After Hours Medical Group

9200 Colima Rd. #101 Whittier, CA 90605 (562) 945-2128

Please tell us who referred you?____

CONFIDENTIAL PATIENT INFORMATION

Last Name________________________ **Date of Birth**________________________

First Name____________________ **MI**___ **Sex Male/Female**____________________

Previous Name______________________ **Social Security**______________________

Address__________________________

City____

State______________**Zip**__________ **Language**__________________________

Home Phone__________**Cell Phone**__________**Email**____________**Marital Status**______

Race Amer.Indian/Black/Asian/Hispanic/Pacific Islander/White/Other **Ethnicity** Latino/Hispancic Not Latino/Hispanic Undisclose

IF THE PATIENT IS A *MINOR* or *DEPENDENT ON SOMEONE ELSE'S* INSURANCE, PLEASE PROVIDE FINANCIAL RESPONSIBLE PARTY INFORMATION

Last Name________________________ **Date of Birth**________________________

First Name____________________ **MI**___ **Sex Male/Female**____________________

Home Phone__________**Cell Phone**__________ **Social Security**______________________

Address__________________________ **Relationship**______________________

City__________________________ ☐ **SELF**

State______________**Zip**__________

EMERGENCY CONTACT

Relationship______________________

Last Name________________________

First Name____________________ **MI**___

Home Phone__________**Cell Phone**__________

PHARMACY

Name__________________________

Address________________________

City__________________________

State______________**Zip**______________

I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.

Expenses collected from you at the time of service are an estimated cost of your visit. If, after your insurance is billed, should your policy apply any additional amount to your out of pocket expense, you are personally responsible for that amount and will be billed for that balance then due.

DATE__________**Name**____________________**Signature**________________________

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Patient Name: ________________________________ D.O.B.: ___________ Phone:__________________ Date:___________

Primary Care Doctor's Name: ____ PCP's phone # ___________________

Age: _______ Male [ ] Female [ ] Language: _________________________

Allergies: ____

Reason for visit: ____

Medications/Vitamins: ____

Please circle all that apply (only for new patients):

Past Medical History: Hypertension, Diabetes Mellitus, Insulin Dependent Diabetes Mellitus, Stroke, Heart Attack, Congestive Heart Failure, Gout, Hyperthyroid, Hypothyroid, Asthma, COPD, Hepatitis, Pancreatitis, GERD, Lupus, Rheumatoid Arthritis, Osteoarthritis, Cancer, Hyperlipidemia, Kidney Disease, Dialysis, Depression or Mania, Gastritis

Other: ____

Past Surgical History: Gallbladder Removal, Appendix Removal, Thyroid Removal, Tonsillectomy, Hysterectomy, C-Section, CABG, Hernia Repair, Angioplasty, Cancer

Other(s): ____ Year(s) of Surgery: _________________________

Social History: Have you ever smoked? **Y/N** If yes, how many packs per day? ____ For how many years? ____

Do you drink alcohol? **Y/N** If yes, how many drinks per month? ____

Please circle all that apply for Today's visit. (ALL patients):

General: Fevers, Fatigue, Sweats, Chills

Endocrine: Excessive Thirst, Weight Loss, Weight Gain

Heme: Unusual Bruising, Unusual Bleeding

Allergy/Immunology: Hay Fever (Allergic Rhinitis)

HENT: Sore Throat, Earache, Runny Nose (Rhinorrhea) Sinus Problems

Eyes: Red Eyes, Eye Discharge (Crusting), Double Vision (Diploplia)

Pulmonary: SOB (Dypsnea), Dry Cough (no phlegm), Productive Cough (with phlegm), Wheezing

Heart: Palpitations (Irregular Heart Beat), High Blood Pressure, Rapid Heart Rate (Heart Racing)

GI: Nausea, Vomiting, Diarrhea, Abdominal Pain or Cramps

GU: Burning or Painful Urination (Dysuria), Blood in Urine (Hematuria), Pelvic or Genital Pain, Abnormal Vaginal Pain,

Menstrual Pain, Vaginal Discharge

Musculoskeletal: Joint Pain, Muscle Pain

Neurology: Headache, Seizures, Vertigo (Room Spinning)

Psychiatry: Anxiety, Depressed or Sad

Skin: Rashes

Patient's/Legal Representative Signature:______________________ Relationship if minor:_____________

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Consent to Treat

Consent to Treat: I (or the undersigned on the behalf of the patient) voluntarily consent to allow the physicians of After Hours Medical Group, and the staff to provide health care, encompassing urgently needed procedures and treatments, on an outpatient basis as deemed necessary by the physicians of After Hours Medical Group. I am to be informed about the treatment and services I receive and have the right to refuse treatment when I deem necessary. Furthermore, I am aware of my rights as a patient.

Would you like a copy of the Patients Bill of Rights? **YES** **NO**

Would you like a copy of this Consent to Treat? **YES** **NO**

Patient Name: ________________________________ Date: ___/___/_____

Patient Signature: ______________________________

Parent name, relationship and signature, if patient is a minor:

Relationship: ____________Name: __________________Signature______________

Witness Name: ________________________ Signature______________________