SHASTA REGIONAL MEDICAL GROUP

New Patient Packet

Thank you for choosing Shasta Regional Medical Group. Our office looks forward to serving you.

Prior to your appointment:

- Please complete the attached New Patient Paperwork. Be sure to read the Notice of Privacy Practices prior to completing the acknowledgement.
- You will receive a confirmation phone call the day before your appointment reminding you of your appointment time.
- If for any reason you are unable to keep your confirmed appointment, please call our office to reschedule your visit to better fit your needs.
- Note our telephone hours are 8:30 am to 5:00 pm M – F. Please call us at (530) 605-4260, one of our staff members will be happy to assist you.

The day of your appointment:

- There are additional steps to the registration process that must be competed at the office on your first visit. Please arrive 30 minutes early with your completed paperwork.
- Bring your insurance card to your appointment.
- Please be prepared to satisfy the co-payment required by your insurance company or the balance of any unmet deductible.

Thank you again for trusting Shasta Regional Medical Group with your healthcare needs.

Patient Information

Last Name: _____ First Name: _____

Address: _____

City, State, Zip: _____ Age: _____ Sex: [ ] F [ ] M

Email: _____ Date of Birth: _____

Phone: _____ Home Cell Social Security #: _____

Phone: _____ Home Cell Marital Status: [ ] Married [ ] Single [ ] Divorced

Employer: _____ Phone: _____

Race: American Indian or Alaska Native [ ] Asian [ ] Native Hawaiian or Other Pacific Islander [ ]
Black or African American [ ] White [ ] Hispanic [ ]
Other Race [ ] Do Not Wish to Report [ ]

Ethnicity: Hispanic or Latino [ ] Not Hispanic or Latino [ ] Do Not Wish to Report [ ]

Is your visit due to an injury? [ ] Yes [ ] No Date of Injury: _____

Where did the injury occur? [ ] Work [ ]Auto [ ] Home [ ] School [ ]Other: (Specify)_____

Guarantor Information

[ ] Same as Patient Employer: _____

Name: _____ Phone: _____ Home Cell

Address: _____ Phone: _____ Home Cell

_____ Social Security #: _____

City, State, Zip: _____ Date of Birth: _____

Primary Insurance

Insured Party: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security#: _____

Insurance Carrier: _____ Insured ID/Cert. #: _____

Claim Address: _____ Policy Group: _____

_____ Phone: _____

City, State, Zip: _____

Secondary Insurance

Insured Party: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security#: _____

Insurance Carrier: _____ Insured ID/Cert. #: _____

Claim Address: _____ Policy Group: _____

_____ Phone: _____

City, State, Zip: _____

Emergency Contacts

Name: _____ Relationship: _____

Address: _____ Phone: _____

_____ City, State, Zip: _____

Emergency Contacts

Name: _____ Relationship: _____

Address: _____ Phone: _____

_____ City, State, Zip: _____

I hereby authorize and consent to examination and treatment deemed necessary by the medical providers of Shasta Regional Medical Group. I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any cost incurred by Shasta Regional Medical Group in the collection of amounts due including, but not limited to, reasonable attorney's fees.

I hereby assign all medical and/or surgical benefits, including major benefits to which I am entitled including Medicare, private insurance and other health plans to Shasta Regional Medical Group. The assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I further authorize the release of all information necessary to secure payment.

I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party and any insurance company, reimbursing agency, third party or because of pending legal claims.

Responsible Party: _____ Date: _____

Patient Health History

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Sex: [ ] F [ ] M Height: _____ Weight: _____

Primary Language: _____ Do you need an interpreter? _____

Referred here by: [ ] Self [ ] Family [ ] Friend [ ] Doctor [ ] Other Health Professionals

Name of person making referral: _____

Past Medical History

List any other conditions you currently have or have had in the past that are not already noted:

_____

_____

_____

_____

_____

_____

List all drug allergies

Drug: _____

Type of Reaction: _____

Do we have your permission to access your prescription history? [ ] Yes [ ] No

List all medications you are currently taking. Include such items as aspirin, vitamins, laxative, calcium and other supplements.

Name of Medication	Dose. Include strength & quantity per day.	How long have you been taking this medication?

List all Surgeries

Type of Surgery	Reason for Surgery	Year

Social and Family History

Have you ever used tobacco products? [ ] Yes [ ] No

If yes what type: _____ Quantity/Amount: _____

If you have quit, how long ago? _____

Are you currently exposed to second hand smoke? [ ] Yes [ ] No

Has anyone ever told you to cut down on your drinking: [ ] Yes [ ] No

Do you use recreational drugs, such as marijuana, cocaine or methamphetamine? [ ] Yes [ ] No

If yes what type: _____ Quantity/Amount: _____

List all Family History

	Living	Deceased	Age	Medical Problem
Mother				
Father				
Sister				
Sister				
Brother				
Brother				
Grandfather (paternal)				
Grandfather (maternal)				
Grandmother (paternal)				
Grandmother (maternal)				
Other				
Other				

Systems Review

As your review the following list, please check any of those problems, which have significantly affected you.

CONSTITUTIONAL
- ☐ Recent weight gain Amount _____
- ☐ Recent weight loss Amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

EYES
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Itching eyes

EAR-NOSE-MOUTH-THROAT
- ☐ Bleeding gums
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Runny nose
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Difficulty in swallowing

CARDIOVASCULAR
- ☐ Pain in chest
- ☐ Heart murmurs
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure

MUSCULOSKELETAL
- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Muscle tenderness

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting blood or coffee ground like material
- ☐ Stomach pain relieved by food or milk
- ☐ Blood in stools
- ☐ Jaundice
- ☐ Persistent diarrhea
- ☐ Black stools
- ☐ Heartburn
- ☐ Increasing constipation

GENITOURINARY
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Rash/ulcers
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Cloudy urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to urinate
- ☐ Sexual difficulties
- ☐ Vaginal dryness

RESPIRATORY
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Wheezing
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing up blood

INTEGUMENTARY (SKIN AND/OR BREAST)
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Hair loss
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Color changes of hand or feet in the cold

NEUROLOGICAL
- ☐ Headaches
- ☐ Dizziness
- ☐ Night sweats
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness

HEMATOLOGIC/LYMPHATIC
- ☐ Blood transfusion? When _____
- ☐ Swollen glands
- ☐ Anemia
- ☐ Bleeding tendency

PSYCHIATRIC
- ☐ Excessive worries
- ☐ Easily losing temper
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty falling/staying asleep

ENDOCRINE
- ☐ Excessive thirst

ALLERGIC/IMMUNOLOGIC
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection