JACKSON MEDICAL GROUP, INC.

PATIENT DEMOGRAPHICS

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender	Date of Birth	Marital Status (circle)
☐ *M* ☐ *F*		☐ *Divorced* ☐ *Married* ☐ *Separated* ☐ *Single* ☐ *Widowed* ☐ *Other*

Preferred Language	Race	Ethnicity (circle)
☐ *English* ☐ *Spanish*	☐ Asian ☐ Black ☐ White ☐ Other:	☐ *Hispanic* ☐ *Not Hispanic* ☐ *Unknown*

Mailing Address	Apt / Lot	City / State	Zip Code	Phone #

Email Address	How did you hear about us?	Referring Physician

Responsible Party

Check if same as: ☐ Patient

Last Name	First Name	Gender	Date of Birth	What is Patient's Relationship to Responsible Party?
		☐ *M* ☐ *F*		

Mailing Address	Apt / Lot	City / State	Zip Code	Phone #

Employer Information

Employer	Address	City / State	Zip Code

Insurance Information

Check if: ☐ Self Pay

Check if same as: ☐ Responsible Party			Check if same as: ☐ Responsible Party		
Subscriber / Member Name		Date of Birth	Subscriber / Member Name		Date of Birth
What is Patient's Relationship to Subscriber?		Gender ☐ *M* ☐ *F*	What is Patient's Relationship to Subscriber?		Gender ☐ *M* ☐ *F*
Primary Insurance Company		Begin Date	Secondary Insurance Company		Begin Date
Insurance Mailing Address	City / State	Zip Code	Insurance Mailing Address	City / State	Zip Code
Subscriber / Member #	Group #		Subscriber / Member #	Group #	

Patient Signature _____ Date _____ Print Name _____

JACKSON
MEDICAL GROUP, INC.

☐ **Pacific Oaks Office**
220 Pacific Oaks Rd Ste 2
Goleta, CA 93117
P: (805) 979-4646
F: (805) 685-2800

☐ **Hollister Office**
5333 Hollister Ave Ste 110
Goleta, CA 93111
P: (805) 683-0055
F: (805) 683-0149

☐ **Santa Barbara Office**
517 W Junipero St
Santa Barbara, CA 93105
P: (805) 682-8844
F: (805) 682-6499

☐ **Carpinteria Office**
5565 Carpinteria Ave Ste 4
Carpinteria, CA 93013
P: (805) 684-4119
F: (805) 566-2181

HOW ARE WE AUTHORIZED TO CONTACT YOU?		
☐ **RESIDENCE TELEPHONE**	☐ **WORK TELEPHONE**	☐ **CELLULAR TELEPHONE**
☐ **NUMBER:**	☐ **NUMBER:**	☐ **NUMBER:**
☐ **Leave call back number only**	☐ **Leave call back number only**	☐ **Leave call back number only**
☐ **Okay to leave detailed message with person**	☐ **Okay to leave detailed message with person**	☐ **Okay to leave detailed message with person**
☐ **Okay to leave detailed message on Answering Machine**	☐ **Okay to leave detailed message on Answering Machine**	☐ **Okay to leave detailed message on Answering Machine**
Other specifications/restrictions:		

Authorization for Release (Disclosure or Use) of Protected Health Information

1. Name, specific relationship and contact number of relative or friend authorized to receive released medical information on behalf of patient:

2. Description of information to be released:

3. Restrictions regarding released information:

This authorization may be revoked in writing at any time. Released information is no longer under our control and further disclosures may not be prohibited by federal privacy regulations.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

If guardian, print name & relationship: _____

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Notice of Privacy Practices

The medical practices of **Jackson Medical Group, Inc.** and associates have implemented policies to protect the privacy of your medical records. The following is a description of how we manage your individual medical information.

A written or electronic record of your health care is constructed at each encounter. This record may include your symptoms, examination, test results, treatment plan, outside records, and other medical information. Transcription services are often utilized. Our employees access this record only for legitimate medical or business reasons. All employees are trained in patient confidentiality procedures. Safeguards are taken to prevent the unintended disclosure of your health care information during creation, utilization, storage, and destruction. Anything that identifies a patient with their individual medical care is protected.

By law your medical information may be shared (without your authorization) for:

1. **Treatment** – To facilitate your care we may share information with consulting physicians, health care entities, Public Health and legal entities, and on call physicians. For example, we will send a consulting physician relevant chart notes.
2. **Payment** – To obtain payment from third parties, we will provide requested information to insurers. For example, your insurance company may request chart notes before payment.
3. **Healthcare Operations** – We may supply medical information for the purposes of quality control, business activities, and other health care operations. For example, we may need to call your home to remind you of an appointment.

Any other disclosures of your medical record will require your written or expressed authorization.
This even includes disclosures to non-dependent family members. All disclosures of your record requiring authorization will be documented.

You have certain rights regarding your individual record including the right to:

1. To inspect and copy your record and its disclosures. Certain conditions like legal actions may restrict this right. Written 30-day notice is required prior to inspection, and a supervision fee may be required.
2. To request restrictions and amendments regarding your record. Your request must be in writing, specific, and time sensitive. We will accept or deny your request in writing. Special handling creates a burden for us and we may charge a fee.
3. To file written complaints concerning your record to our office manager.
4. To revoke in writing any prior disclosure authorizations at any time.
5. To request in writing that we communicate with you in alternative methods.

Some of the specific actions we have taken to protect your privacy include:

1. All employees with access to your medical record are trained to protect your privacy. Privacy training includes protection both in the office and in the community.
2. Contracted and business associates with access to your medical record have been instructed regarding the confidential handling of your record and have signed agreements to protect your privacy.
3. Your medical record and demographic information is never knowingly sold or otherwise released for non-medical or commercial purposes.

If there are any parts of this privacy policy you do not understand, please consult our office manager. We are happy to address your questions and concerns. This notice becomes effective on August 1, 2015. A written copy of this notice is available upon request.

Your signature is acknowledgment that our privacy policy has been made available to you:

Print Name: _____

Patient Signature: _____ Date: _____

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Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance and by your insurance company. We accept Visa, Mastercard, American Express and Discover.

2. Keep in mind your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim/s if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive payment from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits and we will bill them. If a co-pay is applicable, it will be due at the time of your visit.

4. If you are insured by a plan with which Jackson Medical Group does not contract with, we will prepare and send the claim to you. This means the insurer will send the payment directly to you.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided by Jackson Medical Group. You are responsible for any balance due.

I have read and I understand Jackson Medical Group's financial policy and I agree to be bound by its terms. I also understand agree that such terms may be amended by the practice from time to time.

_____

Signature of Patient (or responsible party, if minor **Date**

_____

Please print name of patient

JACKSON
MEDICAL GROUP, INC.

New Patient

Adult Health Questionnaire

Patient Name: _____

Date of Birth: _____

1. What symptoms, medical problems and concerns have prompted this visit today?

   _____
   _____
   _____
   _____
   _____
   _____
   _____

2. What expectations do you have and what goals do you hope to accomplish by the conclusion of this office visit?

   _____
   _____
   _____
   _____
   _____
   _____
   _____

3. Please list any conditions or chronic illnesses you have (such as high blood pressure, diabetes, etc): ☐ None

   _____
   _____
   _____
   _____
   _____
   _____
   _____

4. Please list allergies to food or medications:

   ☐None

   _____
   _____
   _____
   _____
   _____
   _____

5. Please list all surgeries including the approximate date or age each was performed:
   ☐ None

   _____
   _____
   _____
   _____
   _____
   _____

6. Do you presently smoke cigarettes? ☐ Yes ☐ No
7. Have you ever been a smoker? If so, when did you quit? ☐ Yes ☐ No
8. How much alcohol do you consume in a week?
9. Do you have a history of alcoholism or chemical dependency? ☐ Yes ☐ No
10. When did you have your last complete physical examination or checkup?
11. When did you have your last tetanus shot?

    Did it include vaccination against pertussis (whooping cough)? ☐ Yes ☐ No
12. Have you ever had a sigmoidoscopy? (Screening test for colon polyps and tumors)?

    ☐ Yes ☐ No If so, when? _____
13. Have you ever had a total colonoscopy? ☐ Yes ☐ No

    If so, when? _____
14. When did you have your last mammogram?
15. Have you ever had the Pneumovax or pneumonia vaccine? ☐ Yes ☐ No

    If so, when? _____

16. Have you ever had the shingles (Zostavax) vaccine? ☐ Yes ☐ No

    If so, when? _____

17. If you are diabetic, when did you have your last eye examination?
18. Have you ever had a bone mineral density (osteoporosis/DEXA) test? ☐ Yes ☐ No

    If so, when? _____

19. Have you ever had a treadmill test/cardiac exercise test to screen for coronary artery disease? ☐ Yes ☐ No
20. Have you filled out an "advanced directive" for advanced planning? ☐ Yes ☐ No
21. Is there any other information you feel we should know concerning you past health? ☐ Yes ☐ No
22. If so, please elaborate

23. Is ther any family history of colon cancer, breast cancer, diabetes, ovarian cancer or early onset heart attacks, coronary disease in the family? If so, indicate YES and discuss with the provider. ☐ Yes ☐ No
24. Describe your exercise program:

25. Do you have a personal problem you wish to discuss with the physician? ☐ Yes ☐ No

_____ _____

Signature Date

JACKSON
MEDICAL GROUP, INC.

Please list all currently prescribed medications (including those taken for chronic conditions, etc.) as well as those taken regularly without a prescription (such as aspirin, antacids, vitamins, allergy pills, "natural" products, etc.)

MEDICATION	DOSAGE	HOW TAKEN For example: 1 tablet twice a day	MEDICAL PROBLEM

Signature

Date

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed or hopeless	○	○	○	○

1. How often do you have a drink containing alcohol?

□ Never
□ Monthly or less
□ 2-4 times a month
□ 2-3 times a week
□ 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

□ 0
□ 1 or 2
□ 3 to 4
□ 5 to 6
□ 7 to 9
□ 10 or more

3. How often do you have six or more drinks on one occasion?

□ Never
□ Less than monthly
□ Monthly
□ Weekly
□ Daily or almost daily

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

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

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my 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 may hold, by means of mail, fax, or other electronic methods.

To: _____
Name

_____
Address

_____
City, State, Zip Code

The medical information will be used for the following purpose: _____

This authorization is:

☐ **ALL** health information to pertaining to the last two years of my medical history, as well as treatment received. {*OPTIONAL*}
EXCEPT (*describe*): _____

I also consent to the release of the following records:

Drug/Alcohol/Substance Abuse _____ {initial}
Psychiatric/Mental Health _____ {initial}
Tests for Antibodies to HIV _____ {initial}
HIV Diagnosis/Treatment _____ {initial}
Genetic Information _____ {initial}

☐ **ONLY** the following medical records or types of health information, include given dates (explain):

_____

DURATION: This authorization shall be effective immediately and remain in effect until: _____

RESRICTIONS:

Permissions for further use of disclosure of this medical information is not granted unless another authorization is obtained from or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____
Signature of patient or legal/personal representative

_____
Relationship if other than patient

_____
Patients Name (PRINT)

_____
Date

_____
Patients Social Security Number

_____
Patients Date of Birth

_____
Witness Name

_____
Witness Signature