PATRIOT FAMILY MEDICINE

Patient Registration Form

Name | SSN | Gender | Sex | Marital Status

Date of Birth | Primary Phone | Secondary Phone | Email

Street Address | City | State | Zip

Employer/Occupation | Employer Phone | Employer Address

Primary Insurance | Policy Holder Name / DOB | ID# | Group # | Provider Services #

Secondary Insurance | Policy Holder Name / DOB | ID# | Group # | Provider Services #

EMERGENCY CONTACT - Person to be contacted in case of emergency or if we cannot reach you	
Name	
Address	
Phone Number	
Relationship	
Please check box for permission to share any necessary medical information with this person	☐

Signature | Date

Patriot Family Medicine
885 Patriot Dr Unit F, Moorpark, CA 93021
Phone 805.334.1371 Fax 805.823.6201
www.patriotfamilymedicine.com

PATRIOT FAMILY MEDICINE

Notice of Privacy Practices Acknowledgement Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- **How this office will use and disclose your protected health information.**
- **Your privacy rights with regard to your protected health information.**
- **This office's obligations concerning the use and disclosure of your protected health information.**

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

_____ _____

Patient or Patient Representative Signature Date

_____ _____

Patient or Patient Representative Printed Name Date

Patriot Family Medicine
885 Patriot Dr Unit F, Moorpark, CA 93021 Phone 805.334.1371 Fax 805.823.6201
www.patriotfamilymedicine.com

PATRIOT FAMILY MEDICINE

Confirmation of Eligibility

Patient Name _____

Patient Date of Birth _____

Social Security Number _____

I _____ (patient name) am eligible and have active Medical/Health coverage for services rendered with the following insurance company _____ (name of the insurance company). My insurance is in good standing and active as of the following date _____ (month)_____(day)_____(year). I have decided to have medical care and services provided by Patriot Family Medicine and understand if the information I have provided is not correct or true, I or the person responsible for all medical charges will be responsible for full payment within **21 days** of initially receiving notice or a bill from Patriot Family Medicine.

Signature of Patient or Responsible Party _____

Date _____

*If patient is a minor, I authorize I am the parent/guardian _____ (initials)

PATRIOT FAMILY MEDICINE

Consent to Use Telemedicine

Patient Name_____ Doctor's Name **Dr. Fadel Abdulhai**

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require and in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality for my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and

will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable image or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California Law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in the Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Patient Signature Date

_____

Patient Printed Name

PATRIOT FAMILY MEDICINE

About Telemedicine

WHAT IS TELEMEDICINE?

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient self-management and caregiver support of the patient. Telemedicine services often provides a broader access to medical care, eliminates transportation concerns, and increases comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to-computer exchanges), or it may transfer medical information through the use of store-and-forwarding technology (for example, emails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

I read and understand the information provided in this document. I discussed any question I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Patient Signature Date

_____

Patient Printed Name

Patriot Family Medicine
885 Patriot Dr Unit F, Moorpark, CA 93021 Phone 805.334.1371 Fax 805.823.6201
www.patriotfamilymedicine.com

PATRIOT FAMILY MEDICINE

Patient History Form

Office Use Only
Today's Date:
Height:
Weight:
BP:
Pulse:
SpO2:
Temp:
CC:
Pharmacy:
Lab:

Name DOB

Race / Ethnicity Birthplace

Occupation Marital Status

Last Doctor Visit / Last Doctor or Healthcare Provider

Past Medical Problems	Past Surgeries or Procedures	Allergies & your reaction: (ex/ penicillin, adhesives, dust, grasses)
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

Please list current medications (prescription or over the counter) include name, strength, dose and frequency (ex: metoprolol succinate 10mg 1 tablet twice a day)
1.
2.
3.
4.
5.
6.
7.

** If you take more medications, please provide the office with a complete medication list **

Patriot Family Medicine
885 Patriot Dr Unit F, Moorpark, CA 93021 Phone 805.334.1371 Fax 805.823.6201
www.patriotfamilymedicine.com

PATRIOT FAMILY MEDICINE

Do you drink alcohol? If yes, how many drinks / how often?	
Do you use recreational drugs? If yes, please list which ones / how often.	
Tobacco use / Vaping (current / former / # of packs / how frequently?)	
Caffeine Use (coffee, tea, soda) - if yes, how much / how often?	
How many hours do you sleep at night?	
Do you exercise? How often? Which activities?	
Have you received all recommended vaccines?	
Are you sexually active? Have you had an STD test? Do you use protection?	
Females - Last menstrual cycle / 1st day of last period, number of pregnancies, number of births	
Have you had any injuries? If so, please describe, including when.	
Have you had a colonoscopy? If so, when / who?	
Have you had a mammogram? If so, when / who?	
Have you been hospitalized in the last year? If so, when and why? Which hospital?	
When was your last blood work and why?	
Do you have any family history of medical problems? Please list all and specify which side of the family (i.e. maternal grandmother, paternal grandfather)	

Previous or Current Medical Symptoms (Please Circle All Applicable)

Constipation	Depression	Allergies	Shortness of Breath
Fatigue	Hallucinations	Syncope / Fainting	Heart Palpitations
Dizziness	Paranoia	Incontinence	Insomnia
Chest Pain	Diarrhea	Blurry Vision	Cancer
Loss of Balance	Anxiety	Sexual Disorder / ED	Low Energy

Please fill in any additional information you would like to notify the doctor about. Please feel free to discuss with Dr. Abdulhai or current Caregiver.

Patriot Family Medicine
885 Patriot Dr Unit F, Moorpark, CA 93021 Phone 805.334.1371 Fax 805.823.6201
www.patriotfamilymedicine.com

PATRIOT FAMILY MEDICINE

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly every day
1.Little interest or pleasure in doing things	0	1	2	3
2.Feeling down, depressed, or hopeless	0	1	2	3
3.Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.Feeling tired or having little energy	0	1	2	3
5.Poor appetite or overeating	0	1	2	3
6.Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7.Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9.Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add columns + +

TOTAL:

(Healthcare professional: For interpretation of Total, please refer to accompanying scoring card).

10.If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

A2663B 10-04-2005

Patriot Family Medicine
885 Patriot Dr Unit F, Moorpark, CA 93021 Phone 805.334.1371 Fax 805.823.6201
www.patriotfamilymedicine.com