Same Day Medical Care

850 E Latham Ave
Hemet, CA 92543-4391
(951) 791-1111

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#	
ADDRESS OF INSURANCE COMPANY			COPAY AMT $	
CITY, STATE ZIP	PHONE		DEDUCTIBLE $	
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________________

SAME DAY MEDICAL CARE, INC.
Nathan S. Howard, M.D.
850 East Latham Avenue, Suite 205
Hemet, California 92543

P (951) 658-7205 F (951) 766-1016

NextMD

What is NextMD?

*Easy and accessible way to contact Dr. Howard through Same Day Medical Care, Inc.'s NEW and SECURE website.

What does NextMD Offer?

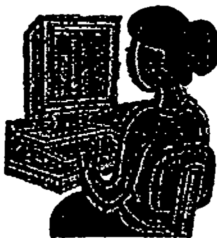
*Ability to request new, change, or cancel appointments from the convenience of your home computer.

*Communicate with Dr. Howard and the staff regarding:

_Medication refills

_Test Results

_Private questions for Dr. Howard



How do I Enroll?

*Contact Dr. Howard's staff to get you enrolled and started

TODAY!

all you need is a current email address

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NEXTMD SIGN-UP

Patient Name ____________________ Date of Birth ____________________ Date ____________________

E-mail Address ____________________ Patient Signature ____________________

Same Day Medical Care, Inc.
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NO SHOW POLICY

EFFECTIVE 01/05/2009

Effective January 01, 2009 there will be a NO-SHOW charge in the amount of $25.00 for any cancelled or NO-SHOW appointments with less than a 24 hour notice.

I apologize for this inconvenience, but due to rising costs in all areas, our practice will be implementing this NO-SHOW charge to patients' giving less than 24 hour notice. This will ensure that we can accommodate all patients' that need to be seen in the office.

I acknowledge that I have read and understand this new policy:

________________________________ ____________________

Patient Signature Date

SAME DAY MEDICAL CARE INC.
Nathan S. Howard, M.D.
850 East Latham Avenue, Suite 205
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NEW POLICY ON LATE APPOINTMENT ARRIVALS

Effective March 1, 2011 the office reserves the right to reschedule your appointment if you arrive more than fifteen (15) minutes late from your scheduled appointment.

I apologize for this inconvenience, but we will be implementing this new policy in order to provide quality care to all patient's in a timely manner.

I acknowledge that I have read and understand this new policy:

______________________________ ______________

Patient Name Date

____

Patient Signature

Same Day Medical Care
850 E. Latham Avenue, Suite 205
Hemet, CA 92545

Authorization for the Use or Disclosure of
Protected Health Information

I, ____________________________ hereby authorize Same Day Medical Care to use or disclose Protected Health Information to the following: relative, friend, or other...

_____ Release to ____

_____ Release to ____

_____ Release to ____

The following Protected Health Information ____

____

____

This authorization is in full force and effect until __________________ or ________________ at which time this authorization to use or disclose Protected Health Information expires.

I understand that I have the right to revoke this authorization in writing by sending notification to: Same Day Medical Care, 850 E. Latham Avenue, Hemet, CA 92543.

I understand when I revoke this authorization; it is not effective to the extent that Same Day Medical Care has already relied on the use or disclosure of the Protected Health Information.

I also understand Protected Health Information released prior to this authorization may be re-disclosed by the party who received that information and may no longer be protected by federal or state law.

Same Day Medical Care will not condition my treatment or payment on whether I provide an authorization for the requested use or disclosure.

I understand I have the following rights:

____To inspect or copy the Protected Health Information to be used or disclosed

____To refuse to sign this authorization

____ ________________________

Signature (patient, parent, personal representative) Date

____

Name of patient, parent or personal representative Description of personal representatives authority

Same Day Medical Care, Inc.
Nathan Howard, M.D.
850 East Latham Avenue, Suite 205
Hemet, CA 92543
Phone: 951-658-7205 Fax: 888-696-1501
howard@kmmedrecmail.com

Authorization to Release Medical Information

Date of Request: ____

To: ____
Full Name of physician or entities in possession of Health Information

Complete Address: ____

Office Telephone #: ____________________ **Office Fax #:** ____________________

I, ______________________________ Date of Birth: ____________________
Name of recipient or legally authorized representative

Hereby consent and authorize you to release to Dr. Nathan Howard,

Circle One: All Records X-Rays / Labs Progress Notes

Pertaining to the health care services that were provided to:

____
Name of recipient (Please Print **Patient Name**)

During the following dates of treatment: ______________________________

This authorization is given for the sole purpose of: ______________________________

I understand that this authorization is subject to revocation at any time, except to the intent that the individual or entity that is to make the disclosure has already taken action in reliance upon it.

I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation this authorization shall remain in full force and effect and shall not otherwise expire.

Date: ____________________ Signature: ______________________________

It is the policy of this medical practice that we will adopt, maintain, and comply with our Notice of Privacy Practices, which shall be consistent with HIPPA and California Law.

PLEASE NO CD'S

ADVANCE DIRECTIVE STATUS

I have been informed of my right to formulate an Advance Directive and I have been provided with information regarding the execution of an Advance Directive.

Please check one of the following:

[ ] I have previously completed an Advance Directive and have provided a copy for inclusion in my record.

[ ] A copy of my Advance Directive is on file with ______________________________.
(Physician or health care facility)

[ ] I have not executed an Advance Directive and I am not interested in any further information.

[ ] I am interested in the formulation of an Advance Directive and will discuss my options with my primary care provider.

______________________________ ______________________
Patient's Signature Date

Comments:

____

____

____

____

[ ] The patient was given a brochure/information on Advance Directives.

______________________________ ______________________
Practitioner and/or Staff's Signature Date

Patient Name	DOB:

Same Day Medical Care

850 East Latham Avenue Suite 205 Hemet, CA 92543

Patient Name:________________________ **DOB:**______________ **Date:**__________

What is your medical problem and how long have you had it? ______________________________

____

What is your main symptom?____

____

Check illness or conditions you have had:

☐ Cancer ☐ Asthma ☐ Hepatitis ☐ Diabetes ☐ Glaucoma ☐ Heart Trouble ☐ GERD ☐ Vein Trouble
☐ Emphysema ☐ Nervous Disorder ☐ High Blood Pressure ☐ Bleeding Tendencies ☐ Thyroid Problem
☐ Pneumonia ☐ Kidney Disease ☐ High Cholesterol ☐ Arthritis

Previous Operations with Dates: ☐ Tonsillectomy Year_____ ☐ Appendectomy Year_____

☐ Other Operations with Year ____

Have you ever had a Blood Transfusion? ☐ No ☐ Yes When________

When was your last colonoscopy? Year______

When was your last TB skin test or Chest X-ray? ________

Please list any other illnesses NOT requiring operation for which you were hospitalized:________________

____

Have you had serious injuries, broken bones, Etc.? ☐ No ☐ Yes **List:**______________________________

Dressed Weight:__________ **How long have you been at this weight?**_____________

Women only:

Number of Pregnancies?:____**Number of Miscarriages?:**____ **Onset Date of Last Menstrual Period?:**_____

Periods are: ☐**Regular** ☐**Irregular** **Have you gone through Menopause?** ☐ **Yes** ☐ **No**

Any complications in pregnancies? Please list: ______________________________________

Last Mammogram **Date:**__________ ☐ **Normal** ☐ **Abnormal**

Last PAP Smear **Date:**__________ ☐ **Normal** ☐ **Abnormal**

Men Only: **When was your last PSA (prostate blood test)?:** ________________

Please list all medications you are currently taking and why?

Medications/Dosage	Reason for Medication

Do you take? Mark YES OR NO Aspirin______ **Vitamins**_______ **Laxatives** _______ **Steroids**_______

Please list any medication allergies:

Medication	Reaction/symptom

Are you allergic to Iodine? ☐ **YES** ☐ **NO**

Review of Systems:
Within the last year have you had any of the following:

SKIN:

	YES	NO
Change in hair texture		
Change in skin texture		
Any skin rash		
Any new or change in moles		

HEAD, EAR, EYE, NOSE, THROAT:

	YES	NO
Blurred vision		
Double vision		
Spots before eyes		
Infected eyes		
Pain behind eyes		
Any change in vision		
Do you wear glasses		
When were they last checked		
Earaches		
Discharge from ears		
Ringing in ears		
Decrease in hearing		
Recurrent nose bleeds		
Recurrent head colds		
Sinus trouble		
Hay fever		
Strange persistent odors		
Strange taste or loss in taste		
Persistent hoarseness		
Difficulty swallowing		
Enlarged glands		
Recurrent sore throats		
Recurrent sores in mouth		
Soreness or bleeding of gums on brushing		

CARDIOVASCULAR:

	YES	NO
Chest pain		
Pain in arms		
Wake up at night short of breath		
Shortness of breath:		
One flight of stairs		
On laying down		
Purple lips or fingers		
Palpitations or fluttering of heart		
Swelling of hands, feet or ankles:		
At what time of day_______		
Leg cramps on walking or at night		
Enlarged veins in legs		
How many bed pillows do you use	______	

GASTROINTESTINAL:

	YES	NO
Recurrent stomach pain		
Belching or heartburn		
Relieved by food or medication		
Appetite Good Fair Poor		
Nausea or vomiting		
Vomited blood		
Avoid some foods		
What kinds__________________		
Avoid spices		
Abdominal cramping		
Black bowel movement		
Any blood in bowel movement		
Rectal pain with bowel movement		
Bowel movements		
Frequency per day		
Change in size, shape or texture of BM		

Review of systems continued:

RESPIRATORY:

	YES	NO
Shortness of breath		
Night sweats		
Chronic or frequent cough		
Chronic or frequent cough on laying down		
Wheezing		
Coughed up blood		

MUSCULO-SKELETAL:

	YES	NO
Recurrent back pains		
Backaches		
Joint pains		
Swelling of any joints		
Redness or heat of any joint		

NEUROLOGIC:

	YES	NO
Frequent or severe headaches		
Fainting spells		
Dizziness on change of position		
Unconscious spells		
Tingling or weakness of hands or feet		
Muscle spasms		
Loss or change of sensation in hands or feet		
Trembling of any extremity		

SIGMOIDOSCOPY OR COLONOSCOPY

	YES	NO
Sigmoidoscopy		
Colonoscopy		
Do you know the findings?		

EKG:

	YES	NO
Ever had an electrocardiogram?		
Abnormal		

ECHO:

	YES	NO
Ever had an echocardiogram?		
Abnormal		

STRESS TEST:

	YES	NO
Ever had a treadmill stress test?		
Abnormal		

GENITOURINARY:

	YES	NO
Lose urine on coughing or sneezing		
Discharge from penis		
Pain in urinating		
Difficulty in starting urination		
Do you get up at night to urinate		
How many times?________		
Any blood in urine		
Full feeling of bladder but only small amount of urination		

ENDOCRINE:

	YES	NO
Goiter		
Hotflashes		
Tiredness without apparent reason		
Brittleness of nails		
Dryness of skin		
Inability to stand heat		
Inability to stand cold		

HEMATOLOGIC:

	YES	NO
Easy bruising		
Bleeding problems		

Family History:

Has anyone of your blood relatives had the following problems? Please give the family member and other relevant information below:

Cancer:

Who	What Kind	Age Found	Still Living	Did they die of this?
____________	______________	___	Yes or No	Yes or No
____________	______________	___	Yes or No	Yes or No
____________	______________	___	Yes or No	Yes or No

Heart Attack or Stroke:

Who	Heart or Stroke	Age of Problem	Still Living	Did they die of this?
____________	______________	___	Yes or No	Yes or No
____________	______________	___	Yes or No	Yes or No
____________	______________	___	Yes or No	Yes or No

Any other Problems or Diseases among your blood relatives?

Alcoholism	Yes ☐	No ☐	______________________________
Anemia	Yes ☐	No ☐	______________________________
Allergies	Yes ☐	No ☐	______________________________
Asthma	Yes ☐	No ☐	______________________________
Arthritis	Yes ☐	No ☐	______________________________
Depression	Yes ☐	No ☐	______________________________
Diabetes	Yes ☐	No ☐	______________________________
Glaucoma	Yes ☐	No ☐	______________________________
High Cholesterol	Yes ☐	No ☐	______________________________
Hypertension	Yes ☐	No ☐	______________________________
Kidney disease	Yes ☐	No ☐	______________________________
Migraine Headaches	Yes ☐	No ☐	______________________________
Obesity	Yes ☐	No ☐	______________________________
Osteoporosis	Yes ☐	No ☐	______________________________
Thyroid disease	Yes ☐	No ☐	______________________________
Tuberculosis	Yes ☐	No ☐	______________________________
Ulcer disease	Yes ☐	No ☐	______________________________
Other (Specify)	Yes ☐	No ☐	______________________________

Your Immunizations: Have you had?

Tetanus shots	☐	Year of last shot_____
Measles Mumps Rubella	☐	Year of last shot_____
Pneumovax	☐	Year of last shot_____
Polio shots within the last 2 years	☐	Year of last shot_____
Influenza	☐	Year of last shot_____

Childhood Illness: Circle below those you have had

Measles	Chicken Pox
German Measles	Whooping cough
Mumps	Scarlet Fever
Rheumatic Fever	Polio
Diptheria	None

Social History:

Occupation:________________________________ Married:________________________________

Have you traveled outside the US? ☐ Yes Where? ______________

Do you Smoke? ☐ Yes ☐ No How many packs per day?_____ How Long?_____ When did you quit?______

Do you drink alcoholic beverages? ☐ Yes ☐ No How often?_____

Have you ever used or do you currently use illicit drugs? ☐ Yes ☐ No Please explain:________________

Caffeine intake? Type:______________ Amount:______________

Established Adult Patient With No Prior TB test or Prior Negative Results: Periodic TB Risk Assessment

Patient Name____________________Birth Date: _______ _Medical Record #:______________
Assessment to be done with routine/annual PE

TB SYMPTOM REVIEW:

Do you currently have any of the following symptoms? ☐ Yes ☐ No

☐ cough >3 weeks ☐ coughing up blood ☐ unexplained weight loss
☐ chronic fever ☐ drenching night sweats

IMMEDIATE chest x-ray and medical evaluation is needed if the answer is YES to any of the above symptoms

NEW TB MEDICAL RISKS FOR TB DISEASE PROGRESSION:

Since you last saw your doctor, do you have a NEW diagnosis of: ☐ Yes ☐ No

☐ HIV? ☐ diabetes? ☐ cancer ? ☐ kidney failure?

OR started taking any of the following immunosuppressive medications: ☐ Yes ☐ No

☐ Prednisone ☐ methotrexate ☐ cyclosporine
☐ Chemotherapy for cancer
☐ IV rheumatoid or psoriatic arthritis/Crohns disease drugs

NEW TB EXPOSURE RISK

In the past 2 years ....

1. Have you had any contact to someone with known TB disease of the lung? ☐ Yes ☐ No
2. Have you spent more than 2 weeks in Asia, Africa, Latin America, or Eastern Europe? ☐ Yes ☐ No
3. Have you been in prison or jail? ☐ Yes ☐ No
4. Have you been homeless or live in a single room occupancy hotel? ☐ Yes ☐ No
5. Have you injected street drugs? ☐ Yes ☐ No
6. Have you work with homeless persons, migrant workers or drugs users? ☐ Yes ☐ No
7. Have you worked as a health care worker? ☐ Yes ☐ No

New or repeat TB test (Mantoux or blood test) is needed if the answer is YES to any of the above questions

Required: Document the date of the Mantoux, return visit and the millimeter result in the medical record and database

Person completing the form: ____________________________ **Date:** ____________