SALCIDO
FAMILY MEDICINE
FRANCISCO SALCIDO, MD - BOARD CERTIFIED
Your health is our family business.

PATIENT REGISTRATION

Date: _____

Patient's Full Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Number: _____

Sex: _____ Date of Birth: _____ Age: _____ Marital Status (circle): M S D W

Social Security #: _____ Email address: _____

Race: _____ Ethnic Group: _____ Language: _____

Employer: _____

Employer's Phone # _____

Name of Spouse/Insured/Guardian: _____ Phone#: _____

Date of Birth: _____ Social Security #: _____

In case of emergency, contact: _____

Phone #: _____

Payment is requested at the time of service. Your policy and coverage is a contract between you and your insurance company. You are responsible for payment of the medical services regardless of the status of your claim.

Salcido Family Clinic issues monthly statements. The balance due for each account is payable upon receipt, unless otherwise specified. A 1-1/2 % per month (18% APR) service charge may be assessed on all amounts not paid by the 30th of the following month.

The Applicant agrees that all invoices and monthly statements are conclusive and accurate in all respects unless the Applicant notifies Salcido Family Clinic in writing within fifteen (15) days of receipt of the invoices or statements.

The Applicant agrees that if an account becomes past due, this account and any other amounts due to the clinic may become immediately due and payable. The Applicant further agrees that if any portion of an account is referred to an attorney or collection agency for collection, the undersigned agrees to all costs of collection and/or litigation including attorney's fees. If suit is brought, venue can be laid in a jurisdiction designated by Salcido Family Clinic. The Applicant also agrees to pay all existing and future service charges while the account is assigned to an attorney or collection agency. A charge of $ 30.00 will be assessed for all returned checks. _____Patient Initials

_____

Responsible Party Signature Date

Health Questionnaire

Your Name:_____Date of Birth: _____

Today's Date: _____ Last Doctor Seen: _____

Chief Complaint (describe briefly the problem which brings you to the doctor): _____

_____

_____

Prior Operations with Dates: _____

_____

Prior Medical Problems: _____

_____

_____

Current Medications: _____

_____

Drug Allergies: [] None _____ please initial the blank

[] Listed as follows: _____

_____

Family History (please provide any history of family health problems which may be significant): _____

_____

_____

_____

Social History: [] Never smoked [] Quit smoking as of _____ [] Still smoke

If you smoked or still smoke, how much?_____

How much alcohol do you consume in an average week? _____

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

I, _____(printed name of patient or personal representative), acknowledge that Salcido Family Medicine has provided a written copy of its Notice of Privacy Practices for Protected Health Information to:

_____ Myself (or personal representative)

And _____ (name of any other person you would want your information released to).

_____ _____

Signature of Patient or Personal Representative Date

_____ _____ _____

Printed Name Phone #

Relationship to Patient

To be completed by Salcido Family Medicine

We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____

_____ _____

Signature of Employee Date

_____

Printed Name and Job Function