Woodland Hills Medical Clinic

HOW DID YOU HEAR ABOUT US: ☐ Insurance ☐ School ☐ Internet ☐ Word of Mouth ☐ Drive By

PATIENT INFORMATION

Date of Birth____/____/____ Age____ Address____

Last Name____ Apt____ Preferred Phone (____) ____-____

First Name____ City____ Alternate Phone (____) ____-____

Middle Initial____ Sex ☐ M ☐ F State____ ZIP____ Email____

Social Security#____-____-____

Ethnicity: ☐ Hispanic or Latino Race: (Specify)____

Preferred Language:____ Marital Status (circle one): Married/ Single/ Widowed/ Divorced

Primary Care Physician	In Case Of Emergency	Employer
Name____	Name____	Name____
Phone(____) ____-____	Phone(____) ____-____	Phone____
	Relation____	

PARENT/RESPONSIBLE PARTY INFORMATION (if minor)

Date of Birth____/____/____ Age____ Address____

Last Name____ Apt____ Preferred Phone (____) ____-____

First Name____ City____ Alternate Phone (____) ____-____

Middle Initial____ Sex ☐ M ☐ F State____ ZIP____ Email____

Social Security#____-____-____ Relation to Patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Employer

PRIMARY INSURANCE

Insurance Name____ is address same as patient or guarantor? ☐ YES ☐ NO

Member ID____

Group#____ Address____

Date of Birth____/____/____ Age____ Apt____ Preferred Phone(____) ____-____

Last Name____ City____ Alternate Phone(____) ____-____

First Name____ State____ ZIP____ Email____

Social Security#____-____-____ Relation to Patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Employer

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Patient Name: **DOB:**

_____ _____/_____/_____

PATIENT HISTORY

Please mark an (X) by the conditions you may have or have had in the past:

_____Heart Disease _____Seizures _____**None**

_____High Blood Pressure _____Mental Health Problems

_____High Cholesterol _____Thyroid Cancer

_____Diabetes _____Cancer (past or present)

_____Stroke Other_____

PLEASE LIST CURRENT MEDICATIONS (include non-prescription products) _____**None**

1_____ 2_____ 3_____

4_____ 5_____ 6_____

7_____ 8_____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE ALLERGIC TO _____**None**

1_____ 2_____ 3_____

4_____ 5_____ 6_____

OTHER ALLERGIES _____**None**

1_____ 2_____ 3_____

MAJOR SURGERIES _____**None**

1_____ APPROX DATE_____/_____/_____

2_____ APPROX DATE_____/_____/_____

3_____ APPROX DATE_____/_____/_____

PERSONAL HABITS

1) Do you drink caffeinated beverages (coffee, tea, soda)?_____Daily intake?
2) Do you drink alcoholic beverages?_____If yes,_____drinks/□ day,□week,□month
3) Do you smoke or chew tobacco?_____If yes,_____/day,_____years of use
   If No, any prior nicotine use?_____years

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FAMILY HISTORY

Please mark if your mother or father has had any of these symptoms in the past:

Mother	Father		Mother	Father		Mother	Father	
☐	☐	Heart Disease	☐	☐	Serious Injury	☐	☐	Scarlet Fever
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Nervousness
☐	☐	Arthritis	☐	☐	Measles	☐	☐	Numbness
☐	☐	Asthma	☐	☐	Headaches	☐	☐	Polio
☐	☐	Heart Trouble	☐	☐	Poor Circulation	☐	☐	Venereal Disease
☐	☐	Bladder Trouble	☐	☐	Reproductive Disorders	☐	☐	Hepatitis
☐	☐	High Blood Pressure	☐	☐	Rheumatic	☐	☐	Stroke
☐	☐	Cancer	☐	☐	HIV/ARC	☐	☐	Rheumatism
☐	☐	Chest Pain	☐	☐	Kidney Disorder			
☐	☐	Concussion	☐	☐	Bowel Control Loss			
☐	☐	Convulsions	☐	☐	Menstrual Cramps			
☐	☐	Diabetes	☐	☐	Multiple Sclerosis			
☐	☐	Muscular Dystrophy	☐	☐	Tuberculosis			

Other Problems: **As you review the following list, please check any that apply to you recently**

o Decreased hearing	o chest pain	oRinging in ears	oIrregular pulse
o Palpitations	oHives oSwollen ankles	oHair loss	oLeg pain
o Mole, changing	oTremors	oCold/numb feet	o Headaches
o Varicose veins/phlebitis	oLoss of appetite	oRashes	oBlurred vision
o Difficulty swallowing	oEye pain	oHeartburn	oWeight changes
o Foot Pain	oGout	oTesticular pain	o Foot pain
o Diverticulosis	oSinus	oPersistent vomiting	o Numbness
o Shortness of breath lying flat	oArthritis	oBack pain	oShortness of breath
o Constipation	oPain/burning during urination	oBronchitis/cough	oBlood in urine
o Hemorrhoid	oIncontinence	oDiarrhea	oBladder leakage
o Hernia	oHoarseness	oSleeping problems	oSore throat
o Kidney Stones	oJaundice/Hepatitis	oHay fever/allergies	

Males:

oTesticular pain

o Penile pain/discharge

Females:

o Irregular menstrual cycles

o Pain/bleeding during/after sex

o Flushing/menopause

o Date of last PAP_____ o Normal o Abnormal

oDate of last Menstrual Period_____

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AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment: The administration and cost of all medical and surgical procedures, x-ray, and medication for myself and for my dependents.

Guarantee of Payment:

_____**Initial SELF PAY** – I elect to pay for all services rendered in full today. I understand that my insurance will **NOT** be billed by woodland Hills medical clinic.

_____**Initial INSURANCE**- Assignment of Benefits: I authorize payment directly to Woodland Hills Medical Clinic for all benefits otherwise payable to me. I also acknowledge that Woodland Hills Medical Clinic will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance based on the best available information of my current policy and Woodland Hills Medical Clinic current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While Woodland Hills Medical Clinic makes every effort to verify my correct insurance information prior to leaving, I understand Woodland Hills Medical Clinic cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

If you have an outstanding balance on your account that is not paid within 90 days we will turn your account over for collections. I understand and agree that all collection agency fees and/or attorney fees associated with the collection process will be my responsibility. **There will be a 30% charge for any account over $100 and 50% charge for any account under $100.**

LAB WORK POLICY

Any Labs not conducted in clinic are are sent out in accordance with your insurance carrier and/or preference. Be advised that the fees associated with these tests are **in addition** to your current charges with Woodland Hills Medical Clinic and will be billed separately to your insurance carrier as a courtesy by the lab; however, you are ultimately responsible for these charges and may receive a bill directly from the lab. These charges are NOT associated with Woodland Hills Medical Clinic. Should you have any questions in regard to the billing of these particular lab charges, you will need to contact the lab company directly.

By voluntarily signing this form I acknowledge that I have provided Woodland Hills Medical Clinic with all current insurance information, read and understand ALL content within and agree to the release of records, responsibility of payment, treatment, procedures and lab work policy as stated.

Patient/Responsible Party Signature_____ **Date**_____/_____/_____