LISA BRAND MD., F.A.C.S
4542 LAS POSAS RD, SUITE D
CAMARILLO, CA 93010
PHONE (805)322-8490 FAX (805)586-8066

Camarillo
GENERAL SURGERY

Patient Demographic Form:

Please Print

Last name: _______________________First name: _________________ Nickname: __________
Date of birth: ______/_______/_________ Social Security Number: ______-______-________
Sex: Male/ Female Gender Identity:_______________ Preferred Pronoun:________________
Email address: ____

Address:

Home Address: ____
City: ______________________________________ State: _____ Zip Code: _________________
Cell phone number: _____________________________ Home: ____________________________
Preferred method of contact: (place an X on one) Phone Email Letter

Marital Status: Married_____ Single____ Divorced: _____ Widowed: ____ Separated: _______
Language (other than English): ___________________________________

Emergency contact:

Name: ____ Relation to patient: __________
Phone: _____________________________

How did you hear about us: ____
Primary Care Doctor: ____

Insurance Information

Ins Co Name: ________________________ Policy/ Member ID #: _________________________
Patient Relation to Insured: Self: ________ Spouse: _________ Child: ______ Other: _______
Policy Holder: ____ Sex: ______________
Address: ___________________________________ City: _________________________
Employer: ____

Secondary Insurance

Ins Co Name: ________________________ Policy/ Member ID #: _________________________
Patient Relation to Insured: Self: ________ Spouse: _________ Child: ______ Other: _______
Policy Holder: ____ Sex: ______________
Address: ___________________________________ City: _________________________
Employer: ____

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Your answers on this form will help your clinician understand your medical concerns and conditions better. Best estimates are fine if you cannot remember specific details. *Please fill out the form completely for what applies to you.*

Advanced directive type: *please check the box that applies to you.*
☐ No advanced directive ☐ Living Will ☐ Durable Power of Attorney, name: ______________________
☐ **Do Not Resuscitate**

Reason for visit:____

____

Immunizations:
Are you up to date on immunization ☐ Yes ☐ No

Women's Health:
Your age of first delivery of child: _____________ Age of first menses: __________________
☐ Pre menopause ☐ Post menopause Age of menopause: ___________

Allergies or Reactions to medications:

Allergic to:	Reaction or Side Effect:

☐ **No known drug allergies**

Medications: Prescription and non-prescription medicines vitamins, and birth control pills.
☐ **Consent** to pull medication records from pharmacy.

☐ **Not currently taking medications**

Personal Medical History:
Please indicate whether you have had any of the following medical problems:

☐ Alcoholism
☐ Bleeding problems
☐ Blood Disorder
☐ Cancer(malignancy)type: ___________
☐ Congenital heart disease
☐ Depression/ Anxiety
☐ Diabetes: ☐ type I ☐ type II
☐ High cholesterol
☐ Hypertension (high blood pressure)
☐ Hypotension (low blood pressure)
☐ Myocardial Infraction (heart attack)
☐ Stroke
☐ Thyroid problem

Other:____

____

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Surgical History:

To the best of your knowledge please list the surgical history and dates.

Operation	Date

☐ **No operation/ surgical history.**

Family History:

Significant family history: ____

____

____

History of family cancer ☐ Yes☐ No. If yes, type: ______________________________

Social History:

Tobacco Use	Alcohol Use	
Cigarettes Current: smoker: ☐ yes ☐ no ☐ Never ☐ Quit date: ________________ Packs/day_______ # of years ____________ **Other tobacco** ☐ cigar ☐ chew ☐ pipe ☐ snuff Are you interested in quitting? ☐ yes ☐ no **Secondhand Smoke:** Smoke exposure in the home? ☐ yes ☐ no Where you exposed when you were a child? ☐ yes ☐ no	Do you drink alcohol? ☐ yes ☐ no # of drinks/week **Drug use** Do you use any recreational drugs? ☐ yes ☐ no If yes, indicate what type:___________________________ Have you ever used needles? ☐ yes ☐ no **Marijuana** Do you used marijuana? ☐ yes ☐ no ☐ Inhalant ☐ Pen ☐ Edible	Is alcohol use a concern? ☐ yes ☐ no

Pharmacy Information:

Pharmacy name: ____

Pharmacy location (cross streets or streets. We do not need the exact address): _________________________

Preferred imaging center: ____

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Review of symptoms that you are experiencing today: please indicate either yes or no by placing an X in the box provided.

Constitutional

Y N
☐ ☐ Recent fever or chills
☐ ☐ Recent chills
☐ ☐ Unexplained fever fatigue/ weakness

Eyes

Y N
☐ ☐ Blurred vison
☐ ☐ Eye pain
☐ ☐ Eye drainage

Cardiovascular

Y N
☐ ☐ Chest pains/discomfort
☐ ☐ Palpitations

Respiratory

Y N
☐ ☐ Chronic cough
☐ ☐ Wheezing
☐ ☐ Acute Cough
☐ ☐ Shortness of breath

Gastrointestinal

Y N
☐ ☐ Heartburn
☐ ☐ Acid Reflux
☐ ☐ Nausea/ vomiting
☐ ☐ Diarrhea

Genitourinary

Y N
☐ ☐ Painful urination
☐ ☐ Nighttime Urination
☐ ☐ Frequent Urination

Musculoskeletal

Y N
☐ ☐ Muscle pain
☐ ☐ Joint Pain
☐ ☐ Joint Stiffness
☐ ☐ Recent back pain

Skin

Y N
☐ ☐ Rashes
☐ ☐ Itching
☐ ☐ History of skin cancer

Neurological

Y N
☐ ☐ Headaches
☐ ☐ Memory Loss
☐ ☐ Fainting
☐ ☐ Dizziness
☐ ☐ Numbness

Psychiatric

Y N
☐ ☐ Anxiety
☐ ☐ Sleep problems
☐ ☐ Depression

Blood/ Lymphatic

Y N
☐ ☐ Unexplained lumps/nodes
☐ ☐ Excessive bleeding.
☐ ☐ Easy bruising

Allergy/Immunological

Y N
☐ ☐ Seasonal Allergies
☐ ☐ Altered Immune System

Ears/ Mouth

Y N
☐ ☐ Difficulty hearing
☐ ☐ Hoarseness or voice change
☐ ☐ Ear pain

I authorize Camarillo General Surgery to provide medical diagnosis, treatment, and care to myself and or my child. I authorize Camarillo General Surgery to bill my insurance for services rendered. Any amount not by insurance will be my responsibility. I authorize the release of medical information for treatment, payment and health care purposes as defined in Camarillo General Surgery's Notice of Privacy Practices.

Patient name *(please print):* ____________________

Signature: ____________________

Date: ____________________

Relation to minor (if applicable): ____________________

Camarillo GENERAL SURGERY

Office and Financial Policies

Please read this form and **initial** and **sign** in the space provided. Please let us know if you have any questions. A copy will be provided upon request.
Thank you for choosing Camarillo General Surgery. We are committed to building a respectful relationship with you and a clear understanding of our Office & Financial Policies is important for our professional relationship in order to serve you better.

_____ **Copays:** Copays are due at time of service and will not be billed.

_____ **Late Arrival Policy:** If you are running late for an appointment, we ask that you call the office to let us know. Please be advised that calling does not guarantee that you will be seen and may result in a longer wait. To keep on task with our schedule and provide quality care to the other scheduled visits, we are unable to see any patient that is more than 15 minutes late.

_____ **Cancelation/No-Show Policy:** Patients who fail to show for their scheduled appointment and did not notify the office within 24 hrs of their scheduled appointment time will be subject to a "No Show/Cancellation" fee of $50.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.

_____ **Surgery Cancelation Policy:** Patients who fail to show up for or cancel their scheduled surgery within 7 days will be charged a fee of $200.00. It is the patient's responsibility to complete all preoperative labs and clearance exams or procedures prior to 7 days before the scheduled surgery date, or your surgery may be canceled and you will be subject to the cancellation fee. If any surgery is cancelled by the physician or office and needs to be rescheduled, the patient is not subject to this charge. Patients will not be charged this fee if their Insurance denies authorization for their surgery.

***This no Show/Cancellation fee is not covered by insurance and is therefore the sole responsibility of the patient. ***

____ **Forms Policy**: A $20 fee will be charged for all requests for forms, notes, and disability paperwork outside of the standard postoperative work/school excuse note.

____ **Respect Policy**: Camarillo General Surgery recognizes that each patient is an individual with unique health care needs. It is the expectation of all employees that care of our patients is provided in a manner that is considerate and respectful of each patient's personal dignity. Accordingly, Camarillo General Surgery expects each patient to treat its provider and staff in a manner that is considerate and respectful. We reserve the right to refuse service to anyone who does not honor this policy.

I have read and initialed the above policies and agree to them.
Patient Name _______________________________________
Signature ____ **Date**_____________________

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AUTHORIZE FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

I hereby authorize:

Camarillo General Surgery
4542 Las Posas Rd. Ste D
Camarillo, CA 93010
P: 805-322-8490
F: 805-586-8066

To release information regarding my or my child's (if patient is a minor) medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider my hold, by means of mail, fax, or other electronic methods.

From:

____
Physician/Healthcare Facility

____
Address

____
City ST Zip

____
Phone Fax

The medical records released will only be used for the purpose of what you are being seen for at Camarillo General Surgery.

PATIENT NAME: ________________________________ D.O.B.______________ SEX: M____ F____

SIGNATURE: ______________________________________ DATE: ____________________________

RELATIONSHIP TO MINOR (IF APPLICABLE) ____

Notice of Health Information Privacy Practices

This notice describes how information about you may be used and disclosed, and how you may get access to this information. Please review it carefully.

At our office, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 4/14/03, and applies to all protected health information as defined by federal regulations.

Each time you visit our office, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical records, serves as a:

- Basis for planning your care and treatment,
- Means of communication among health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer receive information required for billing,
- A source of information for public health officials, when/if they require access to our records,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we

Understanding what is in your record and how your health information is used, helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and to make an informed decisions when authorizing disclosure to others.

Although your health record is the physical property of our office., the information belongs to you. You have the right to:

- Obtain a copy of this Notice of Information Practices upon request,
- Inspect and copy your health record, and we may charge you a reasonable fee for copies.
- Request an amendment to your medical record in writing. We may, or may not make a change in your record, however we will include your statement in your file. Either way, we will not remove or alter earlier documents.
- Obtain an accounting of the disclosures of your health information.
- Request communications of your health information by alternative means or at an alternative location.
- Request a restriction on certain uses and disclosures of your information in writing. and
- Revoke your authorization to use or disclose health information except to the extent that action has already

We are required to:

- Maintain the privacy of your health information,
- Advise you of our privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or location.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide you with a revised notice. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

If you believe your privacy rights have been violated, you can file a complaint with the Office for Civil Rights, U. S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201.

There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The law provides use or disclosure of your health information for treatment, payment and operations. An example of treatment would be a review of your file by other physicians involved in your care. An example of payment would be to provide a description of services performed for billing. An example of operations would be to allow our staff access to your records for authorization for services, or leaving a message regarding scheduling at the contact number you have provided to our office..

Business Associates: There are some services provided in our organization through agreements with business associates. Examples include physician services in the radiology department, certain laboratory tests, services provided by a copy service when making copies of your health record and services provided by an outside transcription service. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to the institution or agents thereof, health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

☐ No one is authorized to pick-up or discuss my medical information other than myself. To include x-ray results, scheduling surgery, appointments, etc.

Patient Signature: ______________________________ Date: ________________

Print Name: ____

If signing as parent or guardian, Patient Name: ________________________ DOB: __________