPIRATORY: Cough, Wheeze, Hay Fever, Asthma, Spitting up blood, Pneumonia, Frequent Bronchitis, Tuberculosis. Sleep Apnea, Emphysema, Blood Clots in Lung. Last chest X-Ray ________

4. CARDIOVASCULAR: Chest Pain/Discomfort, Racing Heart, High Blood Pressure, Swollen Feet, Shortness of Breath during sleep/exertion, Pain in legs while walking, Heart Attacks, Angina, Arrhythmias, Heart Murmurs, Rheumatic Fever. Last EKG ________

5. BREASTS: Breast Lump, Pain or Discharge, Breast Infections (Mastitis), Abnormal Mammograms or Biopsies. Do you do self exams?______

6. GASTROINTESTINAL: Nausea, Vomiting (with or without blood), Food Intolerance, Trouble Swallowing (liquids/solids), Heartburn, Abdominal Pain, Bloating or Gas, Diarrhea, Constipation, Blood in Stools, Black Tarry Stools, Change in Eating/Bowel Habits, Anal Discomfort, Hemorrhoids, Skin turning yellow (jaundice), Hepatitis, Ulcers, Helicobacter Pylori, Gallbladder problems, Diverticulosis, Colon Polyps or Cancer, Inflammatory Bowel Disease or Irritable Bowel Syndrome?

7. GENITOURINARY: Urinary Frequency, Burning or pain with urination, Frequent Urinary Tract Infections, Difficulty starting or stopping urine flow or change in flow, Increased urination at night, Ever leak or dribble urine (without control), Urinary urgency, Blood, Puss, or Discharge, Prostate Trouble, Sexual Difficulties, Homosexual encounters, Sexual Preference____________, Multiple sexual partners, Sexually transmitted diseases, Genital Herpes (vaginal or penile sores), Ever been tested for HIV? Kidney Stones, Groin Hernias, Testicular swelling, infection, pain or mass, Corrections of undescended testis?

8. MUSCULOSKELETAL: Joint or Bone Pain, Swelling or Redness, Trauma, Infection or Arthritis, Stiffness or Limitation of motion or activity, Gout?

9. CIRCULATORY: Varicose Veins, Leg Cramps with walking or at rest, Past history of Blood Clots (i.e. leg/thigh), Cool Extremities, Decreasing hair on legs?

10. SKIN: Skin Problems, Non healing or poorly healing ulcers, Change in a wart or a mole, History of skin cancer, Unusual rash, Lesions, Lumps, Itching or dry skin?

11. NEUROLOGICAL: Seizures, Tremors or other involuntary movements, Dizziness, Memory Loss, Loss of Consciousness, Behavior Changes, Change in Coordination, Change in Sensation, Numbness or Tingling, Weakness, Fainting Spells or Strokes?

12. PSYCHIATRIC: Depression, Cry often, Health worries. Work/Facility problems, Suicidal considerations. Changes in mood, Motivational problems, Sleep pattern or

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appetite changes, Drug or Alcohol problems. Decreased interests, inability to experience periods of joy, Changes in concentration or recent memory recall, Nervousness, Tensions, Fear or Phobias?

13. ENDOCRINE; Significant weight loss/gain____pounds in _____months. Changes in clothes size, Weakness, Reoccurring fever, Chills, Fatigue or Sweats, Increased thirst, hunger or urination, Heat or Cold intolerance, Diabetes, Thyroid problems?

14.GYNOCOLOGY: Age at first period____, Last normal menstrual period___/___/___, Days in cycle____, Frequency_____, Flow_____, Abnormal bleeding, Type of Contraception___________________, Hysterectomy, Menopause at age:_____, Abnormal spotting, Discharge or Itching, Pain with intercourse or periods, Number of Pregnancies _____, Deliveries _____, Abortions _____, Miscarriages _____, Last PAP ___/___/___, Any other history?

15. HEMATOLOGY: Bleeding tendency, Easy Bruising, Persistent swollen glands, Anemia (low iron count), Blood Transfusion or reaction to transfusions?

16. Use of alternative Doctors or Medical Treatment?

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17. Below please list any non-routine tests or procedures done in the past i.e. CT scans, sonograms, kidney/intestinal X-Rays or Procedures, Stress Test etc. with approximate dates, reason for test (if known), Results of tests (if known) and the Doctor who ordered the test in case more information is needed.

Procedure / Test Done	Approx. Date Done	Reason	Result	Ordering MD
1.____________	____________	________	______	________
2.____________	____________	________	______	________
3.____________	____________	________	______	________
4.____________	____________	________	______	________
5.____________	____________	________	______	________

Patient Signature____________________

Date____________________

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ADVANCED DIRECTIVES
THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

IT IS NOW A REQUIREMENT THAT ALL PHYSICIANS MUST OFFER TO ALL ADULT PATIENTS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. THIS IS ALSO KNOWN AS AN ADVANCED DIRECTIVE.

IF YOU DO NOT WISH TO COMPLETE AN ADVANCED DIRECTIVE AT THIS TIME, SIMPLY MARK THE DECLINE BOX BELOW AND SIGN THE FORM. IF YOU DO WISH TO COMPLETE AN ADVANCED DIRECTIVES FORM, THE RECEPTIONIST WILL BE HAPPY TO SUPPLY YOU WITH THE PAPERWORK.

WE WILL BE HAPPY TO ANSWER ANY OF YOUR QUESTIONS.

DECLINE ADVANCE DIRECTIVES_____________

SIGNATURE_________________________________

DATE__________________

THANK YOU

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FULL CARE MEDICAL GROUP, Inc.

Hamid Khonsari, MD
Florentina Duke, NP-C
Sophie Eath Barnes NP-C

Patient Consent for Use and Disclosure or Protected Health Information

I hereby give my consent for Full Care Medical Group to use and disclose protected health information about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Full Care Medical Group describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Full Care Medical Group reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by asking the receptionist at the front desk or forwarding a written request to 3903 Lone Tree Way Suite 104 Antioch, CA 94509.

With this consent, Full Care Medical Group may call my home or other alternative location supplied by me on my patient demographic sheet and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or health care operations. This includes such things as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Full Care Medical Group may mail to my home, or other alternative locations, any items that assist the practice in carrying out treatment, payment or health care operations, such as appointment reminder cards, lab test results, and patient statements as long as they are marked "Personal and Confidential".

With this consent, Full Care Medical Group is given permission to discuss my medical condition in the presence of anyone I bring with me to appointments. I understand it will be my responsibility to ask anyone I bring to my appointment to leave the room if the discussion turns to subjects I desire to keep privileged.

With this consent, I give permission to the staff of Full Care Medical Group to call my name aloud in the reception area and to agree to allow my name be on a sign-in sheet at the front desk. If I do not want my name announced or my name on a public sign-in sheet, I will let the receptionist at the front desk know.

Signed by____________________________________ Date__________________
Signature of Patient or Legal Guardian

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RIGHT TO A PAPER COPY OF THIS NOTICE:

You have the right to a paper copy of this notice. You will be given a copy for your records today and can ask us to give you another copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to health information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date of the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact any of the receptionists. All complaints must be made in writing. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

Print Name________________________________

Signature__________________________________ Date____________________

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Full Care Medical Group

Hamid Khonsari, M.D.
Florentina Duke, N.P.-C
Sophie Eath Barnes NP-C

Attention All Patients:

Due to limited appointment time available, effective April 1, 2016 **the no show policy has changed.**
If you are unable to attend a scheduled appointment, we kindly ask that you give our office a call **24 business hours prior** to your appointment time. This will allow acutely ill patients to be seen in your appointment slot. As a deterrent, we now have a fee of **$50.00** for any no shows or appointments not cancelled within 24 business hours.
After two missed appointments you will be sent a final notice. **If you miss a third time we will have to dismiss you from our practice.**
Your cooperation and understanding is greatly appreciated.

Thank you,
Full Care Medical Group

Signature_______________________________ Date:____________________
Patient or Guardian of Patient

CONSENT FOR THE RELEASE OF MEDICAL RECORDS

TO: CUSTODIAN OR RECORDS

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I, ___________________________, hereby consent and request that **Hamid Khonsari, MD, Florentina Duke, NP-c, or Sophie Eath Barnes, NP-c** be permitted to examine and obtain copies of all hospital and medical records of every sort and kind regarding all matters relating to examination, diagnosis, care and treatment of above named patient.

I understand and agree that this consent for the release of medical information will remain valid until __________________.

Patient or Guardians Signature______________________________________

Patient's Address: ______________________________________

____

____

Date of Birth: __________________

Mail Records to:

Full Care Medical Group, Inc.
3903 Lone Tree Way, Suite 104
Antioch, CA 94509
(925) 755-1255
(925) 755-1259 FAX

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