FAMILY CARE OF SANTA MARIA

915 E. Stowell Rd. Suite C
Santa Maria, CA 93454
(805) 934-5140

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Home Address:
Work Address:

Social Security no:	Home phone no:	Cell phone no:
Occupation:	Employer:	Employer phone no:

Chose clinic because/referred to clinic by:
Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: [Choose an item] | Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber:	Other:		

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

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Name: _____ DOB: _____

HAVE YOU EVER HAD PROBLEMS WITH:

__Headaches
__Eyes, Ears or Throat
__Hay Fever
__Heart
__Breathing
__Digestion
__Bowels
__Neurological
__Urination/Kidneys
__Menstruation
__Sexual Function
__Depression
__Arthritis
__Diabetes or Thyroid
__Cancer
__Weight Change
__Dizziness
__Other

Please Explain: _____

_____

_____

Do you smoke?_____ Drink Excessively?_____ Exercise Regularly? _____

Circle diseases in blood relatives:

Diabetes Stroke Heart Disease Cancer Thyroid

ALLERGIES TO MEDICATIONS: _____

List current medications (include strength and dose):

_____

List prior Surgery:

_____

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NOTICE OF PRIVACY PRACTICES

The medical practices of Doctor's Robert W. Okerblom M.D., Donald J. Hole M.D., Rachel L. Zonca D.O., Sean Christiansen, D.O. and associates have implemented policies to protect the privacy of your medical records. The following is a description of how we manage your individual medical information.

A written or electronic record of your health care is constructed at each encounter. This record may include your symptoms, examination, test results, treatment plans, outside records, and other medical information. Transcription services are often utilized. Our employees access this record only in legitimate medical or business reasons. All employees are trained in patient confidentiality procedures. Safeguards are taken to prevent the unintended disclosure of your health care information during creation, utilization, storage, and destruction. Anything that identifies a patient with their individual medical care is protected.

By law, your medical information may be shared (without your authorization) for:

1. Treatment- To facilitate your care we may share information with consulting physicians, health care entities, Public Health and legal entities, and on call physicians. For example, we will send a consulting physician relevant chart notes.

2. Payment- To obtain payment from third parties, we will provide requested information to insurers. For example, your insurance company may request chart notes before payment.

3. Healthcare Operations- We may supply medical information for the purposes of quality control, business activities, and other health care operations. For example, we may need to call your home to remind you of an appointment.

Any other disclosures of your medical record will require your written or expressed authorization. This even includes disclosures to non-dependent family members. All disclosures of your record requiring authorization will be documented.

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You have certain rights regarding your individual record including the right to:

1. To inspect and copy your record and its disclosures. Certain conditions like legal actions may restrict this right. Written 30 day notice is required prior to inspection, and a supervision fee may be required.

2. To request restrictions and amendments regarding your record. Your request must be in writing, specific, and time sensitive. We will accept or deny your request in writing. Special handling creates a burden for us and we may charge a fee.

3. To file written complaints concerning your records to our office manager.

4. To revoke in writing any prior disclosure authorizations at any time.

5. To request in writing that we communicate with you in alternative methods.

Some of the specific actions we have taken to protect your privacy include:

1. All employees with access to your medical records are trained to protect your privacy. Privacy training includes protection both in the office and in the community

2. Contracted and business associates with access to your medical record have been instructed regarding the confidential handling of your record and have signed agreements to protect you privacy.

3. Your medical records and demographic information is never knowingly sold or otherwise released for non-medical or commercial purposes.

If there are any parts of this privacy policy you do not understand, please consult our office manager. We are happy to address your questions and concerns.

A written copy of this notice is available upon request.

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Robert W. Okerblom, M.D.
Donald J. Hole, M.D.
Rachel L. Zonca, D.O.
Sean Christiansen, D.O.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Signature of Patient/Patient Representative | **Date**

Patient Name | **Patient Date of Birth**

Relationship to patient

ASSIGNMENT OF BENEFITS

I authorize this office to release to the beneficiary's insurance companies any information necessary to expedite insurance payment. I authorize payment directly to the provider of service.

I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent or Guardian Signature | Date

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Okerblom, Hole, Zonca and Christiansen

Missed Appointment Policy For New Patient

As a new patient, if you are not able to keep your appointment please call and cancel 24 hours in advance. By cancelling or rescheduling in advance this allows the doctor's time to be spent efficiently and our other patients receive timely care. If you do not cancel or reschedule and miss your appointment there is a $50.00 charge.