Name: _____ Social Security Number: _____

First Name Last Name

Sex: ☐ Male ☐ Female Birth Date: _____

Home Address:

Street _____

_____

City _____

State, Zip _____

Contact Information:

Mobile Phone: _____ ☐

Home Phone: _____ ☐

Work Phone: _____ ☐

*Other Phone:*_____ ☐

*Email:*_____

Preferred number *(choose one)*

Optional information:

Mother's Maiden Name: _____

Place of Birth:_____

In case we cannot reach you with important medical information, may we leave a message on your preferred number voicemail?

☐ Yes ☐ No

Per government regulations, we are required to document race and ethnicity. The format below is required by the government.

Race
- □ decline to disclose
- □ race not known
- □ American Indian or Alaskan Native
- □ African American or Black
- □ White
- □ Asian

Ethnicity
- □ decline to disclose
- □ ethnicity not known
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Marital Status
- □ single
- □ married
- □ divorced
- □ widowed
- □ partnered

We understand that filling out extensive forms can be cumbersome, and we appreciate the time you spend completing them.

The information collected in these forms was carefully compiled, and assists us in providing you with the highest standards of medical care.

Primary Care Doctor Information:

Name:_____ Office Tel number:_____

Referring Physician (if different than primary care doctor)

Name:_____ Office Tel number:_____

What is your occupation?_____

Emergency Contact:

Name: _____ Phone number:_____

Relationship:_____

In case we cannot reach you with urgent and important medical information,
may we relay the information to your emergency contact?
☐ Yes ☐ No

Pharmacy Information:

Primary Pharmacy Name/Location: _____

Phone number: _____

Other Pharmacy Name/Location: _____

Phone number: _____

If you have questions for the doctor or her staff regarding our care please note the following:

She has a full-time staff, including a nurse and receptionist, who answer the phones in the office on a daily basis from 9:00am – 5:00pm with answering service coverage. The doctor prefers that you DO NOT message her directly through CS-Link for lab results, medications, etc.

Please call the office and speak to her staff for any questions you may have and they will inform her and get back to you.

Are you allergic to any medications?

□ No

□ Yes

Medication:_____

Reaction:_____

Medication:_____

Reaction:_____

Allergic to latex? □ No □ Yes

Family History:

□ **Family members have no significant medical conditions**

	Arthritis – unknown type	Osteoarthritis	Rheumatoid Arthritis	Psoriatic Arthritis	Psoriasis	Crohn's Disease or Ulcerative colitis	Lupus	Osteoporosis or hip fracture	Gout	Cancer	Coronary Artery disease/heart attack
Mother											
Father											
Sister											
Brother											
Other:											

Smoking habits:

□ Current every day smoker
□ Current some day smoker
□ Former smoker
□ Never smoked

Recreational drug use:

□ Never use
□ Medicinal marijuana
□ Recreational marijuana
□ Other recreational drugs:_____
□ Used regularly in past, but not any more:_____
How often?_____

Alcoholic beverage habits:

□ Never or rarely drink
□ 1-2 servings per week
□ 3-8 servings per week
□ 9 or more servings per week
□ Used to drink daily, but not any more
□ Current or former member of AA

Have you received the following vaccines?

Zoster vaccine (shingles vaccine)?
□ No
□ Yes: approximate date:_____
Pneumonia vaccine (Pneumovax or Prevnar13)?
□ No
□ Yes: approximate date:_____
Hepatitis B vaccine?
□ No
□ Yes: approximate date:_____
Flu vaccine (influenza)?
□ Never
□ Yes: approximate date
of recent dose:_____
BCG (tuberculosis) vaccine
□ No
□ Yes: approximate date:_____

When were your last recommended screening exams?

Last chest xray?_____
Last colonoscopy?_____
Last PAP and Pelvic Exam? _____
Last mammogram?_____
Last Bone Density exam for osteoporosis? _____
Last PPD test (tuberculosis skin test)? _____
Results: □ Negative □ Positive

Medications:

Please include vitamins, supplements, and herbal agents.
If you brought a list, we will be happy to photocopy it, and you may skip this section.

Medication Name	Milligrams per tablet	How many pills per dose?	How many doses per day?
Example: **Advil**	**200mg**	**2 pills**	**Twice a day**

Medical History:

□diabetes
□high blood pressure
□history of heart attack
□history of stroke
□congestive heart failure
□history of bone fracture
□sleep apnea
□anxiety
□depression
□other mental health difficulties:_____
□taking blood thinner:_____
□infertility
□frequent heartburn
□history of stomach ulcer
□eating disorder (bulimia or anorexia nervosa)
□genetic predisposition to cancer
□rapid loss of hair
□heart condition: _____
□chronic kidney disease or renal insufficiency
□history of cancer
what type?_____
when diagnosed?_____
□history of skin cancer
□basal cell □squamous cell
□melanoma □other_____
□history of leukemia or lymphoma
□hepatitis B
□hepatitis C
□other hepatitis or chronic liver problem: _____
□Crohn's Disease
□Ulcerative Colitis
□asthma
□chronic bronchitis (COPD)
□other lung condition:_____
□history of kidney stones
□predisposition to blood clots
□history of blood clot
□psoriasis, diagnosed by doctor
□history of diverticulitis or diverticulosis
□history of seizure
□hypothyroid (low thyroid)
□hyperthyroid disease (Grave's disease)
□frequent infections, requiring antibiotics more than twice a year
□history of tuberculosis
□positive PPD test or positive blood test for dormant tuberculosis
□HIV infection
□history of histoplasmosis or Cryptococcus infection (valley fever)
□history of tick bite
□history of lyme disease
□*Other:*_____

Women only

□currently pregnant
□miscarriages
if yes, how many ___,
and how far along in the pregnancy _____?)
□excessive menstrual bleeding
□menopause
□vaginal dryness
□history of vaginal or labial ulcers
□urine tract infections more than twice a year
□genital herpes
□history of other sexually transmitted disease:_____

Men only

□history of urine tract infection
□history of ulcers on penis or scrotum
□using medications for erectile dysfunction
□genital herpes
□history of other sexually transmitted disease:_____

□*None of the above apply to me*

Surgical History:

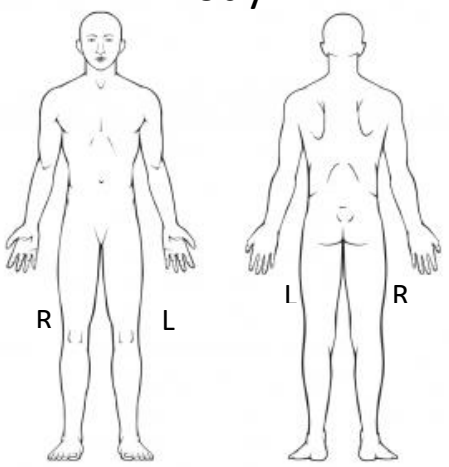
Surgery Type:	Approximate Date:

Name:_____

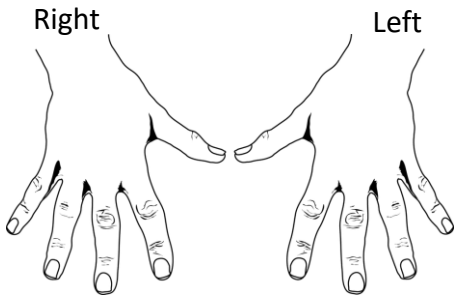
What brings you in to see the doctor today?

Where do you have pain (please shade in affected areas)?

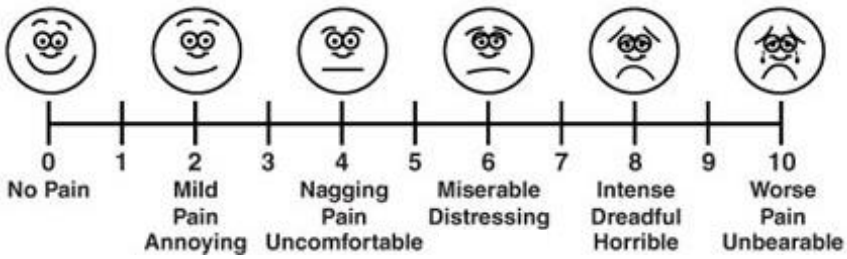
Body:



Hands:



How severe has your pain been in the last few days?



How Long has the pain been there?_____

Pain feels: □ sharp □ dull □ burning □ achy □ electric

Pain is most severe in the: □ morning □ mid-day □ evening □ night □ after activity □ random □ constant

What makes your pain feel better?

Over the past couple of weeks, have any of the following symptoms concerned you?

□ fever
□ sweats
□ more than 5 lbs weight loss
□ red eyes
□ dry eyes
□ dry mouth
□ difficulty swallowing
□ vomiting
□ ulcers in the mouth
□ chest pain
□ shortness of breath
□ cough
□ palpitations
□ nausea
□ blood in the stool
□ black stool
□ severe frequent headaches
□ vision changes
□ pain with urination
□ diarrhea
□ fingers turning funny colors in the cold
□ skin rash with sun exposure
□ fatigue
□ sleep problems
□ brain fog
□ swollen lymph nodes
□ allergies
□ depression
□ difficulty rising from a chair due to weakness

□ *none of the above*

Please inform the front desk staff of any changes of address, phone number, or insurance carrier!

(1) NOTICE OF PRIVACY PRACTICES

In accordance with the *Health Insurance Accountability and Portability Act* (HIPPA), you have been provided with a Notice of Privacy that provides information about how we may use and disclose *protected health information* ("PHI") about you. This Notice provides a more complete description of information uses and disclosures.

As a part of your healthcare, we maintain health records that describe your health history, symptoms, examination, test results, diagnosis, treatment, and plan for future care or treatment. This information serves as a basis for planning you care and treatment; a means of communication among other health professionals who contribute to your case; a source of information for applying your diagnosis and healthcare information to bill third parties, a means by which a third party payer can verify that services billed were actually provided; and a tool for routine healthcare operations such as assessing quality and reviewing the delivery of medical services.

You have the right to review our Notice before signing this consent. We have provided you with a copy of the Notice on page 2.

You have the right to object to the use or disclosure of your health information. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use of disclosure of PHI about you for treatment, payment and healthcare operations in accordance with the Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we already made disclosures in reliance on you prior consent.

Initial: _____ I request the following restrictions to the use or disclosure of my health information:

_____

I have received and read the Notice of Privacy Practices and consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described therein.

_____ _____

Signature *Date*

ACKNOWLEDGEMENT OF RECIEPT

I, _____, hereby acknowledge that on _____, I received copies of the following documents:

1. **NOTICE OF PRIVACY PRACTICES (see above page (1))**

SIGNATURE: _____

DATE: _____

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
PH:(800)633-2322 www.mbc.ca.gov

PRESCRIPTION DRUG POLICY, EFFECTIVE 8/17/2015

In order to focus our attention directly on your medical care and utilize our time more efficiently, we have developed an official prescription drug policy as follows:

- If you need a prescription refilled, please ask your pharmacy to submit an electronic request to our office. If they are unable to do so, they may fax or call in the request. **We will do our best to respond to refill requests within 2 business days**. If our nursing staff is busy assisting other patients, they will make every effort to get back to you by the end of the day.
- Some medications require physician monitoring and regular blood tests. **We cannot authorize a refill if we have not seen you in more than six months or if scheduled blood tests were not done.** If the doctor is unable to see you due to scheduling difficulties before your refill expires, our staff will work with you to ensure that treatment is not interrupted.
- For Biologic therapies, we will submit your first prescription to arrange prior authorization and enroll you in the pharmacy program through your insurance. Once you are enrolled, you will be contacted by the pharmacy to arrange payment and delivery. For refills, please contact the pharmacy and have them send us the refill request.
- Prescriptions for narcotic pain medications require a doctor visit.

I acknowledge that I have reviewed and understand this policy:

Print Name: _____

Signature: _____

Date: _____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby request/authorize _____ to release the following information from my healthcare records to **Renee Z. Rinaldi, M.D./ Dahlia T. Carr, M.D.** for the purpose of continuation of medical care:

( ) ALL RECORDS

( ) History and Physical Exam
( ) Discharge Summary
( ) ER Physician Note/ER Labs
( ) Echo/Stress Test/Cardiac Cath. Report
( ) Endoscopy/EGD/Colonoscopy
( ) Other _____

( ) Progress Notes
( ) Laboratory Reports
( ) Pathology Report
( ) DEXA Scan
( ) Operative Report

This authorization will expire 1 year from the date the authorization was signed.

Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

Patient Name: _____ **Phone:** _____

Social Security #: _____ **Birth date:** _____

Signature _____ **Date** _____

Legal representative (relationship to patient) _____

Witness _____ **Date** _____