BRENTVIEW MEDICAL
URGENT CARE & WALK-IN CLINIC

Medical history questionnaire • Confidential information

PATIENT INFORMATION

Name _____
Last First Middle
Today's Date _____ Birthdate _____ Age _____ Sex _____

Home Phone (_____) _____ Cell Phone (_____) _____ E-mail _____

Do we have permission to leave voice messages on your phone? Yes ❑ NO ❑

Address _____

City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ State _____

In Emergency - Contact Name _____ Phone (_____) _____

Employer _____ Business Phone (_____) _____

Address _____

City _____ State _____ Zip _____

Occupation _____

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Ethnicity ❑ Caucasian ❑ African American ❑ Asian ❑ Hispanic ❑ Middle Eastern ❑ Other _____

How did you learn about Brentview Medical? ❑ Google ❑ Yelp ❑ Friend ❑ Employer ❑ Physician

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Spouse/Responsible Party _____

Home Phone (_____) _____ E-mail _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ State _____

Cell Phone (_____) _____ Business Phone (_____) _____ Birthdate _____

INSURANCE INFORMATION

Do you have medical insurance? ❑ Yes ❑ No. If yes, please provide us with your card for a photocopy to be made.

Relationship to the insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insured's Name _____

Primary Insurance _____ Group # _____ Policy# Insurance Holder _____

Secondary Insurance _____ Group # _____ Policy# Insurance Holder _____

RELEASE ASSIGNMENT

I hereby authorize Brentview Medical or designee to disclose when requested by the above named / attached medical insurance carrier or its representative or any other insurance entity any and all information with respect to any illness, injury, medical history, or treatment and copies of all medical records. A Photo Static copy of this authorization shall be as effective and valid as the original.

Signed _____ Date _____

I hereby authorize payments and/or any medical benefits to Brentview Medical or designee for professional services rendered to me. I understand that I am financially responsible for charges not coved by this authorization. A photo static copy of this authorization shall be considered and effective as the original, although I have requested the physician to bill my medical insurance carrier on my behalf as a courtesy to me, I clearly understand that it is my responsibility to make sure that the bill is paid in a reasonable time. If for any reasons any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

Signed _____ Date _____

AUTHORIZATION FOR TREATMENT OF MINOR

I authorize Brentview Medical Inc. Urgent Care to treat _____

I hereby authorize payment to Brentview Medical Inc. Urgent Care, or its designee to treat my son or daughter, a minor child, in any manner deemed necessary to include examination, treatment and/or surgery if required. This authorization will remain in effect unless written notice terminating authorization is received by this office.
This information is correct and accurate to the best of my knowledge

Patient Signature _____ Date _____

BRENTVIEW MEDICAL
URGENT CARE & WALK-IN CLINIC

Please provide us with your preferred pharmacy to send your prescription(s) to:

Pharmacy Name:	
Address:	
City, State:	Zip:

PREFERRED PHARMACY INFORMATION

Name: _____ Date: _____

MEDICAL INFORMATION

Reason for visit _____

_____

PAST & PRESENT MEDICAL HISTORY: Please list all current medical problems (ie. High Blood Pressure, Diabetes, etc...)

Medical Problem	Year Diagnosed

PAST SURGICAL HISTORY

Surgery	Date

MEDICATIONS

Medication name	Dose	How often

ALLERGIES

	YES	NO
Are you sensitive/allergic to any medications?	❑	❑

If yes, please list: _____

If yes, what happens? _____

FAMILY HISTORY

	Living?	Age/Age of Death	Medical Problems/Cause of Death
Mother	❑ Yes ❑ No		
Father	❑ Yes ❑ No		
Brother(s)	❑ Yes ❑ No		
Sister(s)	❑ Yes ❑ No		
Children	❑ Yes ❑ No		

Do you have a family history (parents, siblings, children) of:

	YES	NO
Heart attack	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Stroke	❑	❑

If yes, which family member _____

SOCIAL HISTORY

Do you drink alcohol? ❑ YES ❑ NO

If yes, how often? _____

Have you ever smoked? ❑ YES ❑ NO

Do you smoke now? ❑ YES ❑ NO

If yes, how many packs per day? _____

Have you ever used recreational drugs? ❑ YES ❑ NO (Leave blank

Do you use recreational drugs now? ❑ YES ❑ NO if desired)

If yes, how often? _____

If yes, what type of drugs? _____

FEMALE HISTORY

Number of pregnancies you have had: _____

Number of abortions/miscarriages you have had: _____

Number of children you have: _____

Ages of your children: _____

Age at first menstruation: _____

How many days apart are your periods? _____

How long do your periods last? _____

Are you currently taking birth control pills? _____

Age at menopause: _____

PREVENTIVE MEDICINE: When was your last:

Colonoscopy _____

Mammogram _____

Pap smear _____

Breast exam _____

Prostate exam/PSA _____

Self testicular exam _____

Flu shot _____

Pneumonia vaccine _____

Cardiac stress test _____

MISCELLANEOUS

Birthplace: _____

How long you have lived in this area: _____

Have you ever had a job/hobby involving plastics, chemicals, sandblasting or industrial dusts? ❑ YES ❑ NO

If yes, please describe: _____

Have you traveled to any second or third world countries in the last 2 years? ❑ YES ❑ NO

Would you like to be tested for sexually transmitted diseases? ❑ YES ❑ NO

Name: _____ Date: _____

MEDICAL INFORMATION (continued)

REVIEW OF SYSTEMS

Please check all that apply to you currently:

	YES	NO
GENERAL		
Fever	☐	☐
Chills	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Unexplained weight loss	☐	☐
SKIN		
Rashes	☐	☐
Lumps	☐	☐
Color change	☐	☐
Dry skin	☐	☐
Hair loss	☐	☐
Irregular moles	☐	☐
HEAD		
Headaches	☐	☐
Dizziness	☐	☐
EYES		
Blurry vision / Double vision	☐	☐
Eye pain	☐	☐
EARS		
Difficulty hearing	☐	☐
Ear ringing	☐	☐
Ear pain	☐	☐
NOSE		
Runny nose / Stuffy nose	☐	☐
Nose bleeding	☐	☐
THROAT		
Sore throat	☐	☐
Difficulty swallowing	☐	☐
BREASTS		
Breast lumps	☐	☐
Breast tenderness	☐	☐
Nipple discharge	☐	☐
LUNGS		
Shortness of breath	☐	☐
Wheezing	☐	☐
Cough	☐	☐
Sputum production	☐	☐
What color _____		
Tuberculosis	☐	☐
Night sweats	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
CARDIOVASCULAR		
Chest pain	☐	☐
Palpitations	☐	☐
Heart murmur	☐	☐
Heart attack	☐	☐
Chest pain with walking	☐	☐
Shortness of breath with lying down	☐	☐
Shortness of breath with exercise	☐	☐
Leg swelling	☐	☐
GASTROINTESTINAL		
Abdominal pain	☐	☐
Heartburn	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐

	YES	NO
Abnormal stool	☐	☐
Blood in stool	☐	☐
Hepatitis	☐	☐
Yellow skin	☐	☐
Hemmorrhoids	☐	☐
URINARY		
Burning with urination	☐	☐
Increased frquency of urination	☐	☐
Urinary incontinence	☐	☐
Blood in Urine	☐	☐
Loss of urine with cough/laugh	☐	☐
Kidney stone	☐	☐
Urination at night	☐	☐
How many times per night? _____		
MALE REPRODUCTIVE		
Erectile dysfunction	☐	☐
Decreased libido	☐	☐
Genital sores	☐	☐
Testicular pain	☐	☐
Testicular lumps	☐	☐
FEMALE REPRODUCTIVE		
Genital sores	☐	☐
Vaginal itching	☐	☐
Vaginal discharge	☐	☐
Vaginal pain	☐	☐
Vaginal bleeding	☐	☐
Excessive body/facial hair	☐	☐
Breastfeeding	☐	☐
Pregnant	☐	☐
RHEUMATOLOGIC		
Joint pain	☐	☐
Joint stiffness	☐	☐
Weakness	☐	☐
Dry mouth	☐	☐
METABOLIC		
Excessive hunger	☐	☐
Excessive thirst	☐	☐
Excessive heat intolerance	☐	☐
Excessive cold intolerance	☐	☐
Tremor	☐	☐
Change in skin pigmentation	☐	☐
HEMATOLOGIC		
Bleeding problems	☐	☐
Easy bruising	☐	☐
Transfusion reactions	☐	☐
NEUROLOGIC		
Convulsions	☐	☐
Paralysis	☐	☐
Involuntary movements	☐	☐
Numbness	☐	☐
Epilepsy	☐	☐
Memory dificulty	☐	☐
Speech dificulty	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Is there anything not listed on this form that you would like to tell us?

_____

_____

BRENTVIEW MEDICAL
URGENT CARE & WALK-IN CLINIC

CREDIT CARD AUTHORIZATION

Dear Patient:

We will bill your insurance for all charges related to today's visit, and will make every effort to obtain payment from them . However, sometimes there will still be a balance on your account (i.e. deductible , co-insurance, or denials). For these instances, we like to have credit card information on file for the outstanding balances. We will notify you before we make any charges greater than $100 on your card. We will not notify you before charging the credit card if the balance is less than $100. Since you receive an explanation of benefits from your insurance describing what you owe, patients with a credit card authorization on file will not receive a paper bill in the mail. You always have the opportunity to discuss any concerns regarding the payment .

Sincerely,
Brentview Medical Physicians & Staff

I authorize Brentview Medical to charge outstanding balances on my account to the following credit card:

Visa ❑ Mastercard ❑ American Express ❑ Other: _____

Account number_____

Expiration_____ Security Code _____

Billing Address _____

Name on card (please print) _____

Signature _____ Date _____

****PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF THE CREDIT CARD ALONG WITH A PHOTO ID****

BRENTVIEW MEDICAL
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NOTICE OF PRIVACY PRACTICES

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

I. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials , if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

I. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work . We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, but not including psychotherapy notes. You must submit your request in writing to Maurice Darvish, M.D. 11661 San Vicente Blvd., Los Angeles, CA, 90049 or contact number 310 8200013.
4. You may ask us to amend your health information if you be li eve it is correct or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Maurice Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310 820 0013. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the department of Health and Human Services. To file a complaint with our practice, contact Maurice Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310 820 0013. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Maurice Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310 820 0013.

I hereby acknowledge that I have been presented with a copy of Brentview Medical's Notice of Privacy Practices.

Signature _____ Date _____

Printed Name _____