Pajaro Valley Medical Clinic, Inc

Patient Registration Information

To avoid any cancellation, please return paperwork to our office two weeks prior to your appointment

PATIENT'S PERSONAL INFORMATION

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Name: ______________________ (last name) ______________________ (first name) ________ (initial)

Date of Birth: _______ / _______ / _______ Social Security #: _______ - _______ - _______

Home Phone: (_____) ___________________ Work Phone: (_____) ___________________ Cell Phone: (_____) ___________________

Address: ______________________________ Apt. #: ______ City: _______________ State: ____ Zip: ___________

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: Self Spouse Child Other: ___________________

Name: ______________________ (last name) ______________________ (first name) ________ (initial)

Date of Birth: _______ / _______ / _______ Social Security #: _______ - _______ - _______

Home Phone: (_____) ___________________ Work Phone: (_____) ___________________ Cell Phone: (_____) ___________________

Address: ______________________________ Apt. #: ______ City: _______________ State: ____ Zip: ___________

INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: ____

Address: ______________________________________ City: ___________________ State: ____ Zip:

Name of insured: ________________________________ Date of Birth: _____________ Relationship to insured: Self Spouse Child Other

Policy #: ____________________SS#________________ Group #: __________________________ Copay: $ ____________

SECONDARY Insurance Name: ____

Address: ______________________________________ City: ___________________ State: ____ Zip:

Name of insured: ________________________________ Date of Birth: _____________ Relationship to insured: Self Spouse Child Other

Policy #: ___________________________________ Group #: ____________________________ Copay: $ ____________

WHO REFERRED YOU TO US?

Name: ____

PHARMACY INFORMATION

Name: ____

Address: ______________________________________ City: ___________________ State: ____ Zip: ___________

Phone: (_____) ___________________ Fax: (_____) ___________________

EMERGENCY CONTACT

Name: ____ Relationship: _________________________________

Address: ______________________________________ City: ___________________ State: ____ Zip: ___________

Home Phone: (_____) ___________________ Work Phone: (_____) ___________________ Cell Phone: (_____) ______________________________

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to PVMC, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ________________ Your Signature: ____

Name: ______________________________ Date: ______________________

Age: _______ Date of Birth: _________________ Reason for visit: ______________________

Current Symptoms

General
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ In an abusive relationship
- ☐ Weight change

Eyes
- ☐ Blurred vision
- ☐ Eye drainage
- ☐ Eye pain
- ☐ Glasses/contacts
- ☐ Light sensitivity

Ears/Nose/Throat
- ☐ Ear pain
- ☐ Hearing problems
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Nasal congestion
- ☐ Nasal ulcers
- ☐ Runny nose
- ☐ Bleeding gums
- ☐ Gum disease
- ☐ Dentures present
- ☐ Hoarseness
- ☐ Oral ulcers
- ☐ Sore throat
- ☐ Sore tongue
- ☐ Thrush
- ☐ Tooth pain

Cardiovascular
- ☐ Chest pain
- ☐ Leg Pain w/ walking
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Swollen feet/ankles
- ☐ Rapid heart rate
- ☐ Varicose veins

Respiratory
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Exposure to TB
- ☐ Coughing up blood
- ☐ Chest wall pain
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Sour taste in mouth
- ☐ Poor appetite
- ☐ Bloating
- ☐ Difficulty swallowing
- ☐ Clay-colored stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Vomiting blood
- ☐ Bloody stools
- ☐ Hemorrhoids
- ☐ Dark/tarry stools
- ☐ Nausea
- ☐ Vomiting
- ☐ Painful chewing
- ☐ Stool caliber change

Genitourinary
- ☐ Painful menstruation
- ☐ Painful intercourse
- ☐ Painful urination
- ☐ Genital lesions
- ☐ Blood in urine
- ☐ Multiple sexual contacts
- ☐ Unprotected sex
- ☐ Frequent bladder infections
- ☐ Impotence
- ☐ Frequent bacterial vaginosis
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Nighttime urination

Genitourinary (Cont.)
- ☐ Frequent urination
- ☐ Change in urine stream
- ☐ Bleeding after intercourse
- ☐ Menopausal bleeding
- ☐ Rape
- ☐ Sexual abuse
- ☐ Urinary incontinence
- ☐ Vaginal discharge
- ☐ Vaginal itching

Musculoskeletal
- ☐ Joint pain
- ☐ Back pain
- ☐ Joint stiffness
- ☐ Arm or leg pain
- ☐ Muscle aches

Skin
- ☐ Acne
- ☐ Concerning moles
- ☐ Dry skin
- ☐ Fingernail problems
- ☐ Jaundice
- ☐ Itching
- ☐ Rashes
- ☐ Warts

Breast
- ☐ Lump
- ☐ Skin changes
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Regular self-breast exams

Neurological
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness

Neurological (cont.)
- ☐ Seizures
- ☐ Tremor
- ☐ Vertigo
- ☐ Weakness

Hematologic
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Blood transfusions
- ☐ Enlarging lymph nodes

Endocrine
- ☐ Enlarging hands/feet
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ New hair growth
- ☐ Hot flashes
- ☐ Darkening skin
- ☐ Infertility
- ☐ Increased thirst
- ☐ Increased hunger
- ☐ Stretch marks
- ☐ Sweating excessive

Allergic/Immunologic
- ☐ Allergies
- ☐ Hay fever
- ☐ Frequent colds
- ☐ HIV exposure
- ☐ Urticaria

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Mood swings
- ☐ Personality change
- ☐ PMS
- ☐ Poor concentration
- ☐ Trouble sleeping
- ☐ Suicidal thought

Other Symptoms ____

____

____

Past Medical History

Cardiovascular
☐ Abnormal Heart Rhythm
☐ Arterial Clot
☐ Carotid Artery Disease
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Deep Vein Thrombosis
☐ High Cholesterol
☐ Hypertension
☐ Heart Attack
☐ Peripheral Vascular Disease
☐ Superficial Vein Clot
☐ Phlebitis
☐ Heart Valve Disease

Pulmonary
☐ Asthma
☐ Bronchietasis
☐ Chronic Bronchitis
☐ COPD
☐ Croup
☐ Cystic Fibrosis
☐ Pneumonia
☐ Pulmonary Embolism
☐ Pulmonary Hypertension
☐ Respiratory Syncytial Virus
☐ Sarcoidosis
☐ Sleep Apnea
☐ TB

Gastrointestinal
☐ Gall Stones
☐ Cirrhosis
☐ Colon Polyps
☐ Crohn's Disease
☐ Incontinence of Feces
☐ GERD
☐ Hepatitis
☐ Irritable Bowel Syndrome
☐ Pancreatitis
☐ Peptic Ulcer Disease
☐ Rotavirus
☐ Ulcerative Colitis

Renal
☐ Acute Renal Failure
☐ Benign Prostatic Hypertrophy
☐ Chronic Renal Failure
☐ Endometriosis
☐ Bed Wetting
☐ Erectile Dysfunction (Impotence)
☐ Glomerulonephritis
☐ Infertility
☐ Polycystic Kidney Disease

Renal (cont.)
☐ Kidney Stones
☐ Multiple Sexual Partners
☐ Homosexual Partners
☐ Urinary Incontinence
☐ Frequent Bladder Infections
☐ Vesicoureteral Reflux

Musculoskeletal/Connective tissue
☐ Chondromalacia Patellae
☐ Chronic Pain
☐ Fibromyalgia
☐ Fractures
☐ Gout
☐ Juvenile Rheumatoid Arthritis
☐ Legg-Calve-Perthes Disease
☐ Osgood-Schlatter Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Paget's Disease
☐ Polymyalgia Rheumatica
☐ Rheumatoid Arthritis
☐ Sjogren's Disease
☐ Slipped Capital Femoral Epiphysis
☐ Systemic Lupus Erythematosis

Endocrine
☐ Addison's Disease
☐ Carcinoid Syndrome
☐ Cushing's Disease
☐ Diabetes
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Osteoporosis
☐ Panhypopituitarism

Neurological
☐ Alzheimer's Disease
☐ ADD/ADHD
☐ Autism
☐ Cerebral Palsy
☐ Stroke
☐ Dementia
☐ Degenerative Disc Disease
☐ Headaches
☐ Huntington's Disease
☐ Meningitis
☐ Mental Retardation
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Myasthenia Gravis
☐ Parkinson's Disease
☐ Sensory Neuropathy
☐ Pervasive Developmental Delay

Neurological (cont.)
☐ Seizures
☐ TIAs

Hematological
☐ Hemolytic Anemia
☐ Iron Deficiency Anemia
☐ Myelofibrosis
☐ Pernicious Anemia
☐ Sickle Cell Disease
☐ Thallasemia

Allergy/Immune/Skin
☐ Allergies
☐ Angioedema
☐ Chicken Pox
☐ Eczema
☐ Giardiasis
☐ Immune Deficiency
☐ Ear Infections (frequent)
☐ Psoriasis
☐ Sinusitis (frequent)

Cancers
☐ Bone
☐ Brain
☐ Breast
☐ Colon
☐ Hepatic/Liver
☐ Leukemia
☐ Lung
☐ Lymphoma
☐ Melanoma
☐ Pancreatic
☐ Prostate
☐ Renal/Kidney
☐ Skin
☐Testicular
☐ Thyroid

Other
☐ Cataract
☐ Glaucoma
☐ Over Weight

Psychiatric
☐ Anxiety
☐ Anorexia Nervosa
☐ Bipolar Disorder
☐ Bulimia
☐ Depression
☐ Obsessive Compulsive
☐ Schizophrenia

Other ___________________________
____

Other ________________________
____

Other ____________________
____

Surgical History - Adult

Cosmetic
- ☐ Eyelids
- ☐ Facelift
- ☐ Liposuction
- ☐ Rhinoplasty
- ☐ Varicose Vein Stripping
- ☐ Breast Implants

Organ Removal/Resection
- ☐ Appendix
- ☐ Gall Bladder
- ☐ Colon
- ☐ Larynx
- ☐ Lung
- ☐ Parathyroid
- ☐ Prostate
- ☐ Sinus

Organ Removal/Resection (cont)
- ☐ Small Bowel
- ☐ Spleen
- ☐ Thyroid
- ☐ Tonsils
- ☐ Uvula

Other Surgeries
- ☐ Abortion
- ☐ Aortic Aneurysm
- ☐ Arthroscopy
- ☐ Breast Biopsy
- ☐ Coronary Artery Bypass
- ☐ Cardiac Valve
- ☐ Carotid Endarterectomy
- ☐ Cataract Removal
- ☐ Coronary Artery Stent

Other Surgeries (cont)
- ☐ C-Section
- ☐ Dilation & Curettage
- ☐ Fracture repair
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Ovaries Removed
- ☐ Joint replacement
- ☐ Laminectomy
- ☐ Laparotomy (exploratory)
- ☐ Nissen Fundoplasty
- ☐ Pacemaker
- ☐ Coronary Angioplasty
- ☐ Tubal Ligation
- ☐ TURP
- ☐ Vasectomy

Other Procedures
- ☐ Circumcision
- ☐ Lasik
- ☐ Lumbar Puncture
- ☐ PRK
- ☐ Bone Marrow Biopsy
- ☐ Liver Biopsy
- ☐ Prostate Biopsy
- ☐ Renal Biopsy
- ☐ Skin Biopsy
- ☐ Vasectomy

- ☐ Other ___________________
- ☐ Other ___________________
- ☐ Other ___________________
- ☐ Other ___________________

Family History

Relation	Medical Problems	Age at Death	Cause of Death
Father			
Mother			
Brothers #			
Sisters #			
Sons #			
Daughters #			

Pregnancy/Gynecological History

Pregnancies # __________
Children # __________
Abortions # __________
Miscarriages # __________

- ☐ Pregnancy Problems ______________________________
- ☐ Menstrual Problems ______________________________
- ☐ Current Birth Control ______________________________
- ☐ Age Periods Started ______________________________
- ☐ Age at Menopause ______________________________

Social History - Adult

Occupation ________________
____

If retired, from what?
____

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Partner

Number of Children _________
Hobbies____________________
____

Exercise
(type): _____________________
____
____
(how often):
____
____

Caffeine: _______ drinks/day

Smoking:
- ☐ Never
- ☐ Now
- ☐ In past

Tobacco:
- ☐ Cigarettes
- ☐ Cigars
- ☐ Chewing Tobacco

Alcohol:
- ☐ None
- ☐ Rarely
- ☐ Social
- ☐ Daily
- ☐ Current alcoholic
- ☐ Past alcoholism

Illicit Drugs:
- ☐ Yes
- ☐ No
- ☐ In past

Are you taking any herbals or supplements?
- ☐ Yes
- ☐ No

Are you currently dieting?
- ☐ Yes
- ☐ No

Medications Taken	Strength	Number of times daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Vitamins and supplements:

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

Medication Allergies

Drug ______________________ Reaction _____________________
Drug ______________________ Reaction _____________________
Drug ______________________ Reaction _____________________
Drug ______________________ Reaction _____________________
Drug ______________________ Reaction _____________________

Do you see any specialists? List the name of the specialist:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

PAJARO VALLEY MEDICAL CLINIC, INC.

65 Nielson St. Ste. 104
Watsonville, CA 95076
Phone # 831-786-8595
Fax # 831-786-8557

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)

Patient Name		Date of Birth	Social Security Number	
Address	City		Zip	Phone

RELEASE FROM: (Name of physician or facility releasing information)

I authorize release of my medical record from

Physician/Facility		Fax#	
Address	City	Zip	Phone

RELEASE TO: (Name of physician or facility receiving information)

Please send my medical record to:

Physician/Facility Pajaro Valley Medical Clinic, Inc			
Address 65 Nielson ST. Ste# 104	City Watsonville	Zip 95076	Phone 786-8595

RELEASE INFORMATION

Reason: [ ] Change of insurance	[ ] Transfer of care	[ ] Personal file
[ ] Moving out of area	[ ] Specialist consultation	[ ] Legal

Please release the following (check all that apply)

RECENT H&P		LAST THREE VISITS	
LAB REPORTS		X-RAY REPORTS	
HOSPITAL REPORTS		OTHER:	

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.) Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.

PAJARO VALLEY MEDICAL CLINIC, INC.
65 Nielson St. Ste. 104
Watsonville, CA 95076
Phone # 831-786-8595
Fax # 831-786-8557

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Pajaro Valley Medical Clinic, Inc.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Pajaro Valley Medical Clinic, Inc.** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice and Privacy Practices prior to signing this consent. **Pajaro Valley Medical Clinic, Inc.** 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 **Pajaro Valley Medical Clinic, Inc.**, **Attn. Privacy Officer 65 Nielson St. Ste 104 Watsonville, CA 95076.**

With my consent, **Pajaro Valley Medical Clinic, Inc.** may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, **Pajaro Valley Medical Clinic, Inc.** may mail to my home or other designated 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.

Pajaro Valley Medical Clinic, Inc. 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 **Pajaro Valley Medical Clinic, Inc.** use and disclosure of my PHI to carry out TPO.

I may 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, **Pajaro Valley Medical Clinic, Inc.** may decline to provide treatment to me.

______________________________ ______________________________
Patient Name Date

____
Signature

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

______________________________ ______________________________
Personal Representative’s Name Relationship to Patient

PVMC Policy and Procedures:

Patient Portal Guidelines

1. **Do not use email to communicate if there is an emergency or urgent need for communication: Call 911 instead or call the office at (831) 786-8595.**

2. **Proper Subject Matter:**

   Prescription refills, lab results, appointment reminders or requests, routine follow-up questions, updating address, phone number, insurance information, etc.

   Sensitive subject matter (HIV results, mental health issues, etc) will not be discussed via email.

3. **Please be concise.**

4. **Current Functionality of Patient Portal**

   Email and secure messaging
   Refill requests (please make sure we know the amount and pharmacy)
   Viewing and printing of "continuity of health record"
   Viewing and updating health information
   (You can request changes to your problem list, medication list, etc, but this will not change your record without our "ok" to any information provided)
   Referral Requests (If you have had at least one related office visit)
   Form Requests

5. **All communications will be included in your patient record.**

6. **Our system checks when messages are viewed, so you do not need to reply just to tell us that you received a message.**

7. **Privacy: a) All messages are encrypted**
   b) All emails to our staff should be via this portal
   c) The reply to your message may come from a different staff person if appropriate (eg Dr. O'Grady may assign it to someone else)

8. **Response Time:**

   After we receive your signed consent, we will send you a "welcome message" that includes a link to login. We will normally respond to your non-urgent inquiries within 24 hours but never later than 2 business days after receipt. We check messages throughout work days. Responses from the doctor may take longer than responses from the staff. If we are unable to access the system for any reason we will attempt to have an automated response inform you of this as soon as possible.

PVMC Informed Consent to use Patient Portal

Name____

Address____

Email Address____

Purpose of this Form

Pajaro Valley Medical Clinic offers secure viewing and communication as a service to patients who wish to view parts of their records and communication with our staff. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is, therefore, intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. The portal allows you to compose, pick up, and reply to secure messages or view information sent to you through a Web site hosted by our electronic records company.

How to Participate in our Patient Portal

Once this form is agreed to and signed, we will send you an email notification that tells you how to register for the first time. The notification will give you the URL (internet address) of the Web site where you can log in. By clicking on the URL you will activate your Internet browser, which will open the Web site. You will then be able to login using the user name and password provided. Next you will be able to look in your "message box" and see any new or old messages or view other parts of your electronic record. Because the connection channel between your computer and the Web site uses "secure sockets layer" technology, you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

You can view more clinic-specific information, including our privacy policy, or access the portal through www.pvmc.biz It is our intent to offer this as a free service, but we reserve the right to change this policy if needed in the future. We will provide adequate notice should this have to happen.

Protecting your Private Health Information and Risks

This method of communication and viewing utilizes the best commercial means available to attempt to prevent unauthorized parties from being able to access or read messages while they are in transmission. Nevertheless, users should be aware that electronic transmissions by their nature carry a risk of interception.

Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. We need you to make sure we have your correct email address, and that we are informed if it changes. You also need to keep track of who has access to your email account, so that only you, or someone you authorize, can see the messages you receive from us. If you pick up secure messages from a Web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the Web site and change it.

Conditions of Participating in the Patient Portal

Access to this secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate this service we will notify you as promptly as we reasonably can. You agree to not hold Pajaro Valley Medical Clinic liable for network infractions beyond our control.

Before you were given this form, we provided you with our policies and procedures for using this web portal. We need you to understand and comply with these, and by signing this form below you will acknowledge that they were explained to you and that you agree to comply with them. If you do not understand, or do not agree to comply with our policies and procedures, do not sign the form. If you have any questions we will gladly provide more information.

Patient Responsibilities

In return for access to the patient portal, you agree not to (1) transmit any electronic information that violates the rights or privacy of any party, (2) use the web portal in any way that violates local, state or federal law, (3) transmit material that is obscene, defamatory, abusive, slanderous, hateful or otherwise likely to result in harm to others, or (4) intentionally distribute viruses or other harmful computer code.

Patient Acknowledgement

Signature____

Date____

Prevention

		Date	Location	Unsure	Never	I want one	I don't want one	I want more info
Last Pap Smear	(F over 18)							
Last Mammogram	(F over 40)							
Last Colonoscopy	(M/F over 50)							
Last Tetanus shot	(M/F every 10 yrs)							
Pneumonia vaccine	(M/F over 65)							
Shingles vaccine	(M/F 60-75)							