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 #**: _____

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: _____

NAME: _____

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 or friend: _____
Name (if also our patient)

☐ Other Physician: _____

☐ Insurance **☐ Online**

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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. Any appointment missed or canceled with less than 24 hours prior notice will be charged a $100 fee. Fee needs to be collected prior to scheduling your next appointment. We implement this policy to encourage patients to give timely cancellation notice so that the reserved appointment slot can be given to another patient who needs to be seen.

III. Patients who are more than 5 minutes late to their appointment will be turned away with opportunity to re-schedule. This is to respect other patient's time.

IV. After 3 no-shows/late cancellations or 3 late shows, we regrettably have to discharge the patient from our practice.

V. Any new patient who no shows to the first appointment will not be re-scheduled with our practice.

VI. Copying of medical records will be assessed a $30 fee.

VII. A late fee will be charged for all outstanding balances; $25 for each 30-day period past the billing statement date.

VIII. If no payments on outstanding balances are received after the 3rd billing statement or past 90 days, claims will be sent to a collection agency.

IX. All returned checks will be assessed an additional $35 fee.

X. We occasionally utilize a medical scribe who is present in the exam room to aid with documentation. If you prefer not to have the presence of the scribe in the room, we will be happy to oblige upon verbal request.

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

I hereby authorize and request my insurance to pay directly to Lakeside Health & Wellness for any medical or surgical or benefits to which I and/or my dependents are entitled. I agree that I am responsible to pay the Practice 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 the release of 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 Medicine

PATIENT HISTORY

Name: _____ **Age**: _____ **Phone #**: _____ **Date**: _____

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

☐ Allergies	☐ Chronic pain (site:_____)	☐ Heart condition (_____)	☐ Migraines
☐ Anemia	☐ Crohn's disease	☐ Hepatitis A / B / C	☐ Seizures or Epilepsy
☐ Anxiety	☐ Depression	☐ High blood pressure	☐ Stroke
☐ Arrhythmia	☐ Diabetes (type I or II)	☐ High cholesterol	☐ Thyroid, high / low
☐ Arthritis	☐ Emphysema/COPD	☐ Irritable bowel syndrome (IBS)	☐ Ulcer, stomach
☐ Asthma	☐ GERD (Reflux disease)	☐ Kidney stones	☐ Ulcerative colitis
☐ Cancer (type: _____)	☐ Heart attack	☐ Kidney disease	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:** (ex: high blood pressure, cholesterol, diabetes, heart disease, thyroid disease, cancer, etc.)
Father			
Mother			
Brothers			
Sisters			
Paternal Grandpa			
Grandma			
Maternal Grandpa			
Grandma			
Other family members			

Name: _____

Social History:

Do you smoke?

☐ Yes. How much daily? _____ When did you start (what year)? _____

☐ No. If you smoked in the past, how much _____ and for how long? _____

When did you quit (what year)? _____

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: _____

Do you exercise regularly? ☐Yes ☐ No If yes, how much do you exercise: _____

Does your diet consist of: Low sodium? ☐ Yes ☐ No Low fat? ☐ Yes ☐ No Low carb/sugar? ☐ Yes ☐ No

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

Total Number of Children: _____

Occupation: _____ Employer: _____

Do you have an Advance Directive? ☐ Yes ☐ No

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		Tetanus	
Pap Smear (Female)		Shingles vaccine	
Mammogram (Female)		Pneumonia vaccine	
Bone Density Test			
Colonoscopy/Sigmoidoscopy			