MAYFLOWER MEDICAL GROUP
Your Health • Our Mission

PATIENT REGISTRATION FORM

Last Name:	**Middle Name:**	**First Name:**
Date Of Birth:	**Social Security #:**	
Street Address:	**City, State, & zip code:**	
Marital Status: (Circle One) **Single Married divorced Separated Other**	**Employment/Occupation:**	

Race:	**Ethnicity:**	**Primary Language:** **Interpretation Services needed: [ ] Yes [ ] No**

PREFERRED METHOD OF COMMUNICATION

Home Phone: _____ Authorized Methods Of Communication **(Check All That Apply)** **[ ]** Leave a call back only, **do not leave a message** **[ ]** Okay to leave detailed message with person **[ ]** Okay to leave detailed message on answering machine	**Cell Phone:** ( ) _____ Authorized Methods Of Communication **(Check All That Apply)** **[ ]** Leave a call back only, **do not leave a message** **[ ]** Okay to leave detailed message with person **[ ]** Okay to leave detailed message on answering machine	**Preferred Phone:** [ ] Home [ ] Cell [ ] Work [ ]Other ** **Email Address:** ***How Did You Hear About Us?*** **[ ] Web site [ ] Insurance** **[ ] Health Fair [ ] Passing By** **[ ] Friend [ ] Employee** **[ ] Other**

INSURANCE & GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)

Insurance Name:	Member ID Number:	Circle One: HMO PPO MEDICARE MEDI-CAL
Subscriber Name : [ ] or check box for self	Subscribers date of birth:	Relationship to patient:

IN CASE OF EMERGENCY

*Emergency Contact Name *Not Living with you*	Relationship:	Phone

PRIMARY CARE DOCTOR, HOSPITAL, AND PHARMACY INFORMATION

Primary Care Doctor Name:	Preferred Hospital:
Pharmacy Name / Street / City:	Pharmacy Phone:

CONSENT FOR TREATMENT, PAYMENT, AND MEDICAL INFORMATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to **MAYFLOWER MEDICAL GROUP**. I understand that I am financially responsible for any balance. I also authorize **MAYFLOWER MEDICAL GROUP** or insurance company to release any information required to process my claims.

I hereby authorize **MAYFLOWER MEDICAL GROUP** and or any associates working on behalf of this group to render any medical care determined by a medical evaluation.

Patient Signature _____ **Date** _____

MAYFLOWER MEDICAL GROUP
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PERSONAL HEALTH INFORMATION (PHI) COMMUNICATION CONSENT AGREEMENT

I understand that under federal law **(HIPAA),** this medical office may **NOT** release any **Personal Medical Information** to any individual without my express written permission. Law Enforcement and Court Order are two exceptions to this requirement. I, therefore, **GIVE** permission to **Mayflower Medical Group to release medical information on my behalf, to the following person(s) below:**

FIRST AND LAST NAME:		RELATIONSHIP:
ADDRESS:		
PHONE #	AGE:	DATE OF BIRTH:
DRIVER LICENSE NUMBER & EXP. DATE:	SOCIAL SECURITY NUMBER	
OTHER FORM OF IDENTIFICATION: **(CREATE A 4 DIGIT PIN)**		

FIRST AND LAST NAME:		RELATIONSHIP:
ADDRESS:		
PHONE #	AGE:	DATE OF BIRTH:
DRIVER LICENSE NUMBER & EXP. DATE:	SOCIAL SECURITY NUMBER	
OTHER FORM OF IDENTIFICATION: **(CREATE A 4 DIGIT PIN)**		

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

MAYFLOWER MEDICAL GROUP
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Patient Consent Form for Health Information Technology for Economic and Clinical Health (HITECH)

Please read through the consent form and provide the following information:

PATIENT NAME: (LAST NAME) _____ (FIRST NAME) _____

DATE OF BIRTH _____ (MM) _____ (DD) _____ (YYYY) GENDER: M____ F____

STREET ADDRESS / P.O. BOX_____

CITY_____ STATE_____ ZIP CODE_____

PHONE NUMBER _____ EMAIL_____

CONSENT CHOICES (CHECK ONE):

[ ] I CONSENT for all **HITECH** participants to access **ALL of my electronic health information** (including sensitive information) in connection with providing me any health care services, including emergency care.

[ ] I CONSENT ONLY IN CASE OF AN EMERGENCY for all **HITECH** participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

[ ] I DO NOT CONSENT for any **HITECH** participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency

X _____ _____

Signature of patient or authorized representative ***Date***

If I sign this form as the ***Patient's Authorized Representative,*** I understand that all references in this form **to "I", "me" or "my" refer to the Patient.**

_____ _____ _____

Name of Authorized Representative (Printed) ***Relationship*** ***Date***

FOR INTERNAL USE ONLY

Name of Organization: Mayflower Medical Group Name of Witness: _____ As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.

MAYFLOWER MEDICAL GROUP
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MEDICAL HISTORY FORM

DATE: _____

PATIENT NAME: _____DATE OF BIRTH_____ AGE_____

SEX M ☐ F ☐ **MARITAL STATUS M ☐ S ☐ W ☐ D ☐ SEP ☐**

PAST/CURRENT MEDICAL HISTORY (check box for any "yes" answers)

☐ Recurrent ear infections	☐ Psychiatric consultation/ Treatment/hospitalization	☐ Venereal disease
☐ Headaches	☐ Suicide attempt	☐ Bone, Joint, back disorder or injury
☐ Dizziness or fainting spells	☐ Excessive bleeding after surgery or dental work	☐ Hearing aid/pacemaker/artificial limb/ other physical apparatus
☐ Paralysis/numbness/tingling	☐ Asthma	☐ Motion limitation: physical disability
☐ Epilepsy-fits, seizures (convulsions)	☐ Pneumonia	☐ Malaria
☐ Eye disease-glaucoma, etc.	☐ Chronic cough	☐ Tuberculosis or Positive TB Test
☐ Wears corrective lenses	☐ Lung disease	☐ Chronic or frequent colds
☐ Eye surgery to correct vision	☐ Frequent indigestion	☐ Skin disease or skin problem
☐ Lack of vision in either eye	☐ Stomach, liver intestinal problems	☐ Diabetes
☐ Chest pain	☐ Hepatitis or yellow jaundice	☐ High cholesterol
☐ Heart Trouble	☐ Kidney disease	☐ Anemia, Blood problems
☐ High blood pressure	☐ Bladder disease	☐ Cancer
☐ Shortness of breath	☐ Hernia or rupture	☐ Benign Tumor
☐ Rheumatic Fever	☐ OTHER	☐ OTHER
FEMALES ONLY LAST MENSTRUAL PERIOD: _____ ☐ REGULAR ☐ IRREGULAR ☐ PAIN/CRAMPS DURATION: _____ NUMBER OF: PREGNANCIES: _____ ABORTIONS _____ MISCARRIAGES _____ LIVE BIRTHS _____	**FEMALES ONLY:** DATE OF LAST BREAST EXAM: _____ DATE OF LAST MAMMOGRAM: _____ ☐ NORMAL ☐ ABNORMAL DATE OF LAST PAP: _____ ☐ NORMAL ☐ ABNORMAL	**MALES ONLY** DATE OF LAST PROSTATE EXAM: _____ ☐ NORMAL ☐ ABNORMAL DATE OF LAST PSA TEST: _____

HOSPITAL/ILLNESS/TYPE OF SURGERY AND YEAR:

LIST ALL MEDICATIONS YOU ARE NOW TAKING:

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____

ALLERGIES: (MEDICATION/REACTIONS)

VACCINE (DATE OF LAST)

TETANUS: _____INFLUENZA: _____ PNEUMOCOCCAL _____HEPATITIS A/B :_____

PREVIOUS TESTS/EXAMS (DATE OF LAST)

CHOLESTEROL _____ EYE _____ RECTAL/STOOL _____DENTAL _____

TUBERCULOSIS SKIN TEST _____

FAMILY HISTORY: If any blood relatives has suffered any of the following, please circle the number and indicate which relative

1) ALCOHOLISM	7) DIABETES	13) KIDNEY DISEASE
2) ANEMIA	8) EPILEPSY	14) MENTAL ILLNESS
3) ASTHMA	9) GLAUCOMA	15) MIGRAINE
4) ARTHRITIS	10) HAY FEVER	16) OSTEOPOROSIS
5) BLEEDS EASILY	11) HEART DISEASE	17) STROKE
6) CANCER	12) HYPERTENSION	18) THYROID

NOTES/COMMENTS:

_____

_____

_____

OFFICE USE ONLY:

ADVANCED DIRECTIVE: □ YES □ NO **□ ADVANCED DIRECTIVE EDUCATION GIVEN**

STAYING HEALTHY ASSESSMENT COMPLETED ON: _____

Provider Name:

Provider Signature: _____ Date: _____

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other (*Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

PATIENT HEATLH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
Total:				

(*Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card*).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

A2663B 10-04-2005

Los Angeles County Adult Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **adults** for TB infection testing
- Re-testing should only be done in persons who previously tested negative, and have **new** risk factors since the last assessment
- For TB symptoms or abnormal chest x-ray consistent with active TB disease → Evaluate for active TB disease

Complete evaluation for active TB disease includes: symptom screen, chest x-ray, and if indicated, sputum AFB smears, cultures, and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

Check appropriate risk factor boxes below.

TB infection testing is recommended if any of the 4 boxes below are checked.

If TB infection test result is positive and active TB disease is ruled out, TB infection treatment is recommended.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and Northern European countries
- If resources require prioritization within this group, **prioritize** patients with at least one medical risk for progression (see Fact Sheet for list)
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥ 2 years old

☐ **Immunosuppression**, current or planned

- HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease at any time

- The Centers for Disease Control and Prevention indicates that the evaluation of contacts and treatment of infected contacts is an important component of the U.S. strategy for TB elimination

☐ **History of homelessness or incarceration**

- The U.S. Preventive Service Task Force (USPSTF) recommends screening populations at increased risk for TB infection based on increased risk of exposure including persons who have lived in high-risk congregate settings (e.g. homeless shelters and correctional facilities)

☐ None; no TB testing is indicated at this time.

Provider: **[ ] Lina Dela Cruz, M.D. [ ] Randy Taylor [ ] Judith Foyabo N.P. [ ] Lara Clark, P.A.**

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

(Place sticker here if applicable)

See the **Los Angeles County Adult Tuberculosis Risk Assessment User Guide** for more information about using this tool.

Adapted for LAC use from the California Tuberculosis Risk Assessment available on the PROVIDERS page at www.ctca.org
To ensure you have the most recent version visit http://publichealth.lacounty.gov/tb/providertoolkit.htm

HIPPA Privacy Rule of Patient Authorization Agreement

Mayflower Medical Group, Inc.

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my health care, Mayflower Medical Group, Inc. originates and maintains health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information service as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Mayflower Medical Group, Inc. notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Mayflower Medical Group, Inc. Notice of Information practices prior to signing this consent;
- That Mayflower Medical Group, Inc. reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Mayflower Medical Group, Inc. is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Mayflower Medical Group, Inc., has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness _____ Date: _____

Printed Name of Patient or Legal Representative Witness _____ Date: _____

HIPPA Privacy Rule Receipt of Notice of Privacy Practices

Written Acknowledgement Form

Mayflower Medical Group, Inc.

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I, _____ (Patient's Name) understand that as part of my health care, Mayflower Medical Group, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Mayflower Medical Group, Inc. Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Mayflower Medical Group, Inc. Notice of Privacy Practices prior to signing this acknowledgement;
- that Mayflower Medical Group, Inc. reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness _____

Printed Name of Individual or Legal Representative Witness _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ▫ Individual refused to sign
- ▫ Communication barrier prohibited obtaining the acknowledgement
- ▫ An emergency situation prevented us from obtaining acknowledgement
- ▫ Others (please specify)

_____

_____

_____ _____

Site Manager Date

Privacy Official