

Andrew D. Smith, M.D., Inc.
 16100 Sand Canyon Ave., Suite 230, Irvine, CA 92618
 Office (949) 653-7000 Fax (949) 453-0553

REGISTRATION FORM

(Please Print)

Today's date:	Referred by:
---------------	--------------

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Cell Phone Number:	Drivers License Number/State:	Social Security Number:		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
()				/ /			
Street address:			Apt. Number		Home phone no.:		
					()		
P.O. box:	City:		State:		ZIP Code:		
Occupation:	Employer:			Employer phone no.:			
				()			
Email Address:							

INSURANCE INFORMATION

(Please give your insurance card and drivers license to the receptionist.)

Name of Primary Insurance:	Prior Auth Req? <input type="checkbox"/> Yes <input type="checkbox"/> No	Authorization Number:		Insurance Phone No.:		
				()		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:	
		/ /			\$	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:		Policy no.:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		()	()

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I assign and request payment of medical benefits be made to Andrew D. Smith, M.D., Inc. for medical services rendered. I authorize the release of medical information necessary to process my claim. **I have read the Financial Policies and understand that I am financially responsible for any non-covered services.**

Patient/Guardian signature	Date

Andrew D. Smith, M.D., Inc.
16100 Sand Canyon Ave., Suite 230, Irvine, CA 92618
Office (949) 653-7000 Fax (949) 453-0553

Patient Name: _____

INSURANCE SERVICES

Andrew D. Smith, M.D., Inc. will submit claims to your insurance company for all medical services rendered that are covered benefits. We will attempt to verify eligibility and benefits with your insurance company; however, this verification is not a guaranty of payment. Any expenses deemed not covered by your insurance company will be your financial responsibility.

All monies owed by the patient, i.e., office visit copayments and non covered services or supplies are due at the time of service. Also, when applicable, coinsurance percentages and/or deductibles may be collected at the time of service. Please be aware that this office will bill only for the physician's services. Any other services related to your office visits, i.e., laboratory, radiology or pathology will be billed by the facility providing these services.

The contract between Andrew D. Smith, M.D., Inc. and your health plan, as well as the contract between you and your health plan requires that you make payment in full of all co-payments and deductible amounts deemed to be your responsibility upon claims processing. Additional discounts are forbidden by contract unless financial hardship is documented and approved by this office.

COSMETIC SURGERY

Patients receiving surgery that is not a covered benefit of your insurance plan must pay for the services in full prior to the surgery. For your convenience, Andrew D. Smith, M.D., Inc. has made financial arrangements with the Surgery Center and the Anesthesiologist to provide a global package rate. You will not receive a bill from the Surgery Center or the Anesthesiologist. You may receive a bill for pathology, lab, ekg, respiratory services if they are required.

During your cosmetic surgery, you may receive a surgical service that is covered by your insurance company. We will bill your insurance company if you receive a covered surgical service. Your doctor will discuss the possible covered services.

PAYMENT

Our office accepts the following forms of payment: Visa, Mastercard, American Express, cash and personal checks. **A twenty dollar (\$20) service charge will be assessed to your account for any check returned by your bank.**

Responsible Signature

Rev. 05/10

Date

Andrew D. Smith, M.D., Inc.
16100 Sand Canyon Ave., Suite 230, Irvine, CA 92618
Office (949) 653-7000 Fax (949) 453-0553

PATIENT CONTACT PREFERENCE

In accordance with Health Insurance and Portability Act (HIPAA) we are required to institute specific confidentiality safeguards regarding your medical health information. It will be necessary for our office staff to contact you regarding scheduled appointments, possible surgery scheduling, lab and other diagnostic test results and other related matters such as insurance coverage and billing.

Many people have multiple communication devices such as cell phones, work or home voice mail/answering machine systems. Consequently, we require specific instructions as to how best to contact you. In addition, if you wish other members of your household or other designated persons to be authorized to receive this protected health information, you must indicate those individuals that are authorized to be made aware of such information.

Please rank in order of preference all communication methods at which we may contact you to leave information about your appointment, surgical time or other related health information:

Home Telephone: (____) _____	1	2	3	(Circle)
Cell Phone: (____) _____	1	2	3	(Circle)
Work Phone: (____) _____	1	2	3	(Circle)
E-mail Address: _____	1	2	3	(Circle)

Would you like to be added to our E-mail list so that you can receive special offers and the latest information from our practice? Yes _____ No _____

If you are not available, may we leave information or instructions with a family member or other authorized person? Yes _____ No _____ (Initial)

Unless otherwise restricted, we will leave a message on your answering machine to contact our office.

Please PRINT the names and relationships of persons authorized to receive protected health information:

Name _____	Relationship _____
Name _____	Relationship _____
Signature of Patient, Parent or Guardian _____	Print Name of Patient _____

Date: _____
Rev. 05/10

Andrew D. Smith, M.D., Inc.
16100 Sand Canyon Ave., Suite 230, Irvine, CA 92618
Office (949) 653-7000 Fax (949) 453-0553

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you as a patient of Andrew D. Smith, M.D., Inc. may be used and disclosed, your rights as a patient and how you can access your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA).

Our commitment to your privacy

Andrew D. Smith, M.D., Inc. is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information as prescribed by HIPAA. These HIPAA guidelines are summarized below for your information and understanding.

Use and Disclosure of your Health Information

The following circumstances may require Andrew D. Smith, M.D., Inc. to use or disclose your health information.

1. To comply with requests from public health authorities and health oversight agencies which are required by law to collect health information.
2. Law suits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Andrew D. Smith, M.D., Inc. will only make such disclosures to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military forces, including veterans, and if required by the appropriate authorities.
6. To federal government officials for intelligence and national security activities required by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

Your rights regarding your Health Information

1. You can request that Andrew D. Smith, M.D., Inc. communicate with you about your health related issues in a particular manner or at a certain location. Therefore, you may ask to be contacted at home rather than at work, via personal fax or cell telephone for appointment confirmation or related scheduling matters, for results of specific diagnostic tests, and such reasonable requests will be accommodated.
2. You can request a restriction regarding the use or disclosure of your health information for treatment, payment, or health care operations by Andrew D. Smith, M.D., Inc.
3. You have the right to request that Andrew D. Smith, M.D., Inc. restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as a family member or friend. However, Andrew D. Smith, M.D., Inc. is not required to agree to your requests, but if we do agree, Andrew D. Smith, M.D. Inc. is bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical and billing records, with the exception of psychotherapy notes. You must submit your request in writing to Andrew D. Smith, M.D., Inc., 16100 Sand Canyon Ave., Suite 230, Irvine, CA 92618. Obtain a request form at the Front Desk.
5. You may ask Andrew D. Smith, M.D., Inc. to amend your health information if you believe it is incorrect or incomplete as long as the information is kept by or for Andrew D. Smith, M.D., Inc. To request an amendment, make your request in writing with a supporting reason for the amendment to your health information to Andrew D. Smith, M.D., Inc. at 16100 Sand Canyon Ave., Suite 230, Irvine, CA 92618. Obtain a request form from the Front Desk.
6. You are entitled to receive a copy of the Notice of Privacy Practices by asking the Front Desk person to make a copy for you.
7. If you believe your privacy rights have been violated, you may file a complaint with Andrew D. Smith, M.D., Inc. or with the Secretary of the Department of Health and Human Resources. Any complaint filed with Andrew D. Smith, M.D., Inc. must be submitted in writing. You will not be penalized for filing a complaint. Obtain the proper form to file a complaint from a person at the Front Desk.
8. Andrew D. Smith, M.D., Inc. will obtain your written authorization for uses and disclosures that are not identified by this Notice of Privacy Practices or permitted by law.

If you have any questions regarding this Notice of Privacy Practices or Andrew D. Smith, M.D., Inc. health information privacy policies, please contact our staff at Andrew D. Smith, M.D., Inc., 16100 Sand Canyon Ave, Suite 230, Irvine, CA 92618.

ANDREW D. SMITH M.D., INC
16100 Sand Canyon Ave., Suite 230
Irvine, CA 92618
Office (949) 653-7000
Fax (949) 453-0553

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT**

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES policy from Andrew D. Smith, M.D., Inc. The Notice of Privacy Practices is supplied in accordance with the Privacy Rule that is an integral part of the Health Insurance Portability and Accountability Act (HIPAA).

SIGNATURE

DATE

PATIENT NAME

SIGNOR RELATIONSHIP TO PATIENT

ANDREW D. SMITH, M.D., INC.
MEDICAL QUESTIONNAIRE

TODAYS DATE: _____

NAME: _____ AGE: _____ DATE OF BIRTH: _____

PRIMARY CARE DOCTOR: _____

DOCTOR WHO REFERRED YOU: _____

OTHER PHYSICIAN(S) CARING FOR YOU: _____

IS THIS VISIT DUE TO A WORK RELATED INJURY? YES NO DATE OF INJURY _____

ARE YOU PREGNANT? YES NO

REASON FOR TODAY'S VISIT: _____

PAST MEDICAL HISTORY:

SURGERIES AND HOSPITALIZATIONS

List all previous surgeries/hospitalizations, and approximate dates:

- 1. _____ 3. _____
- 2. _____ 4. _____

CURRENT MEDICATIONS WITH DOSAGES

- 1. _____ 3. _____
- 2. _____ 4. _____

Do you take any "blood thinners? YES NO
Do you take medication that has aspirin in it? YES NO

ALLERGIES TO DRUGS

YES _____ NO _____

- 1. _____
- 2. _____
- 3. _____

ENVIRONMENTAL ALLERGIES (FOOD)

YES _____ NO _____

- 1. _____
- 2. _____
- 3. _____

USE THIS SPACE TO PROVIDE ADDITIONAL INFORMATION FROM THIS PAGE:

PATIENT NAME: _____ DATE: _____

HAVE YOU BEEN DIAGNOSED WITH OR TREATED FOR ANY OF THE FOLLOWING DISEASES?

Angina or Heart Attack	Yes___ No___	Glaucoma/Cataracts	Yes___ No___
Anesthesia complications	Yes___ No___	Headaches	Yes___ No___
Asthma	Yes___ No___	High Blood Pressure	Yes___ No___
Bladder disease	Yes___ No___	Immune suppression/HIV	Yes___ No___
Bleeding Problems	Yes___ No___	Irregular Heart Beat	Yes___ No___
Blood Transfusions	Yes___ No___	Liver problems/Hepatitis	Yes___ No___
Congestive Heart Failure	Yes___ No___	Sleep Apnea	Yes___ No___
Cancer	Yes___ No___	Snoring	Yes___ No___
Diabetes Mellitus	Yes___ No___	Stroke	Yes___ No___
Emphysema	Yes___ No___	Thyroid Disease	Yes___ No___
Epilepsy	Yes___ No___	Ulcers or Reflux (GERD)	Yes___ No___

REVIEW OF SYSTEMS - PAST THIRTY DAYS (put a check next to any illnesses, problems or symptoms you have had in the past 30 days).

EYES

___ Change in Vision
___ Pain
___ Blurred or double vision
___ Glaucoma

RESPIRATORY

___ Cough
___ Spitting up blood
___ Wheezing

GENITOURINARY

___ Flank pain
___ Problems with urination
___ Abnormal urine color

EAR/NOSE/THROAT/MOUTH

___ Hearing Loss
___ Trouble Swallowing
___ Sore throat
___ Sinusitis

HEMATOLOGIC/LYMPHATIC

___ Slow to heal after cut
___ Bleeding or bruising tendency

CONSTITUTIONAL SYMPTOMS

___ Fevers, Chills, or Night sweats
___ Recent Weight change
___ Skin problems _____

MUSCULOSKELETAL

___ Joint pain/stiffness
___ Muscle pain/cramps/weakness
___ Back pain

CARDIOVASCULAR

___ Chest pain
___ Palpitations
___ Shortness of breath, walking or lying flat
___ Swelling of feet, ankles or hands

GASTROINTESTINAL

___ Problems with bowel movements
___ Nausea or vomiting
___ Rectal bleeding, blood in stool, vomiting blood
___ Abdominal pain or heartburn

NEUROLOGIC/PSYCHOLOGIC

___ Headaches
___ Numbness or tingling sensation
___ Fainting or loss of consciousness
___ Depression/Nervousness/Insomnia

PATIENT NAME: _____ DATE: _____

FAMILY HEALTH HISTORY

	<u>FATHER</u>	<u>MOTHER</u>
Alive	___ Yes ___ No	___ Yes ___ No
Age or Age at Death	_____	_____
Angina or Heart Attack	___ Yes ___ No	___ Yes ___ No
Diabetes Mellitus	___ Yes ___ No	___ Yes ___ No
Congestive Heart Failure	___ Yes ___ No	___ Yes ___ No
High Blood Pressure	___ Yes ___ No	___ Yes ___ No
Adverse Anesthetic Reactions	___ Yes ___ No	___ Yes ___ No
Liver Problems/Hepatitis	___ Yes ___ No	___ Yes ___ No
Bleeding Disorders	___ Yes ___ No	___ Yes ___ No

HABITS

Do you now smoke? (___ cigars ___ cigarettes) ___ Yes ___ No
 How many years _____ Packs per day _____

Have you ever smoked? ___ Yes ___ No
 How long ago? _____ For how many years? _____
 How many packs per day? _____ Month/Year you quit _____

Have you ever used chew or snuff? ___ Yes ___ No

Do you drink alcohol? ___ Yes ___ No
 How many drinks per day (average)? _____
 When did you last drink? _____

Have you used illicit drugs (including marijuana, heroin, cocaine, LSD, crack)? ___ Yes ___ No
 If yes, circle which ones.

Do you exercise on a regular basis? ___ Yes ___ No
 Type of exercise _____ How often _____

Please use this space to provide additional health information you would like us to know _____

The information above is true and correct.

Patient or Person Completing this form/Relationship

Date

Reviewed by M.D. _____