15644 POMERADO RD, SUITE 100
POWAY, CA. 92064
PHONE (858) 485-5111
FAX (858) 485-6747

Patient Name____
Last First Middle

Social Security #:______________________ Date of Birth:____________________

Preferred Language(s) ___________Interpreter needed:☐Yes ☐No Race/Ethnicity__________

Smoker: ☐Yes ☐No Frequency_______ Duration________ Start date_______End date_______

Address____

____
City State Zip code

Home Phone # ______________________ Work Phone # ____________________

Cell Phone #______________________ E-mail:______________________

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Other____________________

Employed: ☐Yes ☐No Employer:______________________________

Student: ☐ Full time ☐ Part time ☐ Non-Student School: ____________________

Allergies? ☐Yes ☐No If Yes, what?______________________________

In case of emergency, contact: ______________ Phone # _______________ ☐ refused

INSURANCE INFORMATION (Fill out if you do not provide us with a copy of your card)

Primary Insurance: ______________________________________

Name of Insured: ______________________ Insured's DOB: ________________

Secondary Insurance:______________________________________

Name of Insured: ______________________ Insured's DOB: ________________

ASSIGNMENT: I hereby assign to FiCareMed P.C. all payments for medical services, including payments or major medical benefits that are due to me. If the insurances do not pay, payment of services will be my own responsibility. I also agree to pay the $40 penalty for any missed appointments that are not canceled within 24 hours from the appointed time.
X______________________________________

PERMISSION: I hereby give permission to FiCareMed P.C. to examine and render medical treatment or shots to my Son, Daughter, or MYSELF. X______________________________

AUTHORIZATION: I hereby authorize to provide information to the appropriate insurance company or doctor concerning my present illness or accident. X______________________________

HISTORY

NAME: **Date of birth:** **Date:**

FAMILY HISTORY IF ANY BLOOD RELATIVE SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER AND INDICATE WHICH RELATIVE

1) ALCHOLOISM	6) CANCER	11) HEART DISEASE	16) OSTEOPEROSIS
2) ANEMIA	7) DIABETES	12) HYPERTENSION	17) STROKE
3) ASTHMA	8) EPILEPSY	13) KIDNEY DISEASE	18) THYROID
4) ARTHRITIS	9) GLAUCOMA	14) MENTAL ILLNESS	19)
5) BLEEDS EASILY	10) HAYFEVER	15) MIGRAINE	20)

HOSPITAL ADMISSIONS (NOT INCLUDING PREGNANCIES)

HOSPITAL	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING INCLUDING OVER THE COUNTER

1) ____________ 2) ____________ 3) ____________ 4) ____________

5) ____________ 6) ____________ 7) ____________ 8) ____________

9) ____________ 10) ____________ 11) ____________ 12) ____________

VACCINES (DATE OF LAST)

TETANUS/ DIPHTHERIA	INFLUENZA	PNEUMOCOCCAL	HEPATITIS

TEST / EXAM (DATE OF LAST)

CHOLESTEROL -	DENTAL -	EYE -	HEARING –
RECTAL/STOOL -	SIGMOIDOSCOPY -	TB SKIN TEST -	PHYSICAL –

PERSONAL/SOCIAL Check (√) and indicate age when you had any of the following symptoms or diseases. Mark (X) for current problems.

__Decreased hearing	__Ringing in ear	__Ear infections (frequent)	__Dizzy spells	__Failing vision
__Eye pain	__ Double/blurred vision	__Eye infections (frequent)	__Nose bleeds (frequent)	__Sinus trouble
__Sore throats (frequent)	__Hayfever/Allergies	__Hoarseness (prolonged)	__Pneumonia/pleurisy	__Bronchitis (frequent)
__Asthma/wheezing	__Shortness of breath	__Chest pain	__High blood pressure	__Heart murmur
__Irregular pulse	__Palpitations	__Swollen Ankles	__Fainting spells	__Leg pain – walking
__Varicose veins/phlebitis	__Loss of appetite (frequent)	__Difficulty swallowing	__Indigestion/Heartburn	__Peptic ulcers
__Abdominal pain (chronic)	__Gall bladder trouble	__Jaundice/Hepatitis	__Change in bowel habits	__Diarrhea (frequent)
__Constipation (frequent)	__Diverticulitis	__Crohn's disease/colitis	__Bloody/Tarry stools	__Hemorrhoids
__Hernia	__UTI (frequent)	__Blood in urine	__Urinary/Stool incontinence	__Kidney stones
__Venereal Disease	__Urethral Discharge	__Chronic fatigue	__Weight loss (recent)	__Anemia
__Bruise easily	__Cancer	__Diabetes	__Thyroid Disease	__Convulsions/Seizures
__Stroke	__Tremor/hands shaking	__Muscle weakness	__Numbness/Tingling sensations	__Headaches (frequent)
__Arthritis/Rheumatism	__Back pain (frequent)	__Bone fracture/Joint injury	__Gout	__Osteoporosis
__Foot pain	__Cold/Numb feet	__Rashes	__Hives	__Psoriasis
__Eczema	__Insomnia	__Nervousness	__Depression	__Memory loss
__Moodiness (excessive)	__Phobias	__Mental illness	__Chicken pox	__Polio
__Mumps	__Measles	__German Measles	__Rheumatic Fever	__Scarlet Fever
__Tuberculosis	__Herpes	__Exposure hazardous fluids	__Alcohol ___oz per week	__Smoking ___cigs/day
__Coffee/tea ___cups/day	__Advanced Directives			

Males – Please complete
Date of last prostate exam ____________ □ normal □ abnormal Date of last PSA ____________

Females – Please complete
Menstrual flow □ Regular □ Irregular □ Pain/Cramps Days of flow ____________ Length of cycle ____________ Date of last period ____________

Number of: Pregnancies ________ Abortions ________ Miscarriages ________ Live Births ________

Birth control method ____________________ Birth control pill name ____________________

Date of last pelvic exam ________________ Date of last pap smear ________________ □ normal □ abnormal

Date of last breast exam ________________ Date of last mammogram ________________ □ normal □ abnormal

Office use only: Advance directive □ Yes □ No Advance Directive education □
Staying Healthy Assessment □ Date ________________

Tuberculosis Evaluation Questionnaire
Cuestionario Evaluatorlo Sobre Tuberculosis

*You (your child) may be at increased risk for TB ifyou answer YES to any of the following questions.
*Sus hijos pueden tener un riesgo muy alto de poder contraer "TB" si contesta en informa affirmative a cualquiera de las siguientas preguntas.

Name: ______________________________
Age: __________________ DOB: ____________________ DOS: _______________

1. Have you (has your child) ever had a positive tuberculosis (TB) skin test? If so, what date?
¿Acaso ested (o su hijo/a) recibido a un resultado positive del examen de tuberculosis?
YES/SI ☐ Date/Fecha: __________________ NO ☐
2. Do you have a family member or close contact with a history of confirmed or suspected TB?
¿Existe algun contacto cercano o algun mimbro de la familia que haya sido declarado enfermo de TB o que se sospeche tener esta enferedad?
YES/SI ☐ NO ☐
3. Were you (was your child) born in or travel to high TB prevalence countries? (Africa, Asia, or Latin America)
¿Nàcio ested (o su hijo/a) fuera de los Estados Unidos o visita lugares donde hay tuberculosis? (Africa, Asia, o Latino America)
YES/SI ☐ NO ☐
4. Do you have any family members or frequent visitors who are from Africa. Asia, or Latin America?
¿Tiene usted familiars provenientes deAfrica, Asia, o Latino America Viviendo en su hogar?
YES/SI ☐ NO ☐
5. Do von (does your child) have a history of confirmed or suspected HIV infection or other problems with their immune system?
¿Acaso ested (su hjjo/a) haya sido diagnosticado(a) con algun tipo de infeccion como el sida o con problemas con su sistema immuno?
YES/SI ☐ NO ☐
6. Do you (does your child) live with any individual who is HIV positive?
¿Acaso ested (o Sn hijo/a) haya sido declarado positive con el examen del sida?
YES/SI ☐ NO ☐
7. Do you (does your child) live in an "out of home" placement facility?
¿Acuso ested (su hjjo/a) se encuentra viviendo temporalmente en un hogar o local sostenido por el gobierno o asistenoia social?
YES/SI ☐ NO ☐
8. Have you been, or do you (does your child) live with any individual who has been incarcerated in the last 5 years?
¿Acaso ested (o su hijo/a) vive con adultos que hayan estado presos or cualquier motivo en los ultimos 5 anos?
YES/SI ☐ NO ☐
9. Do you (does your child) live among, or are you (is he/she) frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or residents in a nursing home?
¿Acaso ested (o su hijo/a) vive o se asocial frecuentemente can personas qua viven an las calles, que sean trabajadores temporales del campo, utilicen drogas ilicitas inyectables o qua residan en asilos o en hospitals de convalescencia?
YES/SI ☐ NO ☐
10. Do you (does your child) consume alcoholic beverages?
Usted (su hijo/a) consume alchol?
YES / SI ☐ how much / cuanto _________________ NO ☐

* A person who is at increased risk for TB should have a yearly TB test.,
(All children are tested routinely for TB at 4-5 years, 13-16 years, regardless of risk)
*cualquir persona que tiene un alto riesgo de contraer TB debe hacerse el examen de la tuberculosis cada ano. (se les examina a los 4 y 5 anosy do los 13 a 16 anos)

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

#	Question				*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	

#	Question				Section
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	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **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:

Ways We May Use and Disclose Your protected Health Information

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all the ways we are permitted to use and disclose your health information fall within one of these categories.

TREATMENT We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician who we have requested to be involved in your care. For example- we would disclose your health information to a specialist.

PAYMENT We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example- we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

HEALTH CARE OPERATIONER We will use and disclose your protected health information to support the business activities of our practice. For example- we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third-party business associates who perform consulting, or transcription services for our practice.

OTHER WAYS WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

APPOINTMENT REMINDER: We will use and disclose your protected health information to contact you as a reminder about your scheduled appointment or treatment.

TREATMENT ALTERNATIVES: We will use and disclose your protected health information to tell you about or recommend possible alternative treatment or options that may be of interest to you.

OTHERS INVOLVED IN YOUR CARE: We will use and disclose your protected health information to a family member, relative, close friend, or any other person you identify that is involved in your medical care or payment for care.

RESEARCH: We will use and disclose your protected health information to researchers provided the research has been approved by an international review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

AS REQUIRED BY LAW: We will use and disclose your protected health information when required by federal, state, or local law. You will be notified of any such disclosures.

TO ALERT A SERIOUS THREAT TO PUBLIC HEALTH OR SAFETY: We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

WORKER'S COMPENSATION: We will use and disclose your protected health information foe worker's compensation or similar programs that provide benefits for work-related injuries or illness.

INMATE: We will use and disclose your protected health information to a corrections institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement officials. This information would be necessary to the institution to provide you with health care and protect the health and safety of others or for the safety and security of the correctional institution.

YOU HEALTH INFORMATION RIGHTS

Although your health records is the physical property of the health care practitioner or facility that complied it, the information belongs to you. **You have the right to:**

A PAPER COPY OF THIS NOTICE: You have to right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

INSPECT AND COPY: You have the right to inspect and copy the protected health information that we maintain about you in our designated records for as long as we posses that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we receive about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request at our office with the receptionist. We have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed 60 days to respond but must inform you of this delay.

15644 POMERADO RD, SUITE 100
POWAY, CA. 92064
PHONE (858) 485-5111
FAX (858) 485-6747

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

Signed: ______________________________ Date: __________________________

Printed Name: ______________________________ Telephone: ____________________

If not signed by the patient, please indicate relationship:

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient

Name of Patient: ______________________________________

THERE IS NO CHARGE WHEN RECORDS ARE SENT TO A PHYSICIAN FOR CONTINUING CARE. A COPYING FEE IS CHAREGED WHEN RECORDS ARE RELEASED TO A PATIENT OR OTHER NON-PHYSICIAN RECIPIENT

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION
(Please fill out completely: incomplete forms mar delay processing)

1. **Explanation**
This authorization to receive or release medical information is being requested of you to comply with the terms of the "Confidentially of Medical Information Act of 1981. Section 56, et. Seq. of the California Civil Code."

2. **Authorization**
I hereby authorize – (Name of Healthcare Provider) ______________________________

____
(address, phone and fax number of physician, hospital, healthcare provider, or other)

To furnish to: **FICARE MED Family Practice Dr.** Marcelo Rivera, **15644 Pomerado Rd. Suite. 100 , Poway, CA 92064 Phone (858)485-5111, Fax (858)485-6747**, records and information pertaining to medical history, mental or physical condition, services rendered, or treatment for:

______________ ______________ ______________
(Name of patient) (Social Security Number) (Date of Birth)

********** **OR** **********

I hereby authorize **Dr.** Marcelo Rivera to release records pertaining to medical history, mental or physical condition, services rendered, or treatment on the above named patient to: ______________________________

____
(address, phone and fax number of physician, hospital, healthcare provider, or other)

3. **I understand** that I have the right to limit the type of information to be released. I have indicated below the information which is authorized for release:
   - ☐ **All medical information, without exception**, including information regarding AIDS and AIDS testing, psychological or psychiatric treatment and drug or alcohol abuse. This includes doctor's notes, labs, x-ray, and all other diagnostic tests.
   - ☐ **All the medical information except the following:** ______________________________
   - ☐ **Only the following information:** ______________________________

4. **Uses**
This information supplied is to be used for the following purpose(s): ______________________________

5. **Duration**
This authorization shall become effective immediately and shall remain in effect until ______________(date).

6. **Restrictions**
I understand that the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

7. **Additional Copy**
I understand that I have a right to receive a copy of this authorization. Copy requested and provided: ☐ yes ☐ no

8. **I hereby release** all parties from any/all legal liability that may arise from the release of this information to the party named above (who reserves the right to charge for copies of medical records.)

______________________________ Date: ______________
(Signature)

______________________________ Witness: ______________
(Print Name)

*if signed by other than patient, indicate relationship: ______________
*Authorized representative must submit copies of legal document supporting assignment of this authority.