LA MESA FAMILY MEDICAL GROUP

Borrego HEALTH

Office use

NOTE: **FOR OFFICE USE ONLY** **PLEASE "PRINT"** **USE BLACK INK ONLY**

Forms Completed With the Assistance of an Interpreter ❑ Yes ❑ No
Interpreter Name/Agency/Health Plan:

PATIENT INFORMATION: USE BLACK INK ONLY

Full Legal Name:

Preferred Name: ❑N/A

Preferred Pronoun: ❑ He ❑ She ❑Other _____

Date of Birth:

Social Security #: Refused ❑

❑ **Hearing** Impaired
❑ **Vision** Impaired

Sex at Birth: ❑ M ❑ F

Gender: ❑Male ❑Female ❑Female-to-Male/Transgender Male ❑Male-to-Female/Transgender Female ❑ Genderqueer, Neither Exclusively male or female ❑ Other, Please Specify:

Sexual Orientation: ❑ Straight or Heterosexual ❑ Lesbian, Gay or Homosexual ❑ Bisexual ❑ Refused to Report ❑ Unknown ❑ Other, Please Specify:_____

Street Address/City/State/Zip

PO Box or Alternate Address N/A ❑

Home Phone Number:

Cell Phone Number:

Work Phone Number:

Email: _____
Would you like to use Patient Portal? ❑Yes ❑No (18+ Only)

ADDITIONAL PATIENT DATA

Patients Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Life Partner ❑Legally Separated

Patients Student Status: ❑Full-Time ❑Part-Time ❑Not in School

Patients Employment Status: ❑ Disabled ❑Full-Time ❑Part-Time ❑ Retired ❑ Student ❑Unemployed ❑None

Spouse Employment Status: ❑ Disabled ❑Full-Time ❑Part-Time ❑ Retired ❑ Student ❑Unemployed ❑None / Not Applicable

Patient Race: ❑American Indian/Alaskan Native ❑Asian ❑Black/African American ❑Native Hawaiian ❑Other Pacific Islander ❑White ❑ Middle Eastern ❑Unreported/Refused to Report

Patients Ethnicity: ❑ Another Hispanic, Latino/a or Spanish Origin:_____
❑ Hispanic/Latino ❑ Cuban ❑ Mexican, Mexican American, Chicano/a, ❑ Puerto Rican
❑ Not Hispanic/Latino ❑ Unreported/Refused to Report

Patients Primary Language:
❑English ❑Spanish ❑Arabic ❑Other_____ **Interpreter Needed? ❑Yes ❑No**

Patients Housing Status: ❑Doubling Up ❑Homeless Shelter ❑Public Housing ❑Street ❑Transitional ❑Stable / Not Homeless – *rent, own, buying…*

Are you a Veteran? ❑ Yes ❑ No Spouse of a Veteran? ❑ Yes ❑ No Dependent of a Veteran? ❑ Yes ❑No

Patients Place of Birth: Refused ❑
City: State:
Country:

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Primary Pharmacy:

Secondary Pharmacy: ❑ N/A

HOW DID YOU HEAR ABOUT US?

❑La Mesa Peds ❑ Insurance ❑ Hospital/ER ❑ Family/Friend ❑ Internet search ❑ Other doctor _____

❑Advertisement/Marketing (specify) _____ ❑ Other _____

EMERGENCY CONTACTS/COMMUNICATION

First/Last Name: Relationship:

Home Phone Number:	Cell Phone Number:	Work Number:

Type of Contact: ❑Emergency ❑Primary Contact ❑Legal Guardian/Health Care Proxy ❑ Patient Resides with Contact ❑Primary Caregiver

INSURANCE INFORMATION

Primary Insurance:

Carrier:_____ ❑ HMO ❑ PPO Group #:_____

Policy number:_____ Holder SSN:_____

Patients relationship to insurance holder: ❑ Self ❑Child ❑Spouse ❑Other:_____

Full Name:_____ D.O.B:_____

Secondary Insurance:

Carrier:_____ ❑ HMO ❑ PPO Group #:_____

Policy number:_____ Holder SSN:_____

Patients relationship to insurance holder: ❑ Self ❑Child ❑Spouse ❑Other:_____

Full Name:_____ D.O.B:_____

RESPONSIBLE PARTY/GUARANTOR

Relationship: ❑ Self ❑ Spouse ❑ Parent ❑ Other/Step Parent/Foster Parent_____

Full Legal Name:

Date of Birth:	Social Security #: Refused ☐	Sex: ❑ M ❑ F

Street Address/City/State/Zip ☐ Same as above

Home Phone Number: ❑ Same as above	Cell Phone Number: ❑ Same as above	Work Phone Number:

MEDICAL POWER OF ATTORNEY / LEGAL REPRESENTATIVE (IF APPLICABLE)

Relationship: ❑ Mother ❑ Father ❑ Other _____

Full Legal Name:

Home Phone Number:	Cell Phone Number:	Work Number:

Address:

SIGNATURE

I certify that the information on this form is complete and correct:

_____ _____

Patient/Legal Representative Signature **Date**

LA MESA FAMILY MEDICAL GROUP

Borrego HEALTH

GENERAL CONSENT FOR MEDICAL TREATMENT

CONSENT FOR TREATMENT: The undersigned patient, responsible relative and/or patient's legal representative hereby voluntarily consents and authorizes such care and treatments, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications by employees and authorized agents of Borrego Health including all affiliated physicians, dentists, nurse practitioners and physician assistants, nursing staff and other ancillary providers, as may be considered necessary or advisable in their professional judgment. I, the undersigned, am aware that the practice of medicine is not an exact science and further acknowledge that no guarantees have been made regarding the effect such treatments may have on any medical condition.

RIGHT TO REFUSE TREATMENT: The undersigned responsible party further understands that he/she has the right to make informed decisions regarding all care and treatments, and that he/she may ask the health care professional to explain anything that is not understood. This right includes the right to refuse any treatments.

TEACHING PROGRAMS: Borrego Health participates/contracts with training institutions for teaching medical students, interns, residents, healing arts students (i.e.: nursing, hygienists, x-ray technicians, dental assistants) and post-graduate students. I understand that these trainees may participate in the care provided under the supervision of qualified and licensed personnel.

RELEASE OF INFORMATION: I hereby authorize Borrego Health employees and affiliates to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payers including employers, health service plans or worker's compensation carriers.

_____I, the undersigned, acknowledge having received the **Notice of Privacy Practices** which outlines which health information may be used or disclosed.

_____I, the undersigned, consent to such disclosures as delineated in the Notice and understand that this may include information related to HIV/AIDS, behavioral health services and treatment for alcohol and/or drug abuse.

ASSIGNMENT OF HEALTH BENEFITS: I, the undersigned, hereby authorize and instruct the insurance carrier to make payment directly to Borrego Community Health Foundation for any medical, dental or vision benefits otherwise payable to me or my guarantor as payment toward the total charges for professional services rendered. I understand that insurance co-payments, co-insurance and non-covered services are my or my guarantor's financial responsibility.

FINANCIAL AGREEMENT: I, the undersigned, agree to pay, whether signing as a patient or representative of the patient, the charges incurred at Borrego Health in keeping with the established fee schedule. I understand that if I am a member of a Health Maintenance Organization (HMO) and have not secured authorization for payment of services, I will be held financially responsible for all non-covered services. I also understand that I am responsible for any balance owed and that a cash deposit will be required for patients not otherwise approved for the sliding fee discount program or other public benefits.

ADVANCE DIRECTIVES: Adults 18 and older have the right (a) to give direction about their future medical care or (b) to designate a patient representative to make medical decisions for them if they lose individual decision-making capacity. I, the undersigned, understand that information about advance directives is available to me upon request.
I have executed an Advance Directive YES___NO___**(If yes please provide us with a copy)**
I would like further information. YES___NO___

Patient Name:_____ Legal Representative Name: _____

Patient/Legal Representative Signature:_____Date:_____

LA MESA FAMILY MEDICAL GROUP

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NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Borrego Health. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website, contacting the Privacy Office, or at the Clinic.

If you have any questions about our "Notice of Privacy Practices," please contact the Privacy Office at (619) 398-2405.

I acknowledge receipt of the "Notice of Privacy Practices" of Borrego Health.

Patient Name:_____ Date of Birth:_____ Medical Record #: _____

Signature: _____ Date Signed: _____

If signed by someone other than patient, indicate relationship: _____

Name of Legal Representative: _____

For Office Use Only: Inability to Obtain Acknowledgment

The patient listed above received a copy of, and had an opportunity to review, the Notice of Privacy Practices. We attempted to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

Employee Name:_____ Date:_____

Employee Signature: _____

LA MESA FAMILY
MEDICAL GROUP

Borrego HEALTH

NOTICE TO PATIENTS TREATED AT LA MESA FAMILY MEDICAL GROUP

Dear Patients,

La Mesa Family Medical Group (LMFMG) is excited to announce that we have are a provider in the Sharp Community Medical Group (SCMG). This decision is intended to optimize the care provided to all of our patients.

As a participating Provider in the SCMG, LMFMG will be using SCMG's Electronic Medical Record system. This will allow for both better continuity of care and higher quality of care for patients who are seen elsewhere in the SCMG system, such as at Sharp hospitals or SCMG specialists.

Your (patient's) records related to treatment received at LMFMG will now be included in the SCMG electronic medical record system. By sharing the same electronic medical record, SCMG providers will have access to your (patient's) health records anytime you (patient) are seen by an SCMG provider. Immediate access to your (patient's) records means the SCMG providers will have detailed information regarding your (patient's) health history, medications, and the treatment you (patient) have received at LMFMG or by other SCMG providers. This access will help SCMG providers, including LMFMG, give the best care for you.

What will not change is that LMFMG will continue handling your medical records requests or any questions or concerns you may have related to your (patient's) care and treatment at LMFMG.

Please let us know if you have any questions. Sincerely,

The Staff and Providers of La Mesa Family Medical Group

_____ _____

Signature of Patient or Legal Guardian/DPOA **Date**

_____

Relationship to Patient

LA MESA FAMILY
MEDICAL GROUP

La Mesa Family Medical Group
8881 Fletcher Parkway Suite 205
La Mesa, CA 91942
Phone (619) 270 – 4388
Fax (619) 464 – 5109

Personal Health Information (PHI) Release

If it becomes necessary to contact you by phone at your HOME or MOBILE number:

	Yes	No
Can confidential messages be left on your home answering machine or voicemail?	☐	☐

	Yes	No
Can confidential messages be left with another person who answers the phone at your home number?	☐	☐

Please list the name(s) of the person(s) authorized by this form to receive/use/disclose/discuss your Protected Health Information:

_____

_____

_____

Correspondence address (if different than your home address):

_____ _____ _____ _____
Street address City State Zip

I understand that I do not have to sign this authorization in order to receive treatment from this office. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA privacy rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon authorization.

_____ _____ _____
Patient name Patient/Legal Representative Signature Date

LA MESA FAMILY
MEDICAL GROUP

Borrego HEALTH

La Mesa Family Medical Group
8881 Fletcher Parkway Suite 205
La Mesa, CA 91942-3187

I hereby acknowledge that **La Mesa Family Medical Group** has provided me with an explanation of his/her/its Notice of Privacy Practices in compliance with the HIPAA Patient Privacy Act.

I understand my rights regarding the handling of my Protected Health Information as a patient of **La Mesa Family Medical Group**.

La Mesa Family Medical Group is participating in San Diego Health Connect to better coordinate our patient's healthcare through the sharing of clinical information.

By default, all records of **La Mesa Family Medical Group** are included in San Diego Health Connect. If you do not want your information shared, please check the box below:

☐ No

Patient's Signature: _____

Date: _____

Patient name: _____

Patient address: _____

_ _____

LA MESA FAMILY MEDICAL GROUP

Borrego HEALTH

ADVANCE DIRECTIVES ACKNOWLEDGEMENT FORM

Patient Name: _____ Date: _____

Please select one of the following:

_____ I **do have** an Advance Directive/ Living Will/ Durable Power of Attorney for medical or health care decisions

_____ I **do not have** an Advance Directive/ Living Will/ Durable Power of Attorney for medical or health care decisions

If you do NOT have an Advance Directive, please select one of the following:

_____ I **would like** further information on Advance Directives

_____ I **would not like** further information on Advance Directives

---

OFFICE STAFF USE ONLY:

_____ **Information regarding Advance Directives was provided**

If information was provided, what type? _____ **Verbal** _____ **Written**

_____ **Info regarding Advance Directives was not provided**

If the member has an Advance Directive, has it been placed in the Medical Record?

_____ **Yes** _____ **No**

Comments:

Staff Signature: _____ **Date:** _____

LA MESA FAMILY MEDICAL GROUP

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ADULT HEALTH HISTORY

Have you ever been diagnosed with any medical conditions? If yes, please list below:

_____

_____

_____

_____

Ever have surgery? ☐ No ☐ Yes. If "Yes", please provide surgery(ies), approximate date(s), and location(s):

_____

_____

_____

_____

_____

FAMILY HISTORY

Check all that apply:

- ☐ Cancer
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart disease
- ☐ Stroke
- ☐ Seizures
- ☐ Mental health diagnosis
- ☐ Other

Details (type, family member(s) affected, etc.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY (please select appropriate responses)

Marital Status: ☐ Married / ☐ Single-Never Married / ☐ Divorced / ☐ Widowed / ☐ Domestic Partnership

Current/former spouse(s): ☐ opposite gender / ☐ same gender / ☐ Not Applicable

Alcohol use: ☐ No / ☐ Yes:____ drinks ☐ daily / ☐ weekly / ☐ yearly; ☐ Former (__/day/__yrs, quit__yrs ago)

Tobacco: ☐ Never / ☐ Current: ☐ Cigarettes (___pack/day) / ☐ Vape / ☐ Chew; ☐ Former (___/day for ___yrs)

Drug use: ☐ Marijuana(☐ smoke/ ☐ vape)/ ☐ Other (drug/route/frequency):_____

Education level: ☐ Grade school ( )/ ☐ Some college/ ☐ Bachelors/ ☐ Masters/ ☐ Professional/Doctorate

OB/GYN HISTORY for patients assigned female at birth (please select appropriate responses)

Age when you had your first period:_____years

First day of last period (approximate): _____

Periods: ☐ Regular / ☐ Irregular / ☐ Not having (☐ Birth control / ☐ Postmenopausal)

Duration:____days; Cramping: ☐ None / ☐ mild/ ☐ mod/ ☐ severe; Flow: ☐ light/ ☐ mod/ ☐ heavy

Total # of pregnancies:_____; # of living children____; miscarriages:_____; abortions:_____

# of vaginal deliveries:_____; c-sections:_____; # of pre-term (<37 weeks) deliveries: _____

Any history of pregnancy complications? _____

_____

Current method of contraception and when started/placed: ☐ None/ ☐ Postmenopausal/ ☐ Condoms / ☐ Pills/ ☐ Patch / ☐ Ring / ☐ Depo / ☐ Nexplanon (placed____)/ ☐ IUD (☐ hormone / ☐ copper, placed_____) / ☐ Other:

Patient/Legal Representative Signature:_____Date:_____

Patient Name: _____

LA MESA FAMILY MEDICAL GROUP

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Tuberculosis Risk Assessment Screening Questionnaire

Today's Date: _____

Name: _____ **Date of Birth:** _____

*If your child has the appointment today, please fill out the form as it pertains to the **child**.

Check off any symptoms you are experiencing today:

☐ Cough ☐ Fever ☐ Loss of Appetite ☐ Coughing Up Blood ☐ Fatigue ☐ Weight Loss ☐ Night Sweats

1. Have you ever had a **positive** TB Skin Test or **positive** TB Blood Test (Quantiferon Level)? **(If YES, also answer A-D below). (If NO, skip to Question #2).** **Answer only if history of positive TB Test:** A. Date of positive test? _____ B. Date of last chest x-ray?_____ Normal: ☐ **Yes** ☐ **No** C. Was a preventive treatment for tuberculosis taken (such as INH)? ☐ **Yes** ☐ **No** D. Preventative treatment dates? _____	YES ☐	NO ☐	UNSURE ☐
2. Have you had any of the following vaccines in the past 4 weeks: MMR (Measles/Mumps/ Rubella), Varicella, Proquad (MMR/Varicella combination vaccine), Zoster (Shingles), or FluMist?	YES ☐	NO ☐	UNSURE ☐
3. Do you have, **or** live with someone who has active Tuberculosis, HIV/AIDS, or any other immune system problems?	YES ☐	NO ☐	UNSURE ☐
4. Do you live **or** work, in a hospital, clinic, nursing home, shelter, or prison?	YES ☐	NO ☐	UNSURE ☐
5. Do you have a family member **or** anyone you see regularly who may be suspected of having active tuberculosis disease?	YES ☐	NO ☐	UNSURE ☐
6. Were you born in, traveled to, **or** lived in, Asia, Africa, Latin America, Caribbean, Eastern Europe, Pacific Islands, South America, or Mexico?	YES ☐	NO ☐	UNSURE ☐
7. Do you live in foster care, **or** a group home?	YES ☐	NO ☐	UNSURE ☐
8. Have you been incarcerated (in prison) in the last 5 years, **or** lived with someone who has been incarcerated in the last 5 years?	YES ☐	NO ☐	UNSURE ☐
9. Are you currently homeless, a migrant worker, a street drug user, **or** have you been exposed to someone who is currently homeless, a migrant worker, or a street drug user?	YES ☐	NO ☐	UNSURE ☐

I have received information about the TB skin test and have had the opportunity to ask any questions which were answered to my satisfaction. I agree to return in **48-72 hours** to have my TB test read. I understand the risks and benefits of the TB skin test and request the test be administered to me. I understand that if I am symptomatic for TB, or the TB skin test is positive, I will need to follow up with my Primary Care Physician and further treatment may be necessary.

Form Completed By (Signature): _____ **Date:** _____

Print Name: _____

Relationship to Patient: (Self), (Parent), (Guardian), Other):_____