☐ **CORONA** 2071 Compton Avenue, Suite 102 Corona, CA 92881 **(951) 549-0900** **Fax (951) 278-8552**
☐ **CHINO** 12488 Central Avenue, Suite B Chino, CA 91710 **(909) 613-0100** **Fax (909) 613-0600**

PATIENT REGISTRATION FORM

Date: / / NEW PATIENT ☐ CHANGE ☐

Patients: *Please fill out completely and return to the receptionist desk. Thank You!*

I. PATIENT INFORMATION

Patient Name (Last, First)
Sex: ☐ Male ☐ Female DOB: / /

Address City State Zip

Home Phone #: ( ) Cell Phone #: ( )

Driver's Lic #: SS #: -- --

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated Ethnicity/Race: Language:

Email: Referred by:

Patient's Employer: Work Phone #: ( )

Employer's Address: City State Zip

Emergency Contact Name: Emergency Contact #: ( )

II. RESPONSIBLE PARTY INFORMATION ☐ Self ☐Parent ☐ Spouse ☐ Other

Name: DOB: / / Phone #: ( )

Employer: Work Phone #: ( )

Employer's Address: City State Zip

Relationship to Patient: Drivers Lic #: SS # -- --

III. HEALTH INSURANCE INFORMATION

Primary Insurance Co.: Phone #: ( )

Name of Insured: DOB: / / SS #: -- --

Group #: Policy #: Co-Pay Amount $: Relationship to Patient:

Secondary Insurance Co: Phone #: ( )

Name of Insured: DOB: / / SS #: -- --

Group #: Policy #: Co-Pay Amount $: Relationship to Patient:

IV. PHARMACY INFORMATION

Name of Pharmacy: Phone #: ( ) Fax #: ( )

Pharmacy Address: City State Zip

V. REASON FOR VISIT

Is this visit due to?: ☐ Vehicle Accident ☐ Work Injury ☐ Other

Description of Accident or Injury:

How will your service be paid today? ☐ Cash ☐ Check ☐ Credit Card ☐ Bill Insurance

How would you like us to communicate with you and/or send your appointment reminder?
☐ Voice Message ☐ Text message ☐ Email ☐ Postal Mail

CONSENT: I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I hereby authorize the physician to release any information acquired in the course of my examination or treatment.
Initial: _________

GUARANTEE: I, (the patient or guardian) am an eligible member as of this date of service of a health plan and a copy of the benefits card is attached to this document. Signature of responsible party below acknowledges full financial responsibility for services rendered to me if it is determined I am I am "Not Eligible" on the date of service in question, or if service rendered is determined to be a non-covered benefit under the plan provisions.
Initial: _________

ASSIGNMENT OF INSURANCE BENEFITS: I hereby irrevocably authorize payment directly to the above named corporation/physician, benefits otherwise payable to me but not to exceed the corporation's/physician's regular charge due as a result of this claim. I understand I am financially responsible to the corporation/physician for charges not covered.
Initial: _________

Signature: ____________________________________ **Date:** ____/____/_____ **Relationship to Patient:** __________________

Staff Initial:

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CHILD HEALTH HISTORY

During which month of pregnancy did you first see the doctor? ________ Month

Where was the baby born?______________________________

How long was your pregnancy? . . . . ________ Months

If baby was born at home, were blood tests for newborn screening done?. . . ❑ Yes ❑ No

HISTORY OF PREGNANCY WITH THIS CHILD:

	Yes	No
1. Did you have any illnesses or problems? *(including sexually transmitted or other communicable diseases)*	❑	❑
2. Did you take any medications prescribed by your doctor?	❑	❑
3. Did you have a difficult/abnormal delivery/C-section?	❑	❑
4. Did the baby have any problems during the 1st week of life?	❑	❑
5. Did you use any non-prescribed drugs? *(tobacco, alcohol, street drugs, over-the-counter or home remedies)*	❑	❑
6. Did the baby go home with you from the hospital?	❑	❑
7. Was more than one baby born?	❑	❑
8. Did the baby receive any shots for Hepatitis B?	❑	❑

CHILD'S HISTORY: ❑ Male ❑ Female Is this child adopted? ❑ Yes ❑ No Birth Weight: ________ lbs. _______ oz. Length: ________ inches.

HAS YOUR CHILD EVER HAD:

	Yes	No
1. Measles, Chickenpox, Mumps, Rubella	❑	❑
2. Tuberculosis or positive TB Test	❑	❑
3. Tonsillitis / Sore Throat	❑	❑
4. Problems with eyes or vision	❑	❑
5. Problems with ears or hearing	❑	❑
6. Difficulty breathing / snoring at night	❑	❑
7. Heart problems	❑	❑
8. Asthma, bronchitis, or pneumonia	❑	❑
9. Anemia, bleeding problems, blood transfusions	❑	❑
10. Stomachaches	❑	❑
11. Diarrhea, soiling self with stool	❑	❑
12. Bladder / Kidney problems / wetting self or bed	❑	❑
13. Constipation	❑	❑
14. Vomiting after eating, refusal to eat	❑	❑
15. Muscle, joint or bone problems	❑	❑
16. Skin problems	❑	❑
17. Headaches or dizziness	❑	❑
18 Convulsions, seizures, epilepsy	❑	❑
19. Diabetes	❑	❑
20. Thyroid problems	❑	❑
21. Allergies	❑	❑
22. Problems with development of school performance	❑	❑
23. Serious illness or accident	❑	❑
24. Surgery or hospitalization	❑	❑
25. (GIRLS) Has she started her period?	❑	❑
26. (GIRLS) Are there problems with her periods?	❑	❑

FAMILY HISTORY: Does mother **M**, father **F**, sister **S**, brother **B**, aunt **A**, uncle **U**, or grandparent **GP** have:

Yes	No		M	F	S	B	A	U	GP
❑	❑	Diabetes	❑	❑	❑	❑	❑	❑	❑
❑	❑	Epilepsy or convulsions	❑	❑	❑	❑	❑	❑	❑
❑	❑	Mental retardation	❑	❑	❑	❑	❑	❑	❑
❑	❑	Heart disease	❑	❑	❑	❑	❑	❑	❑
❑	❑	Cancer	❑	❑	❑	❑	❑	❑	❑
❑	❑	Kidney or urinary disease	❑	❑	❑	❑	❑	❑	❑
❑	❑	Bone or joint problems	❑	❑	❑	❑	❑	❑	❑
❑	❑	High blood pressure	❑	❑	❑	❑	❑	❑	❑
❑	❑	Bleeding disorder	❑	❑	❑	❑	❑	❑	❑
❑	❑	Tuberculosis	❑	❑	❑	❑	❑	❑	❑
❑	❑	Allergy	❑	❑	❑	❑	❑	❑	❑
❑	❑	Lung or breathing problems	❑	❑	❑	❑	❑	❑	❑
❑	❑	Eye disorder	❑	❑	❑	❑	❑	❑	❑
❑	❑	Ear disorder	❑	❑	❑	❑	❑	❑	❑

PARENT INFORMATION:

Mother:	**Father:**
Age:__________ Height:__________ Occupation:____________________	Age:__________ Height:__________ Occupation:____________________

HOUSEHOLD INFORMATION: Do you live in a: ❑ House ❑ Apartment ❑ Mobile Home ❑ Shelter ❑ Homeless

Number of people in home:________. Are both parents living in the home? ❑ Yes ❑ No Language spoken in the home: ____________________

Does anyone in the home smoke, or use drugs or alcohol? ❑ Yes ❑ No

PATIENT IDENTIFICATION:

Signature:______________________________ Date:_____/_____/_____

Relationship to child: ____

REVIEWED BY:

Signature:______________________________ Date:_____/_____/_____

CONSENT FOR PURPOSES OF TREATMENT,
PAYMENT & HEALTHCARE OPERATIONS

Patient's Name ____
(Please Print)
VISTA Medical Group Provider ____

In connection with the medical services that I am receiving from the above-named physician or physician group, I hereby authorize the above-named physician and/or group to disclose any/or all Protected Health Information (PHI) concerning my medical condition and treatment, including copies of applicable hospital and medical records tl:

A. Any third party payor covering the medical services of the patient
B. Other health care professionals and institutions involved in the delivery of health care to the patient
C. The proponent of any legally sufficient subpoena, or in response to a court order
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services
E. Pharmacies
F. Other parties as otherwise required by law

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

Special Restrictions:

____
____
____
____

This consent is valid from the date executed for Six (6) years or until revoked in writing by the patient.

____ ________/_______/_________
Patient Signature Date

____ _______/_______/__________
Witness Date