CROWN SURGERY MEDICAL GROUP, INC.
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PATIENT HEALTH QUESTIONNAIRE (Page 1)

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 (Yes) or N (No))

Y / N Heart Attack When:	Y / N Asthma	Y / N Thyroid	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	Y / N Anticoagulation RX	Y / N Chest Pain
Y / N Back Injections	Y / N Sleep Apnea	Y / N Stroke	Y / N Congestive Heart Failure
Y / N Depression	Y / N Elevated Cholesterol	Y / N Back Injury	Y / N Antiplatelet RX
Y / N HIV	Y / N Short of Breath	Y / N Arrhythmias	Y / N Pacemaker Vendor:

Are you currently pregnant or could you possibly be pregnant? ☐ Yes ☐ No

Have you ever had any problems related to anesthesia? ☐ Yes ☐ No

Has any family member had an unexpected problem or died during an anesthesia or surgery? ☐ Yes ☐ No

Do you have or have ever had MRSA? ☐ Yes ☐ No

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PATIENT HEALTH QUESTIONNAIRE (Page 2)

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

_____

_____

Previous Surgeries and Approximate Dates:_____

_____

_____

Family History of: (Please Circle Y (Yes) or N (No))

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

Current Medications: Prescription and Non-Prescription

Medication Dose Amount How Often Taken

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you take an aspirin daily? ☐ Yes ☐ No If yes, what dose:_____

Do you use Tobacco?_____ In the Past?_____

Do you use Alcohol?_____ Average Daily Amount?_____

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OFFICE POLICY

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. There is a $20.00 fee for each disability form to be completed. The fee and postage must be paid when the form is submitted to our office for completion. For electronic disability forms, please call the office with your claim ID number or you may email it to info@crownsurgery.com. Please allow 48 hours for all forms to be completed.

MEDICAL RECORDS REQUESTS

We require 48-hour notice to process your request for any release of medical records. Medical record requests must be in writing with a signed medical release by the patient. There is a $0.25 charge per page for copies of medical records.

PRESCRIPTION REFILLS

If you are taking medications prescribed by our physician and you need a refill, please call your pharmacy first and ask them to fax a refill request to (951) 973-7299. We ask that you to allow 48 hours for processing your request. Make sure you call in your refill while you still have a few days of medication remaining to get you through the 48-hour period.

PATIENT PORTAL

Crown Surgery Medical Group utilizes a web portal as part of the electronic health record, which communicates information including but not limited to test results and visit summaries. You may activate your patient portal by providing your physician's office with a current email address and completing the user registration process through our patient portal. I understand that I may decide to opt out of participation at any time either in writing, or by completing the Crown Surgery Medical Group Patient Portal opt-out form.

If you have any questions regarding our policies, please do not hesitate to ask. By signing below, I have read and understand the office policies stated above and agree to accept the described responsibilities.

x _____ _____
Patient's Signature Date

x _____ _____
Parent or Guardian Signature Date

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FINANCIAL POLICY

We understand that many patients find insurance coverage and financial responsibility issues complex and confusing so we have outlined our practices policy. Please feel free to contact our office with any questions regarding our policies and our staff will be happy to assist you.

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

For our patient's convenience we participate in most major health plans and have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicaid. As a courtesy, our billing service will submit claims for services rendered to a patient who is a member of one of these plans and assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information at the time the appointment is scheduled. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If you are insured by a plan we contract with but don't have an insurance card with you, payment in full for each visit is required until you furnish us with a copy of the card and your coverage can be verified.

CoPays/Deductibles/Co-Insurance

Please be prepared to pay for your share of cost at the time of your appointment. Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. For your convenience we accept cash, cashiers checks, debit and credit cards (Visa, Mastercard, and American Express). Please note that there is a $1.00 surcharge to process debit and credit cards. If you do not have your co-payment, co-insurance or deductible, your appointment may be rescheduled. Additionally, you may have co-insurance and/or deductible amounts due as required by your insurance carrier.

Surgery

When surgery is scheduled, your insurance benefits and accumulations will be verified. You will be contacted by our office to let you know what your share of cost is. Our office will collect as a pre-payment any remaining deductible you may have and any co-insurance 2-3 days prior to your surgery appointment. Your out of pocket cost is estimated based on your benefits and our fees. Anesthesia, facility, and other providers are separate fees. If your remaining deductible is not applied to our claim by your insurance company, a credit will appear on your account and a refund will be promptly processed and mailed to you.

x _____ _____

Patient's Signature Date

x _____ _____

Parent or Guardian Signature Date

CROWN SURGERY MEDICAL GROUP, INC.
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PATIENT REGISTRATION FORM

Last Name:_____First Name:_____Middle Initial:_____

Date of Birth:_____Age:_____Gender:_____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Patient Social Security Number: _____ Spouse (or Parent) Name:_____

Home Address:_____ City:_____State:_____ Zip:_____

Home Phone:_____Cell Phone:_____ Email:_____

Emergency Contact Name: _____Phone:_____Relationship to Pt:_____

REFERRAL INFORMATION

How did you hear about us? □ Referring Physician □ Website □ Internet □ Family/Friends □ Other_____

Referring Physician Name:_____ Phone:_____ Fax:_____

Primary Care Physician (if diff than Ref MD) :_____Phone:_____Fax:_____

EMPLOYMENT INFORMATION

Employment Status: □ Employed □ Student □ Self-Employed □ Retired □ Unemployed

Occupation: _____ Employer Name: _____

Employer Address: _____Phone:_____

BILLING AND INSURANCE INFORMATION

Primary Insurance Company Name:_____ Phone:_____

Policy ID Number: _____ Group Number:_____

Policyholder's Name:_____Relationship to Pt: _____DOB:_____ SSN:_____

Secondary Insurance Company Name:_____Phone:_____

Policy ID Number: _____ Group Number:_____

Policyholder's Name:_____Relationship to Pt: _____DOB:_____SSN:_____

I, _____, hereby authorize Crown Surgery Medical Group to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the above-named provider (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing-agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care. As the patient or parent or guardian, I agree to the above terms and conditions.

Date: _____Signature of Patient or Guardian:_____

CROWN SURGERY MEDICAL GROUP, INC.
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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:_____

PATIENT SIGNATURE:_____DATE:_____

MEDICAL STUDENTS

Crown Surgery Medical Group participates in clinical education programs with Western University of Health Sciences to give medical students enrolled in medical school experience in clinical practice. Your physician has agreed to permit such students to observe and participate in his patient care activities, including, where appropriate, providing medical care to patients under the physician's direct supervision.

By signing below you agree to permit the students working in your physician's office to observe and participate in your medical care during your appointment today, including, where appropriate, providing direct medical care to you under your physician's direct supervision. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

PATIENT SIGNATURE:_____DATE:_____

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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, 25470 Medical Center Drive Suite 203, Murrieta, CA 92562.

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 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

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RACE AND ETHNICITY FORM

The Federal Government requires us to ask these questions. This information is used to track illnesses by age, gender, race and ethnicity. We will also use this information to identify the needs of different patient groups and develop plans to address them and monitor the quality of our services for all patients so everyone gets the highest quality care regardless of their racial or ethnic background. We ask that you check one box under each category and thank you for taking the time to complete this information.

Patient's Name:_____ Date of Birth:_____ Date:_____

ETHNICITY:

□ Decline Response □ Hispanic or Latino □ Not Hispanic or Latino

RACE:

□ Decline Response □ American-Indian or Alaska Native □ Asian
□ Black or African-American □ White □ Other

PREFERRED LANGUAGE

□ Decline Response (I do not wish to answer)

□ Arabic	□ Italian	□ Sign Language
□ Chinese	□ Japanese	□ Slovak
□ Czech	□ Korean	□ Spanish
□ Dutch	□ Malay	□ Swahili
□ English	□ Other	□ Tagalog
□ French	□ Persian	□ Thai
□ German	□ Polish	□ Turkish
□ Hebrew	□ Portuguese	□ Urdu
□ Hindi	□ Romanian	□ Vietnamese
□ Indonesian	□ Russian	□ Yiddish

PATIENT PARTNERSHIP PLAN

We intend to provide you with the care and service that you expect and deserve. Achieving your best possible surgical outcome requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits as Recommended by My Doctor

I understand that my doctor will explain to me my treatment plan in detail. I will schedule the visits pertaining to diagnostic tests, treatments and other physician specialists as recommended by my doctor.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to complete my treatment as outlined. This may put my overall outcome at risk, as well as preventing detection and treatment of a serious health condition. I will make every effort to reschedule missed appointments as soon as possible. I understand that multiple missed appointments could result in my dismissal from care.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include but is not limited to prescribing medication, referring me to a specialist, ordering labs and tests, recommending surgical intervention, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my overall outcome. I will let my doctor know whenever I decide NOT to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

_____ _____

Signature of Patient or Guardian Date