Family First Medical Care
A Professional Corporation

FAMILY FIRST MEDICAL CARE
Silvia Diego, MD Lisa Gil, MD
1317 Oakdale Rd Suite 440
Modesto CA 95355
(209) 522-FFMC (209) 522-3363 fax

Patient Registration

Last Name: _____ First:_____MI:___ SS#_____-_____-_____

Address: _____ City_____ State_____ Zip_____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

E-Mail for Appointment Reminders: _____ Preferred language_____

Preferred Method of Contact ☐Cell Phone ☐E-Mail ☐Text ☐Home ☐Work ☐Written Communication

Date of Birth: _____ Age_____ Sex: ☐Female ☐Male Status: ☐Married ☐Single

Employer: _____Occupation_____Drivers License_____

Emergency Contact: _____ Home _____ Other Phone_____

How did you hear about us? _____PCP:_____

Insurance Information

Person Responsible for Bill: Last: _____ First: _____ MI: _____

Primary Insurance Carrier: _____ ID#_____ Group#_____

Secondary Insurance Carrier:_____ ID#_____ Group#_____

Effective Date: _____ Guarantor SS# _____ -____-_____ Guarantor DOB _____

Guarantor Relation to Patient: ☐Self ☐Spouse ☐Parent

I have been provided Family First Medical Care "notice of Privacy Practices" and understand my Hippa rights. I directly assign all medical /surgical benefits to the doctor. I authorize the doctor to release all information necessary to secure payment of benefits. We are unable to determine if a valid authorization f or services is required or has been obtained, or if the physician is currently a participating provider. By signing below, you are acknowledging you have been informed of the possibility for denial. I understand that I am financially responsible for all charges whether or not paid by my insurance company.

Signature_____Date:_____

This office does random drug screening.

Do you want Information on Advance Directive? YES_____ NO_____

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HIPPA AUTHORIZATION FORM
PATIENT CONSENT FORM

I consent to the use or disclosure of my protected health information by Family First Medical Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of FFMC. I understand that diagnosis or treatment of me by my physician may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of practice. FFMC is not required to agree to the restrictions that I may request. However, if FFMC agrees to a restriction that I request, the restriction is binding on FFMC and my physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that my FFMC or physician has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review FFMC Notice of Privacy Practices prior to signing this document. The FFMC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in treatment, payment of my bills or in the performance of health care operations of FFMC. The Notice of Privacy Practices for FFMC is also provided in the patient waiting room and on the FFMC website. This Notice of Privacy Practices also describes my rights and the FFMC duties with respect to my protected health information.

FFMC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing FFMC website, calling the office and requesting a revised copy sent in the mail or asking for one at the time if my next appointment.

Signature of Patient _____ Date _____

Print Name of Patient_____ Date _____

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Financial Policy

Financial Policies: Agreement and Acknowledgement

- **Insurance co-pays, deductibles, co-insurance and outstanding patient balances are due prior to services rendered.** Your insurance policies may require you to make a co-payment or pay a deductible for an office visit, a diagnostic test, and/or a procedure; therefore payment is expected on the date of service prior to services rendered.
- Our office accepts many health care plans. We will bill those plans with which we have an agreement. In the event that your insurer determines the service is "not covered" by the terms of your health care plan, you will be responsible for payment in full on the date of service to include office visits, procedures and injection procedures.
- In the event that our physician(s) are not enrolled with your health care plan or not selected/listed as your primary care provider (PCP), you will be responsible for payment in full on the date of service. In this instance, you may submit your claim directly to your carrier to request reimbursement.
- In the event that your medical expenses will not be submitted to an insurance carrier, payment is due at the time of service to include office visits, procedures, and in advance of any surgical procedures.
- Form fees are not covered by your insurance company. All form fees are to be paid at the time of the request in order to complete the form.
- If an overpayment is made by you on the account, the balance will be posted on the account for future balances unless requested for a refund direct. Requested refunds will be issued if there are no other outstanding debts on the other accounts containing the same guarantor or financial responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any changes in address, phone, insurance, or employment. All balances are due in full within 14 days of the billing date. Our practice has a $25.00 return check fee.
- Failure to meet your financial obligations may result in reporting you to our contracted collection agency who in turn may report you to the credit bureau.
- All Medicare patients will be required to pay the 20% patient responsibility based upon the current Medicare Fee Schedule, prior to services rendered, unless proof of a secondary policy is evident. Pre-determined co-pays are due when you check-in for your appointment. If your insurance coverage is based on a percent (example 20% is patient responsibility) and you do not have a secondary policy, please be prepared to pay. For insurance plans with unmet deductibles, please be prepared to pay. Insurance claims are filed as a courtesy; you are ultimately responsible for the rendered services.

Financial Agreement:

I hereby assume full responsibility for all charges incurred for professional services rendered by Family First Medical Care Providers , including collection cost/fees and 50% attorney fees, unless the services are deemed "paid in full" as a result of a contractual agreement between Family First Medical care and my insurer.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Todays Date: _____

Parent/ Guardian Name: _____ Todays Date _____

Parent/ Guardian Signature: _____ Todays Date _____

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(209) 522-3362 (209) 522-3363 fax

Today's Date: _____

Patient Name: _____ Date of Birth_____

CURRENT MEDICATIONS, STRENGTH, DOSAGE, & SIG

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES:

_____side effect / reaction_____

_____side effect / reaction_____

_____side effect / reaction_____

_____side effect / reaction_____

Name: _____ DOB: _____ **Please Circle ALL that Apply**

Past Medical History

Hight Blood Pressure / Cholesterol / Heart Disease

Asthma / COPD / TB / Seasonal Allergies

Gastritis / Acid Reflex / Colitis

Bladder Problems / Kidney Stones

Erectile Dysfunction / STD

Fibromyalgia / Pain: Back / Joint _____

Migraine / Seizure / Stroke

Diabetes / Thyroid Problems

Arthritis / Osteoporosis / Eczema / Skin Cancer

Anxiety / Depression / Bipolar / Schizophrenia

Others: _____

_____

_____

Surgical History

Head or Sinus

Heart or Lungs

Gallbladder or Hernia

Intestine or Bariatric

Hysterectomy: Total or Partial

Kidney or Bladder

Uterus or Ovaries

Spine or Joint

Other: _____

_____

Exams Please write year of last exam

Pap: _____ Mammogram_____

Eye Exam: _____ Dental Exam:_____

Colonoscopy: _____ Foot Exam_____

Adult Vaccination_____

Tuberculosis Clearance _____

Women ONLY

Menses: Yes / No

Last Menstrual Period: _____

Menses come every _____ days

Birth Control Method: Pills / Shot / Ring / Patch / Natural

Menopause: Yes / No

Total Pregnancies: _____ Live Births_____

Vaginal _____ C-Sec _____

Preterm Labor / Complications: _____

_____

Social History

Current Every Day Smoker Yes / No / Never Smoked

Former Smoker Yes / No If yes- How long ago_____

Alcohol: Number of drinks _____ week

Past / Current use of: Marijuana / Meth / Others

_____

Seat Belt Yes / No

Special Diet: _____

Exercise Yes / No Type: _____

Children: Yes / No How Many? _____

Sexually Active Yes / No

Family History

Diabetes / High Blood Pressure / Heart Disease

High Cholesterol / Thyroid Disease / Anxiety

Cancer Type: _____

Other: _____

Please list preferred Pharmacy

Name: _____

Street: _____

Patient name:_____

Staying Healthy Survey					
		(1) Not at all	(2) Several days	(2) More than half the days	(3) Nearly every day
1	During the last 90 days, have you been feeling nervous, anxious or on edge?	0	1	2	3
2	During the last 90 days have you not been able to control or stop worrying?	0	1	2	3
3	During the last 90 days have you had little interest or pleasure in doing things?	0	1	2	3
4	During the last 90 days have you been feeling down, depressed or hopeless?	0	1	2	3
5	During the past 90 days, have you felt that you should cut down or stop drinking or using drugs?	Yes	No		
6	During the past 90 days has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?	Yes	No		
7	During the past 90 days have you felt guilty or bad about how much you drink or about how much you use drugs?	Yes	No		
8	During the past 90 days have you been waking up wanting to have an alcoholic drink or use drugs?	Yes	No		
9	During the past 90 days have you gone on eating binges where you feared you would not be able to stop?	Yes	No		

Adult Tuberculosis (TB) Risk Assessment Questionnaire[1]

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

To be administered by a licensed health care provider (physician, physician assistant, nurse practitioner, registered nurse)

Name: _____ Date of Risk Assessment: _____

Date of Birth: _____

History of positive TB test or TB disease Yes ☐ No ☐

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.*
If no, continue with questions below.

If there is a "Yes" response to any of the questions 1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.[2]	Yes ☐ No ☐
2. Close contact with someone with infectious TB disease	Yes ☐ No ☐
3. Birth in high TB-prevalence country** (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
4. Travel to high TB-prevalence country** for more than 1 month (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
5. Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes ☐ No ☐

**Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.*

[1] Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

[2] Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013. (http://www.cdc.gov/tb/publications/LTBI/default.htm)

Family History Questionnaire for Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth: _____ Gender: M / F Ethnicity: _____

Phone: _____ Email: _____ Date completed: _____

www.genedx.com/MyCancerHistory

Please complete the below questionnaire to assist your healthcare provider in determining if your personal or family history may be placing you or other family members at increased risk to develop cancer, and if you may be eligible for genetic testing (which is often done via a blood test).

Tips: • Each row should be completed independently • Affected relatives on your mother's side of the family should be listed in the pink boxes and affected relatives on your father's side of the family affected should be listed in the blue boxes • Age at diagnosis is the age at which the cancer was diagnosed • Other friends and family can assess their cancer risk by going to www.genedx.com/MyCancerHistory where they can complete this same form and share it with a healthcare professional.

Past genetic testing for cancer: ☐ Self ☐ Relative Result: _____

	You	Immediate Blood Relatives		Extended Blood Relatives (Aunts, Uncles, Grandparents, etc.)			
Breast and Ovarian Cancer	**Age at Diagnosis**	**Parents, Siblings or Children**	**Age at Diagnosis**	**Mother's Side**	**Age at Diagnosis**	**Father's Side**	**Age at Diagnosis**
Example:							
Woman with Breast Cancer at age ≤50	*45*	*Mother* *Sister*	*49* *36*	*Maternal Aunt*	*46*	*Paternal First Cousin*	*50*
Woman with Breast Cancer at age ≤50							
Woman with Breast Cancer >50							
"Triple Negative" Breast Cancer (Estrogen Receptor (ER) negative, Progesterone Receptor (PR) negative, HER2neu negative)							
Ovarian, fallopian tube, or primary peritoneal cancer							
A woman who has been diagnosed with both breast and ovarian cancer in her lifetime (two separate cancers)							
Male breast cancer							
Bilateral breast cancer (cancer in both breasts) or two breast primaries Please specify							
Ashkenazi (Eastern/Central European) Jewish ancestry with breast or ovarian cancer							
Pancreatic or Prostate Cancer Please specify							
Colorectal and Endometrial (Uterine) Cancer	**Age at Diagnosis**	**Parents, Siblings or Children**	**Age at Diagnosis**	**Mother's Side**	**Age at Diagnosis**	**Father's Side**	**Age at Diagnosis**
Colorectal cancer or several pre-cancerous polyps (adenomas) at an age ≤50							
An individual who has been diagnosed with two or more colon cancers (not reoccurrences, but two separate primary cancers)							
A woman who has been diagnosed with endometrial (uterine) cancer at age ≤50 OR both colorectal and endometrial (uterine) cancer Please Specify							
10 or more total pre-cancerous polyps (adenomas) in a person's lifetime							
Relatives with any of the below related cancers* Please Specify							

*Related cancers include colon, endometrial (uterine), ovarian, stomach, pancreas, ureter, kidney, biliary tract, brain, small intestine, and sebaceous gland tumors/cancers

Patient Signature _____ Date _____