REGISTRATION

(PLEASE PRINT)

CROWN SURGERY MEDICAL GROUP

2071 Compton Ave. Suite 105
Corona, CA 92881

Telephone: (951) 736-0696
Fax: (951) 735-4779

Date_____ Home Phone (____)_____ Cell Phone (____)_____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for_____years ☐ Minor

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone (____)_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone (____)_____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (If different from patient's)_____ Phone (____)_____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone (____)_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Birthdate_____ Relation to Patient_____

Address (If different from patient's)_____ Phone (____)_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone (____)_____

Insurance Company_____ Soc. Sec. #_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to
Name of Insurance Company(ies)

Crown Surgery Medical Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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COMMUNICATION CONSENT AGREEMENT

This form allows our physicians and office staff permission to speak with your family members or other individuals noted below.

I,_____understand that under Federal Law (HIPAA) this medical office may not release any medical information to any individual without my expressed written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore give permission to Crown Surgery Medical Group to release medical information on my behalf to the following individual(s).

(1) Name:_____Relationship:_____

Phone Number:_____Date of Birth:_____

(2) Name:_____Relationship:_____

Phone Number:_____Date of Birth:_____

(3) Name:_____Relationship:_____

Phone Number:_____Date of Birth:_____

(4) Name:_____Relationship:_____

Phone Number:_____Date of Birth:_____

(5) Name:_____Relationship:_____

Phone Number:_____Date of Birth:_____

PATIENT NAME:_____DATE OF BIRTH_____

PATIENT SIGNATURE:_____DATE:_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Crown Surgery Medical Group** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **Crown Surgery Medical Group** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Crown Surgery Medical Group** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the **Privacy Officer, 2071 Compton Avenue Ste 105, Corona, CA 92881.**

With this consent, **Crown Surgery Medical Group** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Crown Surgery Medical Group** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Crown Surgery Medical Group** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Crown Surgery Medical Group** to restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Crown Surgery Medical Group** to use and disclose my PHI to carry out TPO.

I may revoke my revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Crown Surgery Medical Group** may decline to provide treatment to me.

Signature of Patient or Guardian **Date**

Please print name of Patient or Guardian **Relationship to Patient**

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VASCULAR PATIENT HEALTH HISTORY FORM
(Page 1)

DATE:

Name:_____ **Date of Birth:**_____ **Age:**_____ **Sex:**_____

Present Weight:_____ **LBS** **Height:**_____

Medical Reason for Visit:_____

Allergies/Sensitivities to Medication:_____

_____

Patients Medical History: (Please Circle Y or N)

Y / N High Blood Pressure	Y / N Asthma	Y / N Renal Insufficiency	Y / N Allergy to Contrast
Y / N Elevated Cholesterol	Y / N COPD	Y / N Phlebitis	Y / N HIV
Y / N Heart Murmur	Y / N Tuberculosis	Y / N Hepatitis	Y / N Kidney Disease
Y / N Diabetes Mellitis Insulin Type/Amount:	Y / N Phlebitis (Blood Clot in Leg)	Y / N Cancer If yes, what type:	Y / N Myocardial Infarction When:
Y / N TIA	Y / N Mini Stroke	Y / N Stroke	Y / N Short of Breath
Y / N Rheumatic Fever	Y / N Chest Pain	Y / N CHF	Y / N Arrhythmias
Y / N Back Injury	Y / N Back Injections	Other:	
Y / N Antiplatelet Rx	Y / N Anticoagulation RX		

List any illnesses you have been hospitalized for, NOT requiring surgery:_____

_____

Surgical History: Please list the month and year of surgery or N/A if not applicable.

Carotid:_____ **Cardiac:**_____ **Leg Bypass:**_____

Stent Angioplasty:_____ **Back Surgery:**_____

Other Surgeries:_____

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VASCULAR PATIENT HEALTH HISTORY FORM
(Page 2)

Family History of: Please indicate relationship, if not applicable please indicate N/A

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
Abdominal Aortic Aneurysm		Renal Insufficiency	
High Blood Pressure		Heart Disease	
Stroke		Kidney Disease	
Bleeding Tendencies		Other:	

Medications:

Prescription : _____

Non-Prescription: _____

Do you take Blood Thinners? _____

Review of Systems: Please circle all that apply to you currently

Y / N	Abdominal Pain	Y / N	Back Pain	Y / N	Claudication
Y / N	Leg Rest Pain	Y / N	Leg Ulcers	Y / N	Edema (Swelling)

Social History:

Do you use Tobacco? _____ **In the Past?** _____ **If yes, when did you quit?** _____

Do you use Alcohol? _____ **How Often?** _____

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WELCOME TO OUR OFFICE

Dear ,

The staff of Crown Surgery Medical Group is committed to providing you with the best possible care. To achieve our objective easily we need your support and cooperation. You, the patient, share a responsibility in reaching this goal. It is your responsibility to know and confirm your benefits prior to coming to our office. Please note the following requirements to minimize delays during your office visit.

- Bring your insurance card and driver's license (or another form of ID)
- Pay your co-payments and deductibles at the time of service
- Keep your appointments and give us 24 hours cancellation notice when you cannot make your appointment. You will be charged your co-payment or $25 for any missed appointments not cancelled more than 24 hours of the scheduled appointment. If you are more than 15 minutes late for your appointment, your appointment will be rescheduled to the next available date.
- Notify us of any changes in your address, telephone numbers, or insurance carriers.
- Most importantly, abide by the follow-up care instructions of the surgeons and professional medical staff.

PAYMENT POLICY

Payment of co-payments, deductibles, and initial consultation fees are collected at the time service is rendered. We accept cash, cashier's checks, money orders, or debit cards. There is a $1.00 surcharge for all debit card payments. If you come unprepared and unable to pay your co-payment or consultation fees, your appointment will be rescheduled.

MINORS

If your minor child is the patient, a parent or legal guardian must accompany them. Minors coming in without the responsible adult will have their appointment rescheduled to a time when the responsible adult can accompany them. It us unlawful for us to treat a minor (under 18 years of age) without the consent of a parent or legal guardian.

DISABILITY FORMS

Please be sure to read the instructions on the form and fill out your section completely. Incomplete forms will be returned to you. The completion of the state disability is free; however there is a $10 fee for the completion of private disability forms. The fee and postage must be paid when the form is brought to our office for completion. Please allow 48 hours for all forms to be completed.

INITIAL _____

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MEDICAL RECORDS REQUESTS

We required 48-hour notice to process your request for any release of medical records. Medical record requests must be in writing with a signed medical release by the patient. There is a $0.25 charge per page for copies of medical records.

PRESCRIPTION REFILLS

If you are taking medications prescribed by our physician and you need a refill, please call your pharmacy first and ask them to fax a refill request to (951) 735-4779. We ask that you to allow 48 hours for processing your request. Make sure you call in your refill while you still have a few days of medication remaining to get you through the 48-hour period

NOTICE OF PRIVACY PRACTICES

You will be provided an opportunity to review the Notice of Privacy Practices. A copy of the current notice will be posted in the reception area and you are able to request a copy at any time.

If you have any questions regarding our policies, please do not hesitate to ask. By signing below, I have read and understand the office policies stated above and agree to accept the described responsibilities.

x _____ _____

Patient's Signature Date

x _____ _____

Parent or Guardian Signature Date