Kolvita Family Medical Group
25982 Pala #180 Mission Viejo CA, 92691
Tel: 949-600-8990 Fax: 949-600-8998

PATIENT:

Last:_____ First:_____ MI: _____
Sex: __(M) ___ (F) Date of birth: _____/_____/_____ SS#: _____-_____-_____
Home phone:_____ Cell phone: _____
Email : _____
Address:_____
City:_____ ST: _____ Zip: _____
Employer: _____ Work phone #: _____
Marital Status: _____

RESPONSIBLE PARTY (FOR MINORS):

Last: _____ First: _____ MI: _____
Address: _____
City: _____ ST: _____ Zip: _____
Home phone: _____ Cell phone: _____

PRIMARY INSURANCE: _____
ID number: _____ Group #: _____
Insured name: _____ DOB: _____/_____/_____
Relationship to patient: _____ Phone #: _____

SECONDARY INSURANCE: _____
ID number: _____ Group #: _____
Insured name: _____ DOB: _____/_____/_____
Relationship to patient: _____ Phone #: _____

AUTHORIZATION: I certify that the above information is true, and I consent to any medical or surgical treatment rendered the patient under the general special instructions of the physician.
Signature of Patient: _____

I hereby authorize Kolvita Family Medical Group to release any and all medical information needed to process my insurance claim or for utilization review and financial audit. I hereby authorize any insurance company to pay he proceeds of any benefit due me directly to Kolvita Family Medical Group. A photstat of this authorization and assignment shall be considered valid.
Insured's Signature: _____ Date: _____

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Dr. Linda Bolling Davis, MD
Dr. Matthew Zeller, DO

CONFIDENTIALITY STANDARDS

The **Health Insurance Portability & Accountability Act of 1996** was put in place to protect the confidentiality & security of personal health data. In order to comply, we would like to know how to relay pertinent health information to you if the doctor cannot speak to you directly.

Please check all that apply:

- **It is OK for the Doctor or staff to leave a message with lab/ test results.**

  Messages may be left at the following number (s):

  _____ Home #: _____

  _____ Cell #: _____

  _____ Work #: _____

- **It is OK to web-enable my account so that lab/tests results may be accessed through the Kolvita patient portal.**

  E-mail address to be used for web-enabling/ message:

  _____@_____

- **It is OK to fax labs/ studies/ tests results to this fax number:**

  _____-_____-_____

- **It is OK to discuss & give verbal results to the members listed below:**

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Patient name (please print): _____

Signature : _____ **Date:** _____

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Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer, whose telephone number is listed in the notice of privacy practices. I further understand that Kolvita will offer me updates to this Notice of Privacy Practice should it be amended, modified, or changes in any way.

Patient Name (please print):_____

Patient/ Representative Signature: _____

Date:_____

_____ **Patient refused to sign.**

_____ **Patient was unable to sign because:**

_____

KOLVITA DIRECT PRIMARY CARE
www.kolvita.com

Patient Name: _____
Date of Birth: _____

HEALTH HISTORY QUESTIONNAIRE

Medical History: *(Please list all current and past medical problems, major diseases, major infections, hospitalizations with your age at diagnosis):*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Surgical History: *(Please list all past surgeries and the year performed):*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Medications: *(Please list all current medications, herbals, supplements and provide the dosages as well):*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.

Allergies: *(List all allergies to medications, foods, etc., as well as the type of reaction):*

1. Reaction:
2. Reaction:
3. Reaction:
4. Reaction:
5. Reaction:
6. Reaction:
7. Reaction:
8. Reaction:

Social History:

Smoker? Yes / No / Previous -if current or previous, # packs per day_____ for _____years
Any other nicotine products? Yes / No / Previous Type: _____
Alcohol? Yes / No / Previous -if yes, #_____drinks per day -if previous, date of last drink:_____
Recreational Drugs? Yes / No / Previous -Type of drug, how often:_____
Caffeine? Yes or No #cups/drinks_____ per day
Exercise? Yes or No How many days per week?_____ Type: _____
Occupation: _____ Work Stress level: Low / Moderate / High
Marital Status: Married / Single / Divorced / Partner / Widowed
Sexually Active? Yes / No
Do you have an ADVANCED DIRECTIVE or POWER OF ATTORNEY for medical decisions? Yes / No
-if yes, please list name and phone #_____

Family History *(please list medical problems in all blood relatives as well as <u>age of diagnosis</u> of any major illnesses- cancer, heart attack, stroke, etc.):*

Father (Alive age____ / Deceased at age____):_____
Mother (Alive age____ / Deceased at age____):_____
Siblings: (list as S-sister or B-brother):_____
_____
Maternal Grandmother (Alive age____ / Deceased at age____): _____
Maternal Grandfather: (A age____ / D at age____):_____
Paternal Grandmother: (A age____ / D at age____):_____
Paternal Grandfather: (A age____ / D at age____):_____
Aunt or Uncles: (list as A-aunt or U-uncle):_____
Children: (list S-son or D-Daughter):_____

Immunizations

Do you get a flu shot every year? Y / N / Sometimes Type: Regular / High dose / Flu mist
When was your last tetanus booster? _____ Did it contain Pertussis (Whooping cough)? Y / N / not sure
Have you had a Shingles Vaccine(Zostavax)? Y / N if No, would you like more information on it? Y / N
Have you had a Pneumonia Vaccine? Y / N if yes, at what age? _____ Was it Prevnar 13 or Pneumovax or Not Sure
Please list any other vaccines within the past 10 years: _____

Health Screening *(list <u>most recent</u>)*

EKG: Y / N year_____ Chest X-ray: Y / N year_____ Treadmill Test: Y / N year_____
Eye Exam: Y / N year_____ Colonoscopy: Y / N year_____ Bone Scan (Dexa): Y / N year_____
Dermatology Exam: Y / N year_____
(Women): PAP: Y / N year_____ Mammogram: Y / N year_____
(Men): Prostate Exam/Rectal Exam: Y / N year_____ PSA blood test: Y / N year_____
Do you see any specialists? Y / N if yes, list type and name: _____
_____

Female History

Current Periods? Y / N Date of last period: _____ Age of 1st period: _____ Irregular? Y / N
Frequency: every _____ days Days of flow? _____ days Light / Moderate / Heavy Cramps? Y / N
Number of Pregnancies: _____ total _____ vaginal deliveries _____ c-sections _____ premature
_____ miscarriages _____ stillborn _____ abortions Any pregnancy complications? _____

HEALTH GOALS ASSESSMENT

- What are your present health goals?

- What are your long term health goals?

- What are your weight/nutrition/dietary goals?

- What are your fitness goals?

- Is there anything about your current health, or future health, or medicine in general, which concerns you?

- What are you looking for from us here at Kolvita Direct Primary Care?