Dr. Joan Sy Medical Corporation **REGISTRATION FORM (1 of 2)**

Patient Information (All fields are required)

Patient Name (First, MI, Last) as listed on insurance card:	Date of Birth	Age	Sex ○Male ○Female
Home Address	City	State	Zip

Home Phone	Work Phone	Cell Phone	Which phone number should we use for primary contact? (auto appt. reminders, results calls, messages, reminder calls) ○Home ○Work ○Cell Phone

Our office participates in the California Immunization Registry (CAIR). It is a secure database for schools/child care to access immunization history: ○ YES share my record ○ NO do not share my record	Email Address: (to receive automated messages from our office)

Secure Online Patient Portal Access: We encourage all our patients to participate in our Secure Patient Portal. Using your own secure password you can log into the online patient portal at any time from the comfort and privacy of your home or office. Please see reception or go to www.drjoansy.com to register. You can: View and request appointments, retrieve test results, view personal health information, update demographic data, view billing activity and make payments, request prescription refills and communicate with your doctor by sending and receiving secure messages. Only you may access your information.

We make every effort to accommodate our patients' preferences. Please indicate your primacy contact preference: ○Home Phone ○Work Phone ○Cell Phone ○Patient Portal ○Mail Please mark if you prefer : ○Do not place any automated phone calls or emails ○Block Portal Access

Social Security Number	Drivers License #	Marital Status ○Single ○Married ○Widowed ○Divorced

Employer Name	Employer Phone	Title

Race: (select one or more) or ☐ decline to disclose ○White ○American Indian ○Alaska Native ○Asian ○Black or African American ○Native Hawaiian or Other Pacific Islander	Ethnicity: or ☐ decline to disclose ○Cuban ○Hispanic or Latino ○Mexican, Mexican American, Chicano ○Non Hispanic or Latino ○Puerto Rican ○Unknown	Preferred Language or ☐ decline to disclose _____

Person Financially Responsible ☐ Same as above

Person financially responsible for account (TO RECEIVE STATEMENTS AND REMIT PAYMENT)	Relation to patient ○Son/Daughter ○Spouse ○Parent ○Other ○Self/Patient

Name (First, MI, Last)	Date of Birth

Mailing Address	City	State	Zip

Social Security Number (SSN)	Phone	Cell Phone

Employer Name

Employer Address	City	State	Zip

Primary Insurance Information

Insurance Carrier (i.e. Aetna, Blue Shield):	○Primary subscriber on plan ○Dependent/spouse on plan	○HMO ○POS ○PPO ○Medicare	Office Visit co-pay

Subscriber's Name (First, MI, Last)	Relationship to patient	Subscriber's Date of Birth	SSN

Subscriber's Address	City	State	Zip

Insurance Policy ID #:	Group #	Phone #

Insurance Carrier Claims Address	Effective Date of Policy

REGISTRATION FORM (2 of 2)

Print Patient Name:_____

Secondary Insurance Information (if applicable)

Insurance Carrier (i.e. Aetna, Blue Shield):			
Subscriber's Name	Relationship to patient	Date of Birth	SSN
Insurance Policy ID #:	Group #	Phone #	
Insurance Carrier Claims Address			Effective Date of Policy

Emergency Contact Information & Authorized persons to discuss your health information

Name	Phone 1	Phone 2	Relationship to Patient
○Yes, I allow or ○No, I do not allow this office to discuss my personal health and medical concerns with this person.			
Address	City	State	Zip
Name	Phone 1	Phone 2	Relationship to Patient
○Yes, I allow or ○No, I do not allow this office to discuss my personal health and medical concerns with this person.			
Address	City	State	Zip

Is there any additional information that you would like us to know about you?

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Signature of Patient: _____ Date: _____

Statement of Patient Financial Responsibility
and
Assignment of Benefits

Dr. Joan Sy Medical Corporation appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your balance in full. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at our office, mailed to the address on your statement, or on the patient portal.

I have read the above policy regarding my financial responsibility to Dr. Joan Sy Medical Corporation, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Dr. Joan Sy Medical Corporation. I agree to pay Dr. Joan Sy Medical Corporation the full and entire amount of bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Consent for Treatment
and
Authorization to Release Information

I hereby authorize Dr. Joan Sy Medical Corporation through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

I further authorize Dr. Joan Sy Medical Corporation, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Notice of Privacy Practices
Acknowledgement of Receipt of Privacy Practices

By signing this section you acknowledge receipt of the Dr. Joan Sy Medical Corporation's Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. A copy of our Privacy Practices is located in the Online Forms section of the portal. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy by contacting our office (949) 460-9200.

Medication History Authority

Our Electronic Medical Records (EMR) program can automatically import your medication history from third party sources (i.e. pharmacies). In order to transfer your current and past medications to our system we must have your authority.

By signing below I hereby certify Dr. Joan Sy Medical Corporation to transfer my Medication History.

Privacy forms are signed at the office's reception desk or on the patient portal.

Dr. Joan Sy Medical Corp.

HEALTH QUESTIONNAIRE

Name _____ Age _____ Date _____

PAST MEDICAL HISTORY:

Measles	NO	YES	Seizure	NO	YES	Peptic Ulcer	NO	YES
Mumps	NO	YES	Heart Disease	NO	YES	Kidney Disease	NO	YES
Chicken Pox	NO	YES	Hypertension	NO	YES	Diabetes	NO	YES
Polio	NO	YES	Tuberculosis	NO	YES	Thyroid Disease	NO	YES
Rheumatic Fever	NO	YES	Pneumonia	NO	YES	Venereal Disease	NO	YES
Scarlet Fever	NO	YES	Asthma	NO	YES	Anemia	NO	YES
Cancer	NO	YES	Hepatitis	NO	YES	Phlebitis/Blood Clot	NO	YES
Stroke	NO	YES	Liver Disease	NO	YES	Gout	NO	YES

Past Surgical History:

Any other significant illnesses, injuries or hospitalizations:

Year		Illness		Year		Surgery	
Year		Illness		Year		Surgery	
Year		Illness		Year		Surgery	
Year		Illness		Year		Surgery	

Allergies: (Medication & Food)

1.	Reaction		
2.	Reaction		
3.	Reaction		
4.	Reaction		

List Current Medications:

1		5	
2		6	
3		7	
4		8	

Immunizations:

Year	
	Influenza
	Tetanus
	Pneumococcol
	Other

Social History: *(*This field is required)*

Marital Status: S M Sep D W #_____Children

Occupation: Hrs/Wk:_____

Job Satisfaction: ○ Yes ○ No

***Smoker: ○ Yes ○ No** ***Pack per Day: #_____ Years: #_____**

Caffeine: ○ Yes ○ No Cups/Drinks per Day: #_____

Alcohol: (Kind, Amount, Frequency):

Recreational Drugs:

Advance Directive/Living Will: ○ Yes ○ No

Family History	If Living: Age	If Living: Health	If Deceased: Age (at death) & Cause		Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother/Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High Blood Pressure	No	Yes
					Stroke	No	Yes
Husband/Wife					Convulsions	No	Yes
Son/Daughter					Suicide	No	Yes
					Mental illness	No	Yes
					Bleeding tendency	No	Yes
					Gout or other arthritis	No	Yes
					Hereditary Defects	No	Yes

Dr. Joan Sy Medical Corp.

SYSTEM REVIEW

Print Name:_____

GENERAL		
Do you eat a well balanced diet?	No	Yes
Approx. weight now _____ 1 yr ago _____		
Maximum weight _____		
Exercise? Frequency / Wk _____		
Activities _____		
Any Sexual Concerns?	No	Yes
Year of Last Complete Physical		
Headaches	No	Yes
Glasses/contacts	No	Yes
Double vision	No	Yes
Eye disease or injury	No	Yes
Year last checked for glaucoma		
Itching eyes or nose/hay fever	No	Yes
Septal deviation / polyps (circle)	No	Yes
Nosebleeds	No	Yes
Sinus trouble	No	Yes
Ear disease	No	Yes
Impaired hearing	No	Yes
Ringing in the ears	No	Yes
Hoarseness	No	Yes
NECK		
Stiffness	No	Yes
Enlarged glands	No	Yes
Injury	No	Yes
RESPIRATORY		
Coughing up blood	No	Yes
Chronic cough (including Smoker's Cough)	No	Yes
Wheezing	No	Yes
Shortness of breath	No	Yes
How many blocks can you walk without having to stop to catch your breath? _____		
Night sweats	No	Yes
Skin test for tuberculosis	No	Yes
If yes, year tested and results _____		
Year of last chest x-ray _____		
CARDIOVASCULAR		
Chest pain or angina pectoris	No	Yes
Shortness of breath when lying fiat	No	Yes
Pain in legs on walking, relieved by rest	No	Yes
Varicose veins	No	Yes
Ankles often badly swollen	No	Yes
Heart murmur	No	Yes
Rapid, hard or skipped heart beats	No	Yes
Year of last EKG? _____		
Have you had a stress treadmill?	No	Yes
GASTROINTESTINAL		
Change in appetite	No	Yes
Heartburn or indigestion	No	Yes
Sour taste in throat or mouth	No	Yes
Intolerance to spicy foods, coffee or alcohol	No	Yes
Ever vomited blood?	No	Yes
Do foods stick in throat?	No	Yes
Gallbladder trouble/ intol. to greasy foods	No	Yes
Intolerance to milk products	No	Yes
Hiatal Hernia	No	Yes
Pancreatitis	No	Yes
Do you often vomit?	No	Yes
Crampy abdominal pain	No	Yes
Chronic constipation	No	Yes
Frequent diarrhea	No	Yes
Change in bowel habits	No	Yes
Bloody or black bowel movements	No	Yes
Hemorrhoids or piles	No	Yes

GENITORURINARY		
Loss of urine when cough or sneeze	No	Yes
Kidney or bladder infection (circle)	No	Yes
Burning or frequent urination (circle)	No	Yes
Feeling must go immediately?	No	Yes
Do you have to get up at night to urinate? #	No	Yes
Blood in urine	No	Yes
Kidney stones	No	Yes
Swelling of hands and feet	No	Yes
Difficulty starting urination?	No	Yes
Decrease in strength of stream	No	Yes
Penile Discharge	No	Yes
Date of last prostate exam _____		
MUSCULOSKELETAL		
Significant Arthritis / Joint pain	No	Yes
Low back pain	No	Yes
Muscle weakness or tenderness	No	Yes
Difficulty walking	No	Yes
Fractures (list)	No	Yes
SKIN		
Skin disorders (list)	No	Yes
NEUROLGIC /PSYCHIATRIC		
Numbness / paralysis (circle)	No	Yes
Fainting spells	No	Yes
Memory loss	No	Yes
Dizziness	No	Yes
Do you have trouble sleeping?	No	Yes
Are you often depressed?	No	Yes
Are you often anxious or nervous?	No	Yes
Do you ever wish you were dead and away from it all?	No	Yes
Do you often worry?	No	Yes
Have you ever been under psychiatric care?	No	Yes
HEMATOLOGIC		
Excessive bleeding or abnormal bruising	No	Yes
ENDOCRINE		
Crave large amounts of fluids	No	Yes
Intolerance to slightly warm rooms	No	Yes
Intolerance to slightly cool rooms	No	Yes
Change in textures of hair or skin	No	Yes
Change in voice (as an adult)	No	Yes
Hair loss	No	Yes
Diminished sex drive	No	Yes
Darkening of skin	No	Yes
GYNECOLOGICAL (This section for women only)		
Age when periods started _____ Years old		
Frequency: every _____ Days; Last Period _____		
Are they abnormal or irregular?	No	Yes
Menopausal Age _____	No	Yes
Number of pregnancies _____ C/sections _____		
Term deliveries _____ Premature _____		
Miscarriages _____ Abortions _____		
Pelvic inflammatory disease	No	Yes
Pain with intercourse	No	Yes
Date of last cancer smear _____ Normal?	No	Yes
Breast masses, lumps, cyst (circle)	No	Yes
Nipple discharge	No	Yes
Skin discoloration / dimpling	No	Yes
Family history of breast cancer	No	Yes
Date of last mammogram	No	Yes
Did someone other than the patient help fill this out?	No	Yes

Patient Signature: _____

Reviewing Physician: _____