NAME: ____________________ DATE: _________ AGE: ________ DATE OF BIRTH: ____________

Primary Care Physician:______________________________Referring (Physician):______________________________

Other physicians:______________________Pharmacy (Name/street/phone number):______________________________

What brings you in to see us today?

____

____

Do you have any ***ALLERGIES?*** *(Please use the back of this sheet if you need more space.)* ☐ *NO*

Allergic to:	*What kind of reaction do you get:*

What ***MEDICATIONS*** *do you currently take? (Please use the back of this sheet if you need more space.)* ☐ *NONE*

Name of Medication	*Dosage*	*Times per day*	*Reason for taking*

PAST MEDICAL HISTORY: ☐ *NONE*

- ☐ Anemia
- ☐ Anesthesia complications
- ☐ Anxiety
- ☐ Bladder problems (specify)
- ☐ Bleeding disorder / Blood clots
- ☐ Breast problems
- ☐ Cancer (specify)
- ☐ Depression
- ☐ Diabetes (type I or II)
- ☐ GI problems (specify)
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney problems (specify)
- ☐ Lung disease
- ☐ Osteoporosis
- ☐ Seizure disorder
- ☐ Stroke / Mini stroke
- ☐ Thyroid disease
- ☐ Other: ______________________
- ☐ Other: ______________________

PAST SURGICAL HISTORY (list month/year or estimated date): ☐ *NONE*

- ☐ Abdominal surgery (specify)
- ☐ Back surgery
- ☐ Caesarean section
- ☐ Cancer surgery (specify)
- ☐ Eye surgery (specify)
- ☐ GYN surgery (specify)
- ☐ Heart surgery (specify)
- ☐ Ears/Nose/Throat surgery (specify)
- ☐ Hysterectomy
- ☐ Laparoscopy (specify)
- ☐ Orthopedic /Joint replacement
- ☐ Pacemaker
- ☐ Plastic surgery (specify)
- ☐ Prolapse repair
- ☐ Sling
- ☐ Tubal ligation
- ☐ Other:______________________
- ☐ Other:______________________

FAMILY HISTORY: ☐ *NONE*

Family member	Living?	Anesthesia problems	Autoimmune disease	Bleeding or clotting disorder	Cancer (specify type)	Diabetes	Heart disease	High cholesterol	Hypertension
MOTHER									
FATHER									
SIBLINGS									

Family member	Liver disease	Lung disease	Neurologic disorders	Osteoporosis	Kidney disease	Stroke	Thyroid disease	Other (specify)
MOTHER								
FATHER								
SIBLINSG								

PREGNANCY HISTORY: ***GYN HISTORY:*** ***SOCIAL HISTORY:*** *(Please circle or check where applicable.)*

PREGNANCY HISTORY		GYN HISTORY		SOCIAL HISTORY
# Total		Date of Last Menstrual Period		Occupation:
# Living		Duration of flow (# of days)		Marital status: Married / Single / Divorced / Separated / Widowed / Domestic Partner
# Full term		Frequency of cycle (every _ days)		Smoking: Never / Former / Some days / Everyday /How much per day/week?
# Pre term		Monthly menstrual cycle (yes/no)		Alcohol: None / Occasional / Moderate / Heavy
# Miscarriage		Current birth control method		Other drugs: ☐YES ☐ NO
# Abortion		Age at menopause (if applicable)		Caffeine intake: None / Occasional / Moderate / Heavy
# Ectopic		Date (year) of last Pap smear		Domestic violence: ☐YES ☐ NO
# Multiple births		Date (year) of last Mammogram		Do you live: ☐ alone ☐ with others:

PLEASE CONTINUE ON TO NEXT PAGE→

NAME: ____ DATE: _________ AGE: ________ DATE OF BIRTH: _____________

REVIEW OF SYSTEMS—Have you experienced any of the following conditions in the **PAST MONTH**?

Please circle ALL that apply.

01. CONSTITUTIONAL	NONE	weight loss ___#, weight gain ___#, fever/chills, fatigue, loss of appetite, headache
02. EYES	NONE	glaucoma, macular degeneration, vision changes, glasses/contacts, blurred vision, double vision, cataracts
03. ENT/MOUTH	NONE	hearing loss, sinusitis, nose bleeds, sore throat, mouth ulcer/canker sores, bleeding gums
04. CARDIOVASCULAR	NONE	chest pain, palpitations, shortness of breath when lying flat, edema
05. RESPIRATORY	NONE	shortness of breath, chronic cough, sputum/productive cough, spitting up blood, wheezing
06. GASTROINTESTINAL	NONE	heartburn, nausea, vomiting, diarrhea, constipation, flatulence, bloody stools, jaundice
07. GENITOURINARY	NONE	blood in the urine, flank pain/kidney stones, incontinence with coughing/sneezing/laughing, incomplete emptying, urinary urgency, urinary frequency, urinate _______ times in 24 hours, nocturia _____ times per night, painful urination, abnormal vaginal bleeding, rash, lesion, dry vaginal mucosa, vaginal discharge, vaginal odor, vaginal itching, painful sex, decreased libido, sexual dysfunction, prior history of sexually transmitted diseases
08. MUSCULOSKELETAL	NONE	muscle aches, muscle weakness, joint pain, joint stiffness, joint swelling, difficulty walking, cold extremities, gout, fracture, back pain
09. SKIN	NONE	abnormal moles, rash
10. NEUROLOGICAL	NONE	headache, dizziness, loss of consciousness, weakness, numbness, seizures
11. PSYCHOLOGIC	NONE	depression, alcoholism, sleep disturbances

ADDITIONAL SPACE if necessary:

NAME: ____ DATE: _________ AGE: ________ DATE OF BIRTH: ____________

PATIENT PRIVACY & HEALTH DATA EXCHANGE

1. A copy of The Health Information Privacy Act (HIPAA) has been provided to me.

______ I have read and understand my rights under HIPAA.
(INITIALS)

MEDICATION HISTORY AUTHORIZATION

2. Our office uses an electronic health record through Eclinicalworks, Inc. to maintain your records. As part of your record, your prescription medicine history can be downloaded from your pharmacy in order to increase accuracy. Your medical history from participating providers and hospitals is imported as well to improve your care. You have the option to OPT OUT of this information exchange, but we do not recommend this as it could delay your care. However, choosing to OPT OUT only prohibits this office from viewing your medical information – it does not remove your information from any other health record.

____ I choose to OPT OUT of medical history sharing.

____ I choose to OPT OUT of medication history sharing.

CONSENT TO CALL

3. As part of our electronic health record, you will receive automated phone calls from our practice to remind you of upcoming appointments, test results and more.

I authorize Eclinicalworks to contact me via – mobile phone – home phone. (Check one).

If I do NOT want Eclinicalworks to contact me via phone, I understand it is my responsibility to log into my portal and modify the mode of communication to email, portal, or text.

Advanced Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance company does not pay for any item below, you may have to pay. Your insurance company *does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance company may not pay for the item below.*

Treatment of Service	Reason Insurance May Not Pay	Estimated Cost
Pessary (for non-surgical management of prolapse)	**Not a covered benefit**	**$65.00**
Uroplasty (treatment for overactive bladder)	**Not a covered benefit**	**$200.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below.

Check only one box. We cannot choose a box for you.

OPTION 1. For item(s) above, and/or any treatment, you may ask to be paid now, but I also want my insurance company billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance company does not pay, I am responsible for payment, but **I can appeal to my insurance company** by following directions on the EOB. If my insurance company does pay, you will refund my payments I made you, less co-pays or deductibles.

OPTION 2. I want the item(s) above, but do not bill my insurance company. I may be asked to be paid now as I am responsible for payment, **I cannot appeal if my insurance company is not billed.**

OPTION 3. I do not want the item(s) above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if my insurance company would pay.**

This notice gives our opinion, not an official insurance decision.

Signing below means that you have received and understand these notices. A copy will be provided upon request.

Signature	Date

NAME: ____ DATE: _________ AGE: ________ DATE OF BIRTH: ____________

FINANCIAL AGREEMENT

PLEASE READ CAREFULLY

Lawrence L. Lin M.D. Professional Corporation agrees to provide professional services by the physician and its employees to each patient and reserves the right to select the physician to perform the services required when he is not present to perform the services.

I hereby authorize Lawrence L. Lin M.D. to furnish information to insurance carriers concerning my diagnosis and treatment and I hereby assign to the physician all payments for services rendered to myself or my dependents. I understand that all professional services rendered are charged to the patient. As a courtesy, necessary forms will be completed to expedite insurance payments. **I understand that I am responsible for any amount not covered by insurance.** Dr. Lawrence L. Lin is a contracted provider for Medicare, Aetna, Anthem Blue Cross, Blue Shield of CA, United Healthcare and most other major insurance companies. Due to the number of different insurance companies and their own numerous policies, we cannot be responsible to know the terms of your individual policy, even if we are a provider. **It is your responsibility as the patient to know your insurance policy's requirements** for prior authorization for office visits, X-rays, laboratory, and the amount of your deductible and co-payments. Furthermore, it is also necessary for you to know which laboratory, X-ray facility, and hospital you are required by your insurance to use for any necessary test and procedures.

We always welcome your questions and are available to help you understand your medical insurance as best as we can.

By signing below you acknowledge that you have read, understood, and accept the above.

The best medical service is based on a friendly mutual understanding between doctor and patient.

Authorized Signature: ____ Date: _____________

Printed Name: ____

Witness: ____ Date: _____________