

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

PATIENT INFORMATION:							
First Name:			Last Name:			M.I.	Date of Birth:
Street Address:			City:			State	Zip code:
*Check Primary Phone		<input type="checkbox"/> Home Phone		<input type="checkbox"/> Work phone		<input type="checkbox"/> Cell Phone	
Alternate name (if different from above):				Email address:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		SSN:		Preferred Language:		Driver's License #:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Preferred Contact: <input type="checkbox"/> Mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone		Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> African American <input type="checkbox"/> Other: _____			
Referred By:							
Employment Status: <input type="checkbox"/> Unemployed <input type="checkbox"/> Full time <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="radio"/> Full time <input type="radio"/> Part time							
Patient's Employer:				Patient's occupation:			
Spouse's Employment Status: <input type="checkbox"/> Unemployed <input type="checkbox"/> Full time <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="radio"/> Full time <input type="radio"/> Part time							
Spouse's Employer:				Spouse's occupation:			
<b>RESPONSIBLE PARTY: (GUARANTOR)</b>						<input type="checkbox"/> SAME AS PATIENT	
Relationship to patient:							
First Name:			Last Name:			M.I.	Date of Birth:
Street Address:			City:			State	Zip code:
*Check Primary Phone		<input type="checkbox"/> Home Phone		<input type="checkbox"/> Work phone		<input type="checkbox"/> Cell Phone	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		SSN:		Preferred Language:		Driver's License #:	
EMERGENCY CONTACT (FOR MINOR, THIS SECTION MAY BE USED FOR OTHER PARENT)							
1. Name: (first, last)				Relationship to patient:		Date of Birth:	
Street Address:				City:		State	Zip code:
*Check Primary Phone		<input type="checkbox"/> Home Phone		<input type="checkbox"/> Work phone		<input type="checkbox"/> Cell Phone	
2. Name: (first, last)				Relationship to patient:		Date of Birth:	
Street Address:				City:		State	Zip code:
*Check Primary Phone		<input type="checkbox"/> Home Phone		<input type="checkbox"/> Work phone		<input type="checkbox"/> Cell Phone	

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**Insurance information:**

1. Primary Insurance Carrier:	Primary Insurance Carrier Address:	Relationship to Policy Holder: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent
Primary Insurance Phone #	Policy and/or Subscriber ID #	Group #
2. Secondary Insurance Carrier:	Secondary Insurance Carrier Address:	Relationship to Policy Holder: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent
Secondary Insurance Phone #:	Policy and/or Subscriber ID #	Group #
Work or Auto Injury <input type="checkbox"/> yes <input type="checkbox"/> no	Do you have an attorney <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, list attorney and/or W/C adjustor's name and phone #

**ADVANCED DIRECTIVES**

☐ None   
 ☐ Do Not Resuscitate   
 ☐ Durable Power of Attorney   
 ☐ Living Will   
 ☐ HC Proxy  
 Date Reviewed: \_\_\_\_\_

**Medical History – check all that apply, include year onset**

Condition	Year	Condition	Year
<input type="checkbox"/> None		<input type="checkbox"/> Gallbladder Disease	
<input type="checkbox"/> Allergies. Type: _____		<input type="checkbox"/> GERD (reflux)	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Hepatitis C	
<input type="checkbox"/> Angina (Chest Pain)		<input type="checkbox"/> Hyperlipidemia (High Cholesterol)	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Hypertension (High Blood Pressure)	
<input type="checkbox"/> Arthritis (Rheumatoid or Osteoarthritis)		<input type="checkbox"/> Irritable Bowel Syndrome	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Atrial Fibrillation		<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Myocardial Infarction (Heart Attack)	
<input type="checkbox"/> Cancer – Type: _____		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Cerebrovascular Accident (Stroke)		<input type="checkbox"/> Peptic Ulcer Disease	
<input type="checkbox"/> Coronary Artery Disease		<input type="checkbox"/> Prostate Enlarged (BPH)	
<input type="checkbox"/> COPD (Emphysema)		<input type="checkbox"/> Renal / Kidney Disease	
<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Seizure Disorder	
<input type="checkbox"/> Depression		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Other: _____	

**Health Maintenance – Check all that apply, include date of most recent exam**

Exam	Date	Exam	Date
<input type="checkbox"/> None		<input type="checkbox"/> Foot Exam	
<input type="checkbox"/> Breast Exam		<input type="checkbox"/> GYN Exam	
<input type="checkbox"/> Cardiac Stress Test		<input type="checkbox"/> Influenza vaccine	
<input type="checkbox"/> Colonoscopy / Sigmoidoscopy		<input type="checkbox"/> Lipid Panel	
<input type="checkbox"/> DEXA/Bone Scan		<input type="checkbox"/> Mammogram	
<input type="checkbox"/> Echocardiogram		<input type="checkbox"/> PAP test	
<input type="checkbox"/> EKG		<input type="checkbox"/> Physical Exam	
<input type="checkbox"/> Eye Exam		<input type="checkbox"/> Pneumococcal Vaccine	
<input type="checkbox"/> FOBT (stool card for hidden blood)		<input type="checkbox"/> Tetanus Vaccine	

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**Surgical History** – Check all that apply, include year performed

Surgical Procedure	Year	Surgical Procedure	Year
<input type="checkbox"/> None		<b>Male Only</b>	
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Prostate Biopsy	
<input type="checkbox"/> Angioplasty w/ Stent		<input type="checkbox"/> TURP	
<input type="checkbox"/> Appendectomy		(Trans-urethral resection of prostate)	
<input type="checkbox"/> Arthroscopy Knee		<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> CABG (heart bypass)			
<input type="checkbox"/> Carpal Tunnel Release		<b>Female Only</b>	Year
<input type="checkbox"/> Cataract Extraction		<input type="checkbox"/> Augmentation Mammoplasty	
<input type="checkbox"/> Cholecystectomy (gallbladder)		<input type="checkbox"/> Bilateral Tubal Ligation	
<input type="checkbox"/> Colectomy		<input type="checkbox"/> Breast Biopsy	
<input type="checkbox"/> Colostomy		<input type="checkbox"/> Cesarean Section	
<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> D and C (dilatation & Curettage)	
<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Hip Replacement		<input type="checkbox"/> Mastectomy	
<input type="checkbox"/> Knee Replacement		<input type="checkbox"/> Myomectomy	
<input type="checkbox"/> LASIK eye surgery		<input type="checkbox"/> Reduction Mammoplasty	
<input type="checkbox"/> Liver Biopsy		<input type="checkbox"/> TAH/BSO	
<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Vaginal Hysterectomy	
<input type="checkbox"/> Small Bowel Resection		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Thyroidectomy			
<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Other surgery: _____	

**Female only:**

Past pregnancies: Total number of pregnancies: \_\_\_\_\_ Number of Births: \_\_\_\_\_ Number of Miscarriages: \_\_\_\_\_

Number of abortions: \_\_\_\_\_ Number of children alive: \_\_\_\_\_

 Date of last menstrual period: \_\_\_\_\_ # of days between cycles: \_\_\_\_\_ ☐ Regular ☐ Irregular

☐ Light ☐ Normal ☐ Heavy

 What kind of birth control do you use? ☐ none ☐ yes, what type: \_\_\_\_\_

**MEDICATIONS** – List all medications you take, prescription and non-prescription, the dosage and frequency

☐ I do not take any medications

Medication Name	Medication Name

**Medication and Food Allergies** – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies


**Family History** – check if any family member(s) has had any of the following conditions

<input type="checkbox"/> No Known Family Medical Conditions		<input type="checkbox"/> Adopted			
Diagnosis	Father	Mother	Brother	Sister	Other: List Family Member
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAD (Heart Disease / Heart Attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer – Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA (stroke)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperlipidemia (High Cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal / Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Social History For Adult Patient**

Do you have Children? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many?	Female(s)	Male(s)
Tobacco Use <input type="checkbox"/> No	<b>For Current Smokers:</b> How many per day? ____ How many years? ____ <b>For Ex-Smoker:</b> How many per day? ____ How many years? ____ <input type="checkbox"/> Former/Year Quit:		<input type="checkbox"/> Cigarette <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Chewing <input type="checkbox"/> Smokeless	
Alcohol Use <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less # of drinks per day? ____ Per week? ____ <input type="checkbox"/> Former/Year Quit:		<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor <input type="checkbox"/> Other: _____	
Illicit Drug Use <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less Last time usage: _____		<input type="checkbox"/> Marijuana <input type="checkbox"/> Crystal Meth <input type="checkbox"/> Speed <input type="checkbox"/> Other: _____	
Caffeine Use <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less <input type="checkbox"/> Former/Year Quit:		<input type="checkbox"/> Chocolate <input type="checkbox"/> Coffee <input type="checkbox"/> Tablets <input type="checkbox"/> Soda <input type="checkbox"/> Tea <input type="checkbox"/> Other: _____	
Exercise Activity	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Vigorous Days/Week: _____ Type of Exercise: _____		Sleep patterns: <input type="checkbox"/> changes <input type="checkbox"/> no changes	

**Social History For Pediatric Patient**

Patient lives with:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Both Parents	<input type="checkbox"/> Other:
Mother's Occupation:		Father's Occupation:		
Parents Relationship: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Childcare: <input type="checkbox"/> Mother <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Father <input type="checkbox"/> Nanny <input type="checkbox"/> Daycare		
Tobacco Exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No Smokers at home: <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient is current smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No		



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## **Payment Policy**

### **CONSENT TO CARE:**

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Stewart Medical Group in regard to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I also hereby authorize Stewart Medical Group to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

\_\_\_\_\_  
Initial

### **PATIENT RESPONSIBILITY:**

- You are responsible for all charges resulting from treatment provided by Stewart Medical Group. We bill most insurance carriers; however, primary responsibility for the account is yours. Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made.
- **Your co-payment is always due at the time of service.** You are responsible for knowing what the amount of your co-pay is, and for assuring that it is collected at each visit. The fee will be assessed for any co-pay that your insurance assesses you that was not paid at the time of service.
- If we find it necessary to send your account to collections, you will be required to make a payment at the time of each of your next visits with us or you may be released as a payment.
- Minor: Patients under 18 years of age will be the responsibility of the custodial parent(s)

\_\_\_\_\_  
Initial

### **INSURANCE BILLING:**

- Please bring your current medical card with you to each appointment as we require a copy of your insurance card to be on file with our office. This is to ensure accuracy.
- It is your responsibility to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information immediately so that we may insure all of your charges are billed to the correct insurance company. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges in full.

\_\_\_\_\_  
Initial

### **NOTIFICATION OF RELEASE FOR PAYMENT:**

I understand that Stewart Medical Group will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions.

I hereby instruct and direct that \_\_\_\_\_ Insurance Company pay by check made out to STEWART MEDICAL GROUP, 1024 S. Garfield Ave. Alhambra, CA 91801-4762, or if my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it to STEWART MEDICAL GROUP at the address above, for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS and BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment.

\_\_\_\_\_  
Initial



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**RETURNED CHECKS:**

It is our office policy to charge a \$25.00 fee for checks that are returned regardless of the reason.

\_\_\_\_\_  
Initial

**AUTHORIZATION TO RELEASE INFORMATION:**

- In obtaining payment for services, I authorize Stewart Medical Group to furnish information from my medical record to any company that may be responsible for payment of all or part of my charges
- If I have been referred by, or am being referred to another healthcare provider, I authorize Stewart Medical Group release my medical information to this provider for continuing care.
- I also assign Stewart Medical Group all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not.

\_\_\_\_\_  
Initial

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE STATEMENTS ABOVE. I HAVE RECEIVED A COPY OF THIS INFORMATION.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

**IF PATIENT IS UNDER THE AGE OF 18 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING:**

Patient is \_\_\_\_\_ year(s) of age is unable to sign because: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**Sign Below if Disclosure of Information is NOT Authorized:**

Therefore, I agree to pay for costs of all treatment and services personally.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

**HIPAA and NOTICE of PRIVACY PRACTICES**

I, \_\_\_\_\_, acknowledge that I have received a copy of Stewart Medical Group Notice of Privacy Practices. This Notice describes how Stewart Medical Group may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient