Lakeside Health & Wellness
Family Practice
*1641 Creekside Dr, Ste 201 * Folsom, CA 95630*
*Tel (916) 983-3069 * Fax (916) 983-4569*

NEW PATIENT DATA SHEET

Please complete the entire sheet. Print legibly – Leave no blanks. Thank You.

PATIENT NAME: ____
LAST **FIRST** **MIDDLE INITIAL**

PATIENT ADDRESS: ____
STREET/PO BOX **APT/UNIT/SUITE**

____
CITY **STATE** **ZIP CODE**

SEX: ☐ M ☐ F **DATE OF BIRTH:** ____________________ **SOCIAL SECURITY NUMBER**:____________________

RACE/ETHNICITY: ____

CELL #: _______________________ **HOME PH :** ______________________ **WORK PH:** _________________________

PREFERRED CONTACT METHOD (please circle one): Cell / Home / Work

E-MAIL ADDRESS: ____

PRIMARY INSURANCE: ____

The subscriber of the primary insurance is: ☐ **the patient** **or** ☐ **spouse** **or** ☐ **other**

If patient is not the subscriber, please enter the subscriber's name: _______________________________________

Subscriber's relationship to the patient: ____

Subscriber's Address (if different from patient's address): ____

Subscriber's Birthdate: ____________________ Social Security Number: _________________________________

Subscriber's Home Phone: ________________________________ Cell: ___________________________________

*****Continued on back of page*****

SECONDARY INSURANCE: ____

The subscriber of the primary insurance is: ☐ **the patient** **or** ☐ **spouse** **or** ☐ **other**

If patient is not the subscriber, please enter the subscriber's name: ________________________________

Subscriber's relationship to the patient: ____

Subscriber's Address (if different from patient's address): ____

Subscriber's Birthdate: __________________ Social Security Number: _____________________________

Subscriber's Home Phone: ____________________________ Cell: _______________________________

PREFERRED PHARMACY: ____

Location: ____

STREET NAME **CITY**

EMERGENCY CONTACT: ____

NAME

____

RELATIONSHIP TO PATIENT

(H)___________________ (C) ____________________ (W) __________________

EMERGENCY PHONE NUMBER

How did you hear about us?

☐ **Family member:**____

Name

☐ **Friend:**____

Name

☐ **Insurance Website** ☐ **Other Website** _________________________

☐ **Other Physician** ____

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OFFICE POLICIES

I. All co-payments, outstanding balances, and estimated deductibles are due at registration on the day of your appointment.
II. All returned checks will be assessed a $25.00 fee.
III. All appointments missed or canceled with less than 24 hours prior notice will be assessed a $20.00 fee.
IV. Any letters or forms that need to be filled out are assessed a $10.00 fee. DMV and FMLA forms will be charged a $25.00 fee. Any form requested to be completed within 72 hours will be charged an additional $10.00 fee. Fees for forms are due at the time of request.
V. Copying of medical records will be assessed a $30.00 fee.
VI. A late fee will be assessed for all outstanding balances; $10.00 for each 30-day period past the billing statement date.
VII. If no payments on outstanding balances are received after the 2nd billing statement, claims will be sent to a collection agency.

I have read, understand, and agree to the above office policies.

I hereby authorize and request my insurance pay directly to the Physician any surgical or medical benefits to which I and/or my dependents are entitled. I agree that I am responsible to pay the physician in-full for any services or tests provided that are not covered by my insurance if not otherwise specified; this may include, but is not limited to, immunizations, injectable medications, and procedures. I also agree to bear the cost of collections and/or court fees and reasonable legal fees in the event of non-payment.

I hereby authorize my physician to release any information acquired in the course of my treatment necessary to process my insurance claims and comply with the insurance company's evaluation and utilization review.

Patient's Name: ____ DOB: ________________

Name of Legal Guardian and Relationship to Patient: ______________________________________

Signature of Patient or Legal Guardian: ____

Date: __________________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

We are required by applicable federal and state law, including the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes.

We may use and disclose medical information about you for the following purposes: Treatment, Payment and Health Care Operations:

- Treatment: We may use your medical information to treat you or disclose your medical information to a physician or other health care provider providing treatment to you.

- Payment: We may use and disclose your medical information to obtain payment for services we provide you.

- Health Care Operations: We may use and disclose your medical information in connection with the normal course of operating our practice. Health care operations may also include quality assessment activities, performance evaluations, conducting training programs, accreditation, and certification, licensing or credentialing activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures of your medical information will only be made with your written authorization or in response to legal requirements such as disaster relief, court orders, suspected abuse, neglect, or domestic violence, or in certain instances affecting national security.

You have the following rights with respect to your protected health information which you may exercise by written request using the contact information at the end of this notice:

- The right to request additional restrictions on the use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement which must be in writing.
- The right to inspect and copy your protected health information.
- The right to request amendments to your protected health information.
- The right to receive an accounting of disclosures of your personal health information for other than treatment, payment, health care operations or pursuant to other authorized disclosures as stated above.
- The right to obtain a copy of this notice

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we have made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Patient Name: ____ DOB: ____________________

Name of Legal Guardian and Relationship to Patient: ____

Patient or Legal Guardian Signature: _______________________________________ Date: _____________________

Lakeside Health & Wellness

Family Practice

PATIENT HISTORY

Name: ___________________________________ **Age**: ______ **Phone #**: _______________________ **Date**: _____________

Please check any of the following disease that you have been diagnosed with:

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arrhythmia
☐ Arthritis
☐ Asthma
☐ Cancer (type: __________)
☐ Chronic pain (site:_________)
☐ Crohn's disease
☐ Depression
☐ Diabetes (type I or II)
☐ Emphysema/COPD
☐ GERD (Reflux disease)
☐ Heart attack
☐ Heart condition (_____________)
☐ Hepatitis A / B / C
☐ High blood pressure
☐ High cholesterol
☐ Irritable bowel syndrome (IBS)
☐ Kidney stones
☐ Kidney disease
☐ Migraines
☐ Seizures or Epilepsy
☐ Stroke
☐ Thyroid, high / low
☐ Ulcer, stomach
☐ Ulcerative colitis
☐ Other ______________________
____

Please mark any surgeries that you have had, and include dates below: Please be specific.

Surgery	***Date***	***Surgery***	***Date***	***Surgery***	***Date***
☐ Appendectomy		☐ Eye		☐ Neck	
☐ Other abdominal (________________)		☐ Gallbladder		☐ Tonsillectomy	
☐ Back		☐ Heart		☐ Thyroid	
☐ Biopsy (site: _______________)		☐ Hysterectomy		☐ Urological	
☐ Breast		☐ Joint (site: ____________)		☐ Other:	

Family History:

Relation	**Alive**	**Deceased**	**Medical Problems:** (ie: high blood pressure, cholesterol, diabetes, heart disease, thyroid disease, cancer, etc.)
Father			
Mother			
Brothers			
Sisters			
Paternal Grandpa			
Grandma			
Maternal Grandpa			
Grandma			
Other family members			

*****Continued on back of page*****

Social History:

Do you smoke cigarette now? ☐ Yes ☐ No

If yes, how much daily? ________________________ If yes, how long have you used tobacco? __________ (In years)

If no, did you ever? ☐Yes ☐ No For how long?____________ When did you quit?:_____________(Date)

Do you drink alcohol? ☐ Yes ☐No How many drinks per week? ____________ For how many years?_________

Do you use street drugs? ☐ Yes ☐ No

If no, have you ever? ☐ Yes ☐ No If so, what did you use before: ____________________

Men and Women:

Marital Status: ☐Married ☐Single ☐Engaged ☐Domestic partner ☐Divorced ☐Separated ☐Widowed

Total Number of Children: ____________

Occupation: _______________________________ Employer: ____

Current Medications:

Name of Medication	***Dose (strength)***	***How Often?***	***For What Condition?***

Please list any ALLERGIES to medications and your REACTION to them below:

____

____

Preventive Healthcare Screening (when did you last have the following?):

Exam	***Date/Year***	***Immunizations***	***Date/Year***
Physical exam		Last Tetanus	
Pap Smear (Female)		Pneumonia Vaccine	
Mammogram (Female)			
Bone Density Test			
Colonoscopy/Sigmoidoscopy			