Burlingame Family Health
1820 Ogden Drive, 1ST Floor
Burlingame, CA 94010

PATIENT INFORMATION FOR MEDICAL RECORDS (Please Print) DATE:

Mr. Last Name First Name Middle Name
Mrs.
Ms.

ADDRESS Street City Zip | HOME PHONE

SOCIAL SECURITY NUMBER | DATE OF BIRTH | AGE | DRIVER'S LICENSE NUMBER

PATIENT'S EMPLOYER | OCCUPATION

EMPLOYER'S ADDRESS STREET CITY ZIP | PHONE

SPOUSE'S NAME | MARITAL STATUS M S D W Sep

SPOUSE'S EMPLOYER

REFERRED BY: NAME Insurance Internet Phone book Other

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THE FOLLOWING SECTION

RESPONSIBLE PARTY LAST NAME FIRST NAME MIDDLE NAME | RELATIONSHIP

ADDRESS STREET CITY ZIP | PHONE

SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER

EMPLOYED BY | OCCUPATION

EMPLOYER'S ADDRESS STREET CITY ZIP | PHONE

MEDICAL INSURANCE INFORMATION

COMPANY 1) | POLICY NUMBER

COMPANY 2) | POLICY NUMBER

LIST MEMBERS OF YOUR IMMEDIATE FAMILY:

IN CASE OF EMERGENCY NOTIFY:
Name: Mr. Mrs. Ms.
.

ADDRESS STREET CITY ZIP | PHONE

RELATIONSHIP | BUSINESS PHONE

Please notify our office if you must cancel an appointment at least 24 hours prior to your appointment time. If you fail to notify us you must be charged for this time. Insurance companies do not pay for missed appointments. I have reviewed a copy of Burlingame Family Health's office policy.

_____
Signature of Patient or Guardian

Susan Fullemann, MD, Medical Director
Jerry Warren, Ph.D., Administrative Director
Dolores Ali, MD

Telephone (650) 697-7202
Fax (650) 697-7059

Burlingame Family Health
1820 Ogden Drive, 1st Floor
Burlingame, CA 94010

Lifetime Signature Authorization

Name of Beneficiary (patient)_____ Patient #_____

I request that payment of authorized insurance and/or Medicare benefits be made either to me or on my behalf to Susan Fullemann, MD, known as Burlingame Family Health Medical Group for any service(s) furnished to me by that physician group. I authorize release to my insurance carrier and/or the Centers for Medicare and Medicaid Services and their agents any medical information about me needed to determine payments for all related services. If other secondary health insurance coverage is indicated on the claim submitted, my signature authorizes release of this information to the insurer or agency on that form. I understand that **the patient is responsible for all deductible, coinsurance, and non-covered services.** Coinsurance and deductible are based upon the charge determination of my insurance carrier.

Signature **X**_____ Date_____
(Patient or patient's representative)

If the beneficiary is unable to sign this form, the patient's representative must complete the following:

Name of representative_____

Relationship to patient_____ Has power of attorney been granted to you?_____

Address_____

Reason that the beneficiary could not sign_____

Review of Burlingame Family Health's Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business we will create, maintain and disclose records regarding you and the treatment and services we provide to you as described in the Burlingame Family Health Notice of Privacy Practices.

I attest that I have reviewed a copy of Burlingame Family Health's Notice of Privacy Practices.

Signature **X**_____ Date_____

Susan Fullemann, MD, Medical Director
Jerry Warren, Ph.D., Administrative Director
Dolores Ali, MD

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Susan Fullemann, MD, Medical Director
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BURLINGAME FAMILY HEALTH

Payment Agreement

This is to certify that I give permission to Burlingame Family Health to provide medical evaluation and treatment for myself and / or my child(ren). I and/or my child(ren) will be treated with respect and honesty throughout treatment.

I understand that I am financially responsible for the evaluation, treatment and other services I receive at Burlingame Family Health. If I am covered by an insurance that is contracted to Burlingame Family Health, I agree to pay any co-payments before service is rendered and to treat the staff of Burlingame Family Health with respect and honesty. A $10 surcharge will be added to any co-payment that is not paid at the time of service. If I receive services that are not covered by my insurance, I agree to pay for those services before they are rendered. If my insurance has lapsed or is not valid at the time of the service, I agree to pay for all services given when presented with a bill for payment. Should my insurance carrier fail to pay the contracted services for any reason, i.e. bankruptcy, I agree to pay Burlingame Family health for the services rendered to me or my children that were not paid.

All charges are due and payable at the time the service is given. I understand that balances not paid after ninety days of the service will accrue interest at the rate of 2% a month. Should my account be referred to an outside collection agency, attorney or court, all costs of collection, attorney fees, and court costs will be payable by me.

Insurance companies will not pay for missed appointments and Burlingame Family Health needs sufficient notice to fill time slots reserved for patients. I agree that if I do not provide Burlingame Family Health with notice twenty-four hours (excluding weekends) in advance of my initial appointment, I will forfeit my deposit. I agree that if I do not give Burlingame Family Health twenty-four hours notice (excluding weekends) when canceling subsequent appointments I will pay the appointment charge in full. I understand that it is not sufficient to leave a voice mail to cancel an appointment. To avoid being charged I must speak to a staff member, give them the date and time of the appointment and receive a cancellation code from them.

A copy of this authorization shall be considered valid.

_____ _____

(Authorization Signature) (Date)

Printed Name: _____

Burlingame Family Health
1820 Ogden Dr. 1st Floor
Burlingame, CA 94010

Medication History Authorization

I give permission to obtain information regarding my medication history by Burlingame Family Health Medical Group from my insurance carrier for coordination of my care.

Signature **X**_____ Date _____

Please provide your email address:_____

Which pharmacy do you use? (local):_____

(mail order):_____

Demographic Survey

Dear patients, we are participating in a government program that encourages the adoption of electronic health records. This program requires that we obtain demographic information on our patients. If you do not wish to provide this information you may simply decline.

Thank you for your assistance!

Please verify your **Date of Birth:** _____ and **Gender:** _____

Preferred Language:_____

The following matches data collection standards defined by the Center for Disease Control (CDC) and US Census Bureau:

(select from list provided by the receptionist)

Race: ___: I decline to answer

Ethnicity: ___: I decline to answer

Thank you!

Susan Fullemann, MD, Medical Director
Jerry Warren, Ph.D., Administrative Director
Telephone (650) 697-7202
Fax (650) 697-7059

Burlingame Family Health Medical Group
Susan Fullemann M.D., Dolores Ali M.D.
1820 Ogden Drive, 1st Floor
Burlingame, CA 94010
PHONE (650)697-7202 FAX (650)697-7059

Authorization for Release of Medical Records

As required by the HIPAA the clinic below cannot release or disclose your protected health information without your prior approval and written authorization.

Previous Provider: ❑ Doctor ❑ Clinic ❑ Hospital ❑ Person

Name: _____

Address: _____

City: _____ **State:** ___ **Zip:** _____

I hereby give authorization and request the release of the following protected health information:

❑ All Files ❑ Treatment Notes ❑ Diagnosis ❑ Insurance Billing
❑ Reports ❑ Dates of Service ❑ Financial Account ❑ X-rays

Concerning my: ❑ All Files ❑ Accident ❑ Injury ❑ Illness

❑ Other _____ Dated: _____

I hereby release all legal responsibility of liability or loss or the above requested records from the above provider that may arise from this authorization. I hereby authorize this office and any of its employees to use or disclose my private health information to the following:

Release to: ■ Doctor ❑ Clinic ❑ Hospital ❑ Person

Name: Susan Fullemann, M.D.
Address: Burlingame Family Health 1820 Odgen Dr. 1st Floor
City: Burlingame **State:** CA **Zip:** 94010

_____ _____ _____
Date of Request **Patient's Name** **Date of Birth**

This authorization is effective from: ____/____/____ through ____/____/____

I understand that I have the right to revoke this authorization at any time by written and signed request. I also understand that if do not sign this document my treatment will not be affected, however, no medical records can be released from this office for any purpose.

_____ _____
Signature of: ❑ Patient ❑ Parent ❑ Guardian Date

Patient's Name: _____ **Date:**_____

Please complete the following and give it to the receptionist. Please add any other information that you feel we should have.

Have you had your eyes checked in the last year?..... ❑Yes ❑No
Is your vision normal *(Other than wearing corrective lenses)*?..... ❑Yes ❑No
Have you been told that you have glaucoma or high pressure in the eye? .... ❑Yes ❑No
Have you lost weight in the last year? ..... ❑Yes ❑No
Do you have allergy symptoms, sneezing, hay fever, itching or food intolerances?. . ❑Yes ❑No
Do you get frequent sore throats?.. ❑Yes ❑No Nasal congestion?.....❑Yes ❑No
Have you had any chest pain? ..... ❑Yes ❑No Palpitations?.....❑Yes ❑No
Describe_____
Do you have a cough? ..... ❑Yes ❑No Shortness of breath? ..... ❑Yes ❑No
Are you wheezing? ..... ❑Yes ❑No Do you have asthma?.....❑Yes ❑No
Do you often have nausea, vomiting or diarrhea?..... ❑Yes ❑No
Do you have back pain? ..... ❑Yes ❑No Swollen Joints?..... ❑Yes ❑No
What areas?_____
Have you noticed lumps? ..... ❑Yes ❑No Rashes? .....❑Yes ❑No
Where? _____
Do you have burning when you urinate? ..... ❑Yes ❑No
How many times do you get up at night to urinate? _____
Do you have leg cramps with walking? ❑Yes ❑No Do you have dizziness?..... ❑Yes ❑No
Do you feel depressed? .....❑Yes ❑No Are you feeling suicidal? .....❑Yes ❑No
Have you ever attempted suicide? .....❑Yes ❑No Have trouble sleeping? ..... ❑Yes ❑No
Have you ever been hospitalized for psychiatric reasons? .....❑Yes ❑No
Do you have excessive thirst? .....❑Yes ❑No Too frequent urination?..... ❑Yes ❑No
Do you snore or awaken frequently?.....❑Yes ❑No Do you fall asleep in the day?❑Yes ❑No
Do you have excessive sleepiness?.....❑Yes ❑No Stop breathing during sleep?.❑Yes ❑No
Have you lost height? .....❑Yes ❑No Have you fractured bones? ...❑Yes ❑No

Please describe your typical diet:

Breakfast _____
Lunch _____
Dinner _____
Frequent Snacks _____
Daily number of services of Fruit- _____ Vegetables _____
(One serving of fruit is one small piece of ½ a large peice or ¾ cup of fruit juice. One service of vegetables in ½ cup or 1 cup of salad.)
Regular exercise? _____ How often? _____
Please write down any new medications _____
_____

Menstruating Women only:

Are your periods: *(please circle)* regular heavy painful
Date of your last menstrual period: _____
Do you use contraception? _____ What type? _____

Are there any health concerns you would like to discuss today?_____
_____
_____

Burlingame Family Health Medical Group
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Name:_____ Date:_____

Chronic Medical Problems

Medications	Dose	How often

Relationship of any relative with:
Diabetes?
Heart disease?
Cancer, *what kind?*
Osteoporosis?
Any other diseases?

Allergies to Medications, etc.

Past Surgeries	Year

How much alcohol do you drink?	
Do you smoke? How many per day?	
How much caffeine do you drink?	

When was your last:	
Physical examination	
Pap smear	
Mammogram	
Bone density test	
Colon cancer test	
Cholesterol test	
Tetanus shot	

IF NONE APPLY STATE "N/A" OR CROSS OUT BOX