Aronson & Rosenthal, M.D. Inc,
824 E Carson St #102
Carson, CA 90745

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual can also request that confidential communication, whether telephone communication or correspondence, be directed to an alternate site such as the individual's office.

I wish to be contacted in the following manner (check all that apply):

___ Home Telephone ___________________

  ___ Leave message with detailed information.

  ___ Leave message with call back number only.

___ Cell Number ___________________

  ___ Leave message with detailed information.

  ___ Leave message with call back number only.

In our efforts to decrease the utilization of paper and printing, we ask you to use the patient portal to access your records and print as necessary. Our office will provide you with an account number to access the portal.

___ Email Address: ______________________________

I hereby consent to the release of Protected Health Information to the following individual(s): family/friends. I understand this authorization will be in effect until which time it is revoked.

1) ___________________________________

2) ___________________________________

3) ___________________________________

______________________________ ______________________________

Patient Signature Print Name

____

Date

My preferred pharmacy is ____

(Please provide name, address and phone number)

NEW PATIENT / UPDATE FORM - PLEASE PRINT

Updated:________

____

(Office use only)

Date:______________

Marital Status:________

Age:______________

Patient Name____
Last | First | M.I. | Pager/Cell Number | Home Telephone

Address____
Number | Apt. # | City | State | Zip

____
Social Security Number | Driver's License Number | Birthdate

Employer____
Name | Occupation | Business Telephone

Business Address____
Number | City | State | Zip

Spouse and/or Responsible Party____
Name | Relationship | Birthdate | Home Telephone

Address____
Number | Apt. # | City | State | Zip

Spouse's Employer____
Name | Occupation | Business Telephone

Business Address____
Number | City | State | Zip

In Case of Emergency____
Name | Relationship | Home Telephone

How did you find out about our office (Please select only one of the following):

Doctor (name): ______________________ Friend/Relative: ______________ Insurance Directory: ______________

Hospital: ______________________ Other (please specify): ______________________________

I plan to make payment of my medical expenses as follows:

____Cash / Check / Credit Card ____Medical Insurance Plan ____Medi-Cal ____Medi-Care

PCP Name & Phone Number: ____

Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Aronson & Rosenthal, M.D., Inc. I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or related to Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Acknowledgment of Receipt of Privacy Notice – I have been presented with a copy of this provider's Notice of Privacy Polices, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medial information, I agree to the disclosures named in the notice:______________________________

______________________________ ______________________________
Patient Signature | Signature of Responsible Party

Financial Responsibility Form

Date: ________________

Patient Name: ______________________________________

Practice Name: Aronson & Rosenthal, M.D., Inc.

As positive verification of my medical coverage cannot be made at this time, I agree to pay for any and all medical services I receive from the doctors and ancillary providers (laboratory fees, etc.) of this practice should my insurance company refuse to pay for my care.

Should my insurance carrier refuse payment (e.g., non-covered services, no benefits for preventive medicine visits, my failure to secure a referral from my primary care physician, the doctor is not a panel member of my medical group / IPA, etc.), I will pay for all services rendered upon receiving a written and/or verbal notice of the denial of my claim. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with the diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

In the event I do not pay for these or any other services provided to me when due, I agree to pay all costs associated with collection, including reasonable attorney fees (whether or not a law suit is commenced) as part of the collection process.

By my signature, I certify to having read the above statements and fully understanding my financial responsibility for ***all care rendered to me so long as I am a patient of this practice*** regardless of any changes in my insurance coverage.

____
Patient Signature (or responsible party if minor)

____
Witness

ARONSON & ROSENTHAL, M.D. INC,
824 E Carson St #102
Carson, CA 90745

Our Commitment to Quality Medical Care

Aronson & Rosenthal, M.D. are committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice.

We also understand that as a patient, you may at times have concerns or complaints about our services. We encourage you to communicate you concerns to us or our staff. **Please tell us if you have a complaint – we value your feedback.** Please tell us if you have questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. We appreciate being part of your health care team and *greatly* value your feedback.

If the above suggestions are not satisfactory, or for any reason, you may contact the Medical Board of California. We offer this NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800-633-2322 or www.mbc.ca.gov).

I have read and understand the options available to me in regards to my medical care. I understand that medical doctors are licensed and regulated by the Medical Board of California.

____

Patient/Patients Representative Signature

____

Patient/Patient Representative Name-Please Print

____

Date

HEALTH QUESTIONNAIRE

NAME:____ **DATE:**____________________________

WHAT IS THE REASON FOR TODAY'S VISIT? (PLEASE CIRCLE)
Pap Smear   Birth Control   Infection   Bleeding   Pregnancy   Other____________________________________

If you have a problem, how long have you had it? ____________________________
Have you consulted anyone before for this problem? Yes   No   Name of Physician: __________________________

GYN SYSTEM REVIEW

When was your last period?________________________How many days did it last?____________________________
How old were you when your periods started? ________ How often do they come?________ How often do they last?_______
Do you have: Bleeding between periods? Yes No   Bleeding after intercourse? Yes No   Painful periods? Yes No
Do you take medication for your period? If so, what medication:____
When was your last **PAP**? ____________ If you have ever had an **abnormal pap**, when and how were your treated?__________
______________________________When was your last **Mammogram**?____________________________________
Do you have a discharge? Yes   No If yes, please describe nature of discharge and prior treatments:_____________________
____
Do you take hormones? Yes No What kind and how often?____
Have you ever had a **Sexually Transmitted Disease**? **(Gonorrhea, Chlamydia, Herpes, Warts)**______________________________

BIRTH CONTROL: (If you are using or have used birth control, please fill in below)

METHOD	DATE	BRAND	DOSE	REASON FOR STOPPING
Pill				
IUD				
Tubal Ligation				
Other				

OBSTETRIC HISTORY: (If **less** than 65yrs old, please fill in below)

Deliveries:

Date	Wt. Gain	# of Months Pregnant	Length of Labor	Birth Weight	Sex of Baby	Complications

Miscarriages:

Date	Length of Pregnancy	Treatment	Complications

Terminations of Pregnancy:

Date	Length of Pregnancy	Treatment	Complications

YOUR PERSONAL PAST MEDICAL HISTORY: (Have **You** had any of the below? Please check and supply the year)

Abnormal Pap		Heart Disease		Pneumonia	
Anemia		High Blood Pressure		Gyn. Disease	
Asthma		Intestinal Problems		Blood Transfusion	
Cancer		Kidney Problems		Rheumatic Fever	
Diabetes		Liver Disease		Urinary Tract Inf.	
Epilepsy		Migraines		Stroke	
Gall Bladder Disease.		Phlebitis		Thyroid Problems	

Have you ever had a **Colonoscopy?** If so when______________ Have you ever had a **Bone Density Exam**? If so when______________

Have you recently had any of the following problems? (Please check all that apply)

Loss of Urine	______	Cough	______
Severe Headaches	______	Breathing Problems	______
Visual Changes	______	Chest Pain	______
Deafness	______	Leg Cramps	______
Nausea / Vomiting	______	Missed Periods	______
Trouble Swallowing	______	Weight Gain/Loss	______
Heartburn	______	Change in Hair Growth	______
Rectal Bleeding	______	Leakage from Nipples	______
Burning with Urination	______	Lump in Breast	______

FAMILY HISTORY (Does anyone in your family have any of the following? Please indicate who, i.e., father, mother, sister, brother... etc.)

Alcohol/Drug Abuse	______	High Blood Pressure	______
Psychiatric	______	Kidney Problems	______
Sugar Diabetes	______	Stroke	______
Glaucoma	______	Thyroid Problems	______
Heart Disease	______	Tuberculosis	______
Breast/Gyn Cancer	______	Colon/Rectal Disease	______
Epilepsy	______	Liver Disease	______

Your race/ethnicity is: (Please circle all that apply)
White Black Chinese Japanese Korean Cambodian Laotian Vietnamese Southeast Asia Filipino Hawaiian
Native American Middle Eastern Asian-East Indian Samoan Unknown Hispanic Other______

PREVIOUS SURGERY:

Date	Procedure	Hospital	Location	Surgeon	Complications

Have you ever been in the **HOSPITAL** for anything not yet discussed?

Date	Hospital	Locations	Reason	Duration	Complications

Please provide the name(s) of any prescription medications, over the counter medications, herbs and/or vitamins you are currently taking: ______

Are you ALLERGIC to any medications or LATEX? Yes No **If yes, please explain and include the name of the medication(s) and reaction**:
______

Do you **SMOKE**?	Yes	No	How many a day?	______
Do you **DRINK?**	Yes	No	How much a day?	______
Do you use **DRUGS?**	Yes	No	How often?	______

Do you have a history of anxiety, depression or mental illness? Yes No ______
Do you have a history of trauma or violence? Yes No ______
Do you have a special diet? Yes No ______

Are there any other matters you wish to discuss?______