

REGISTRATION

(PLEASE PRINT)

CROWN SURGERY MEDICAL GROUP

2071 Compton Ave. Suite 105

Corona, CA 92881

Telephone: (951) 736-0696

Fax: (951) 735-4779

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial
Address _____ E-mail _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthdate _____ Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (____) _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone (____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Birthdate _____ Relation to Patient _____
Address (If different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone (____) _____
Insurance Company _____ Soc. Sec. # _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Crown Surgery Medical Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand
that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and
their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This
consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

COMMUNICATION CONSENT AGREEMENT

This form allows our physicians and office staff permission to speak with your family members or other individuals noted below.

I, _____ understand that under Federal Law (HIPAA) this medical office may not release any medical information to any individual without my expressed written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore give permission to Crown Surgery Medical Group to release medical information on my behalf to the following individual(s).

(1) Name: _____ Relationship: _____

Phone Number: _____ Date of Birth: _____

(2) Name: _____ Relationship: _____

Phone Number: _____ Date of Birth: _____

(3) Name: _____ Relationship: _____

Phone Number: _____ Date of Birth: _____

(4) Name: _____ Relationship: _____

Phone Number: _____ Date of Birth: _____

(5) Name: _____ Relationship: _____

Phone Number: _____ Date of Birth: _____

PATIENT NAME: _____ Date of Birth _____

PATIENT SIGNATURE: _____ DATE: _____

**PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I hereby give my consent for **Crown Surgery Medical Group** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **Crown Surgery 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. **Crown Surgery Medical Group** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the **Privacy Officer, 2071 Compton Avenue Ste 105, Corona, CA 92881.**

With this consent, **Crown Surgery Medical Group** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Crown Surgery Medical Group** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Crown Surgery Medical Group** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Crown Surgery Medical Group** to restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Crown Surgery Medical Group** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Crown Surgery Medical Group** may decline to provide treatment to me.

Signature of Patient or Guardian

Date

Please print name of Patient or Guardian

Relationship to Patient

PATIENT HEALTH HISTORY FORM

DATE: _____

Name: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** _____

Present Weight: _____ **LBS** **Height:** _____

Medical Reason for Visit: _____

Allergies/Sensitivities to Medication: _____

Patients Medical History: (Please Circle Y or N)

Y / N Heart Attack When:	Y / N Asthma	Y / N Thyroid Problems	Y / N Colitis/Colon Polyps
Y / N Heart Failure When:	Y / N Jaundice	Y / N Kidney Disease	Y / N Ulcer Disease
Y / N Heart Murmur	Y / N Tuberculosis	Y / N Hepatitis	Y / N Hypertension
Y / N Diabetes Insulin Type/Amount:	Y / N Phlebitis (Blood Clot in Leg)	Y / N Cancer If yes, what type:	Y / N Prostate Problems (straining to urinate)
Y / N Rheumatic Fever	Y / N Varicose Veins	Other: _____	

List any illnesses you have been hospitalized for, **NOT** requiring surgery: _____

Previous Surgeries and Approximate Dates: _____

Any Family History of: (Please Circle Y or N)

Y / N Diabetes	Y / N Tuberculosis	Y / N High Blood Pressure	Y / N Heart Disease
Y / N Kidney Disease	Y / N Stroke	Y / N Cancer What type:	Y / N Bleeding Tendencies

Medications:

Prescription: _____

Non-Prescription: _____

Blood Thinners: _____

Do you use Tobacco? _____

In the Past? _____

Do you use Alcohol? _____

Average Daily Amount? _____

WELCOME TO OUR OFFICE

Dear _____,

The staff of Crown Surgery Medical Group is committed to providing you with the best possible care. To achieve our objective easily we need your support and cooperation. You, the patient, share a responsibility in reaching this goal. It is your responsibility to know and confirm your benefits prior to coming to our office. Please note the following requirements to minimize delays during your office visit.

- Bring your insurance card and driver's license (or another form of ID)
- Pay your co-payments and deductibles at the time of service
- Keep your appointments and give us 24 hours cancellation notice when you cannot make your appointment. You will be charged your co-payment or \$25 for any missed appointments not cancelled more than 24 hours of the scheduled appointment. If you are more than 15 minutes late for your appointment, your appointment will be rescheduled to the next available date.
- Notify us of any changes in your address, telephone numbers, or insurance carriers.
- Most importantly, abide by the follow-up care instructions of the surgeons and professional medical staff.

PAYMENT POLICY

Payment of co-payments, deductibles, and initial consultation fees are collected at the time service is rendered. We accept cash, cashier's checks, money orders, or debit cards. There is a \$1.00 surcharge for all debit card payments. If you come unprepared and unable to pay your co-payment or consultation fees, your appointment will be rescheduled.

MINORS

If your minor child is the patient, a parent or legal guardian must accompany them. Minors coming in without the responsible adult will have their appointment rescheduled to a time when the responsible adult can accompany them. It is unlawful for us to treat a minor (under 18 years of age) without the consent of a parent or legal guardian.

DISABILITY FORMS

Please be sure to read the instructions on the form and fill out your section completely. Incomplete forms will be returned to you. The completion of the state disability is free, however there is a \$10 fee for the completion of private disability forms. The fee and postage must be paid when the form is brought to our office for completion. Please allow 48 hours for all forms to be completed.

INITIAL _____

