



MEDICAL PATIENT REGISTRATION FORM

Patient Name: _____ **Birth Date:** _____ **Age:** _____ **Sex:** ☐ M ☐ F

Last First Middle Month/Day/Year

Mailing Address: _____ **SSN #:** _____
Street (Apt.) *City* *State* *Zip Code*

Home #: _____ **Cell #:** _____ **Driver's License #:** _____

Email Address: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ **Employer:** _____ **Work #:** _____

Employer's Address: _____

<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>

Preferred Language: ☐ English ☐ Other: _____ ☐ Vietnamese ☐ Interpreter Needed ☐ Spanish	Employment Status: Student: ☐ F/T ☐ P/T ☐ Retired Employed: ☐ F/T ☐ P/T ☐ Disability ☐ Unemployed
Ethnicity: Are you Hispanic, Latino/a, or Spanish origin? ☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, Another Hispanic, Latino/a or Spanish origin ☐ Declined to Specify	Race: What is your race? ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ Declined to Specify ☐ Other: _____
Sexual Orientation: ☐ Heterosexual (not Lesbian or Gay) ☐ Homosexual (Lesbian or Gay) ☐ Bisexual ☐ Chose not to disclose ☐ Other (Please specify): _____	Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Genderqueer, neither exclusively male/female ☐ Declined to specify ☐ Other: _____
Select all that apply: Veteran ☐ Yes ☐ No Seasonal Worker ☐ Yes ☐ No Migrant Worker ☐ Yes ☐ No	Are you currently homeless? If yes, what is your homeless status? ☐ No ☐ Yes, Homeless Shelter ☐ Yes, Transitional ☐ Yes, Doubling Up ☐ Yes, Street ☐ Yes, Permanent Supportive Housing ☐ Yes, Other: _____ ☐ Yes, Declined to Specify

Are you living in public housing? ☐ Yes ☐ No ☐ Declined to answer

Are you a U.S. Citizen? ☐ Yes ☐ No ☐ Declined to answer

Do you have any specific communication needs? ☐ Yes ☐ No

If YES, please select the following: ☐ Sign language ☐ Hearing ☐ Vision ☐ Cognition issues ☐ Other:

Referred by: ☐ Physician ☐ Friend ☐ Other:

EMERGENCY CONTACT:

I authorize personnel of Southland Integrated Services, Inc. to release all medical information to my emergency contact listed below.

Name _____ Relationship _____ Phone number _____

PHARMACY LOCATION:

[Name] [Street] [City] [Zip code]

PRIMARY INSURANCE:

Company Name: _____ Group/Plan #: _____ Member #: _____

Name of Policy Holder/Responsible Party: _____

SELF-CERTIFICATION AFFIDAVIT:

Number of family members (Spouse + Dependents under 18 years old): _____

Monthly family gross income: \$ _____

☐ By checking this box, I certify that the information given is true, correct and complete to the best of my knowledge, any changes will be reported immediately.

Signature of Patient/Parents or Guardian (If minor)

Date

OFFICE USE ONLY:

Self-determination: ☐ A ☐ B ☐ C ☐ D ☐ E

Completed by: _____

ACKNOWLEDGEMENT OF TERMS AND CONDITIONS:

- ☐ This verification will remain in effect until revoked by me in writing.
- ☐ A photocopy or a digital copy of this verification is to be considered as valid as the original.
- ☐ I understand that I am financially responsible for all charges whether or not paid by the insurance.
- ☐ I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plan to Southland Integrated Services, Inc.’s Providers.
- ☐ If my deductible is met and an insurance billing concern arises, I will discuss this issue with the Southland Integrated Services, Inc. Billing Department and/or my insurance company.
- ☐ I will be financially responsible for all charges that are not covered by the insurance.
- ☐ I was assessed for Southland’s Sliding Fee Discount Program. This is a discount program for all patients, based on family size and income, regardless of insurance status. I understand that I can contact Patient Support for additional information or to apply for the program.
- ☐ I hereby authorize my assignee to release all information necessary to secure the payment.
- ☐ I hereby agree to comply with the Terms of Services as stated by Southland Integrated Services, Inc.

Consent to Treatment (for adult patients):

I hereby consent to health care encompassing routine diagnostic procedures, medical and dental treatment and other health services rendered to me by the Southland Integrated Services, Inc. and its duly authorized agents and personnel.

I understand that the practice of medicine and surgery and the rendering of health care including dental are not an exact science and that no guarantees have been made as to the results of treatments, examinations or other health services rendered by this clinic.

☐ By checking this box, I agree to the terms and conditions listed above.

Consent to Treatment of Minor (only applicable to minors):

I (we), being the parent or guardian of _____, a minor, the age of _____ years do hereby consent, authorize and request Southland Integrated Services, Inc. and its duly authorized agents/personnel to administer such treatment deemed advisable, necessary or requested on the above minor.

☐ By checking this box, I agree to the terms and conditions listed above.

NOTICE OF PRIVACY PRACTICES:

Notice of Privacy Practices of Southland Integrated Services, Inc. provides information about how we may use and disclose your protected health information. We encourage you to read it in full here <https://bit.ly/2yEWeHm>. A physical copy will be provided upon request. Our **Notice of Privacy Practices** is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing it here <https://bit.ly/2yEWeHm> or contact our office. If you have any questions about our Notice of Privacy Practices, please contact: (714) 620-7001.

Southland Integrated Services, Inc. abides by the Health Insurance Portability and Accountability Act (HIPAA) to safeguard your privacy. Our HIPAA and confidentiality policies can be found here <https://bit.ly/2yEWeHm>. A physical copy will be provided upon request.

☐ By checking this box, I acknowledge receipt of the Notice of Privacy Practices of Southland Integrated Services, Inc. and HIPAA policies.

CONSENT FOR ELECTRONIC COMMUNICATION

Email/Portal:

Southland Integrated Services, Inc. offers patients access to their health record through the secured Healow Patient Portal. Through the Patient Portal you may request current prescription refills, view laboratory and radiology results once it has been made available and reviewed by the medical provider, request appointments, review medication lists, problems lists, immunization records and allergies. Southland Integrated Services, Inc. also offers online bill payment. Communication sent between yourself and Southland Integrated Services, Inc.’s staff members through the Patient Portal will become a part of your patient records. The Patient Portal is NOT intended to provide internet- based diagnostic medical services. Southland Integrated Services, Inc. additionally uses email to deliver HIPAA secure patient satisfaction surveys. Feedback from these surveys is used to improve upon our services, and is anonymous (NOT a part of your medical record).

Text Message/Voice Message:

I understand that message/data rates may apply to messages sent through Southland Integrated Services, Inc. to my cell phone. I understand that I am under no obligation to authorize Southland Integrated Services, Inc. to send me text messages or leave voice messages.

☐ By checking this box, I authorize Southland Integrated Services, Inc. to use my email address listed below to create a Patient Portal account for the purposes of allowing me access to the information listed under Email/Patient Portal and contact me by SMS text messaging. I authorize the personnel of Southland Integrated Services, Inc. to leave a message on an answering machine or voice mail. I may opt-out of receiving these communications from Southland Integrated Services, Inc. at any time by calling (714) 620-7001 and speaking to a representative.

I would like to opt-out of the following option(s): ☐ Text message ☐ Email/Portal ☐ Voice message

If you would like to complete your Advance Directive at this time, please follow this <https://bit.ly/35aX6Qk> to complete the form and submit to your PCP.

INFORMED CONSENT FOR TELEMEDICINE SERVICES:

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites
- More efficient medical evaluation and management
- Obtaining expertise of a distant specialist

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

I Attest to and Understand the Following Conditions:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these. My provider has fully explained the alternative treatments to my me.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Southland Integrated Services, Inc. of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of California and will be present in the state of California during all telehealth encounters with the providers at Southland Integrated Services, Inc.

Patient Consent to the Use of Telemedicine

☐ I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize Southland Integrated Services, Inc. providers to use telemedicine in the course of my diagnosis and treatment.

By signing this form, I acknowledge that I have read, understood and consented to all of the information stated above. I provided my consent by check-marking the available boxes.

PATIENT'S NAME: _____ **DOB:** _____

PATIENT'S SIGNATURE: _____ **DATE:** _____

MEDICAL HISTORY

Patient's Name: _____
Last First Middle

DOB: ____/____/____
MM/DD/YYYY

Have you or any relatives had a history of any of the following illnesses:

	YES	NO	RELATIONSHIP
1. Asthma	☐	☐	_____
2. Anemia/Sickle Cell/Tay Sachs	☐	☐	_____
3. Cancer	☐	☐	_____
4. Diabetes	☐	☐	_____
5. Epilepsy/Black Outs/Dizziness	☐	☐	_____
6. Hepatitis/Jaundice	☐	☐	_____
7. Heart Problems	☐	☐	_____
8. High Blood Pressure	☐	☐	_____
9. Kidney Disease	☐	☐	_____
10. Lung Cancer	☐	☐	_____
11. Migraine Headache	☐	☐	_____
12. Visual Problems	☐	☐	_____
13. Venereal Disease	☐	☐	_____
14. Other Illnesses	☐	☐	_____

Are you allergic to any medication? ☐ Yes ☐ No

If so, what kind(s): _____

Are you currently taking any medication (including herbal medicines)? ☐ Yes ☐ No

If so, what kind(s): _____

Have you had any operation? ☐ Yes ☐ No

Please specify when and why: _____

Have you been hospitalized? ☐ Yes ☐ No

Please specify when and why: _____

Do you drink alcohol or use drugs? ☐ Yes ☐ No

Have you been diagnosed with any mental or physical disability? ☐ Yes ☐ No

Consent for release of medication history to Southland Integrated Services, Inc.? ☐ Yes ☐ No

What is your smoking status? ☐ Never Smoked ☐ Current Smoker ☐ Former Smoker ☐ Second-hand Smoker

Date of last menstrual period: ____/____/____ Are you pregnant? ☐ Yes ☐ No

Date of Hysterectomy, if done: ____/____/____ If so, how many months? _____

Have you been vaccinated for Tdap (Tetanus shot)? ☐ Yes ☐ No ☐ Unknown

When? ____/____/____

Have you had the following screenings completed?

Tuberculosis (TB) ☐ Yes ☐ No ☐ Unknown

When? ____/____/____ Result: _____ CXR done: ____/____/____

If you are 50 years old or older, have you been screened for Colonoscopy? ☐ Yes ☐ No ☐ Unknown

When? ____/____/____ Result: _____

If you are a female and 40 years old or older, have you had a Mammogram screening? ☐ Yes ☐ No ☐ Unknown

When? ____/____/____ Result: _____

If you are a female over 21 years old or sexually active, have you had a Pap smear done? ☐ Yes ☐ No ☐ Unknown

When? ____/____/____ Result: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____ regarding _____
Name of Physician, Medical Group or Hospital *Specialty*
Tel: _____
Fax: _____

Address *City* *State* *Zip Code*

To release my medical records to:

Southland Integrated Services, Inc.
9862 Chapman Avenue
Garden Grove, CA 92841
PH: (714) 620-7001; FAX: (714) 620-7091

I understand that I have the right to limit the type of information released from my medical records as in the case of HIV test results, mental health information and alcohol and drug abuse information. The following information is to be released:

- ☐ I have no limitations on the information to be released from my medical record including any information concerning AIDS or results of HIV testing, psychological treatment and/or alcohol or drug abuse.
- ☐ The information to be released from my medical records **shall be limited** to: _____

The reason for requesting that my medical records be copied is:

- ☐ Changed Insurance ☐ Second Opinion ☐ Personal Use ☐ Legal Case ☐ Other: _____
☐ Changed Doctor ☐ Moving Out of Area ☐ Accident/Third Party Liability ☐ Unhappy with care

I agree to pay a reasonable charge to cover the cost of clerical costs incurred in making the records available for review. I understand that I will be charged a copying fee of up to twenty-five cents (\$0.25) per page for standard documents and postage costs.

I understand that I may receive a copy of this authorization. This authorization is effective now and will remain in effect of six (6) months from the date signed or _____. I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me unless such use or disclosure is specifically required or permitted by law.

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

Address: _____ **Social Security #:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

Patient's Signature (Parent/Patient's Legal Representative): _____

Relationship to Patient: _____
(Authorized legal representative must submit supporting legal documentation)

This authorization for use of disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et. se. California Civil Code. In compliance with California's Health & Safety Code 1795.12, it is our policy to allow current and former adult patients, parents of minor patients (with exceptions), patients guardians or conservators, and deceased patient's beneficiaries or representatives to inspect the patient's medical record **within five working days** after receiving a written request or to ensure that copies are transmitted **within 15 days after** receipt of the written request and payment of reasonable clerical costs. See 45 CFR §164.508(c)(1)(i-iii)

*To be completed in person

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Instructions

This Authorization Form helps Southland Integrated Services, Inc. protect your privacy. We ask that you complete this form so that we may request for your medical record from your previous primary care provider, specialists or hospitals. Please read the information on this page and complete the form on the previous page. If you have questions or need help completing this form, please ask our staff.

Member Rights

- I understand that I can receive a copy of this Authorization, if requested.
- I understand that I may ask to receive an additional copy of this Authorization.
- I understand that I may refuse to sign this Authorization.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this Authorization.

Right to Cancel

I understand that I have the right to cancel this Authorization at any time. I understand that canceling this Authorization will not affect the ability of Southland Integrated Services, Inc. to use or disclose the medical record that was based on this Authorization. To cancel this Authorization, I understand that I must make my request in writing and clearly state that I am cancelling this specific Authorization. In addition, I must sign my request and then mail, deliver in person or fax my request to:

Southland Integrated Services, Inc.
9862 Chapman Avenue
Garden Grove, CA 92841
Fax: 714-620-7091

Restrictions

I understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEDICAL INFORMATION AUTHORIZATION

Patient's Name: _____ **Date of Birth:** ____ / ____ / ____

I authorize the personnel of Southland Integrated Services, Inc. to release all medical information to my family members and friends listed below.

I may revoke this authorization by phone or in writing at any time.

Name	Relationship to Patient	Phone number(s)	Emergency Contact
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

I authorize the personnel of Southland Integrated Services, Inc. to leave a message on an answering machine or voice mail.

☐ Yes ☐ No

Patient's Signature

____ / ____ / ____
 Today's Date

Witness' Signature (not a family member)

____ / ____ / ____
 Today's Date