Terrisa Ha, M.D.

5451 La Palma Ave. #49, La Palma, CA 90623
Ph: (714) 736-9918 Fax: (714) 736-9952

Patient Registration Form

Patient's Name: _____ _____ _____
Last *First* *Middle*

Date Of Birth: _____ **Age:** _____ **Gender: M / F**

Address: _____ _____ _____ _____ _____
Street *Apt.* *City* *State* *Zip*

Home Phone: (___)_____-_____ **Cell Phone: (___)_____-_____**

Email: _____@_____

Social Security Number: _____ **Drivers License Number:** _____

Martial Status: _____ **Drug Allergies:** _____

Occupation: _____ **Work Phone: (___)_____-_____**

Do you have a preferred pharmacy for prescriptions?

Pharmacy Name: _____ **Phone Number:** _____

How were you referred to Dr. Terrisa Ha?

☐ **Yelp** ☐ **Google** ☐ **Insurance** ☐ **Patient:** _____ ☐ **Other:** _____
(Patients name)

Emergency Contact

Contact Name: _____ **Relation to Patient:** _____

Home Phone: (___)_____-_____ **Cell Phone: (___)_____-_____** **Work Phone: (___)_____-_____**

Primary Insurance Holder *(If not self)*

Guarantor's Name: _____ **Date Of Birth:**_____ **Relation to Patient:**_____

Home Phone: (___)_____-_____ **Cell Phone: (___)_____-_____**

Address: _____ _____ _____ _____ _____
Street *Apt.* *City* *State* *Zip*

Social Security Number: _____ **Drivers License Number:** _____

Financial Agreement

I understand that fees are payable when service is rendered unless prior arrangements have been made. I also understand that all fees and charges are based upon time, amount, and nature of services. I understand I am responsible for my own benefits. Payment of services rendered to me and/or my dependents will not be delayed or withheld, because of pending insurance claims. For per-approved insurance claims, I authorize the release of any medical information necessary to process and claims. And I authorize payment of medical benefits to Dr. Terrisa Ha for services rendered. If I am unable to keep my scheduled appointment, I must notify the staff of Dr. Terrisa Ha within 24 hours or I may be assessed a no show fee of $30.

Signature: _____ **Date:** _____
(Guardians signature if patient is a minor)

1. **May Dr. Ha have your authorization to send <u>NORMAL</u> lab results to you via <u>e-mail</u>?**

_____ **Yes,** my email address is: _____@_____.com
(Print Clearly)

_____ **No,** I prefer my results by mail.

2. **May Dr. Ha have your authorization to leave your lab results by <u>voicemail</u>?** *(Cell phone number preferred)*

_____ **Yes,** at: (____)_____

_____ **No**

3. **May Dr. Ha have your authorization to send you <u>text messages</u> regarding medical information?** *(appointments, reminders, telehealth, etc.)*

_____ **Yes,** at the above phone number.

_____ **No**

Patient Name:_____
(Full Name)

Patient Signature:_____ Date:_____
(Parents signature if patient is a minor)

I,_____ ***hereby authorize*** *the office of Dr. Terrisa Ha to use and disclose my personal medical information to the following person.*

Name:_____ Relation:_____ Phone#: (___)_____

<u>Staff Use Only</u>

1. _____	6. _____	11._____
2. _____	7. _____	12._____
3. _____	8. _____	13._____
4. _____	9. _____	14._____
5. _____	10._____	15._____

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Diplomate, American Board of Family Medicine
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NOTICE OF PRIVACY PRACTICES

Date: _____ Chart#: _____

I understand that a copy of Dr. Terrisa Ha's Notice of Privacy Practices are available on her website at www.drterrisa.com

I understand I can get a copy from her website at any time.

Patients Name: _____

Patients Signature: _____

If patient is a minor

Parent or Guardian Name: _____

Parent or Guardian Signature: _____

PATIENT HEALTH HISTORY FORM

Information contained here will be treated with a confidential manner and not released without our authorization. Please take the time to answer all questions to the best of your knowledge, as this information is very important to your doctor in his decisions regarding your care.

Date: _____ Name: _____

Age:_____ Date of birth: _____ Sex:_____ Marital Status: _____ Hgt: _____ Wgt: _____ Ideal Body Wgt:_____

Family/Personal Physician: _____ Address: _____ Date of Last Visit: _____

Referring Physician:_____ Address: _____ Date of Last Visit: _____

SURGICAL HISTORY

List all previous operations, date and any complications:_____

_____

_____

_____

MEDICAL HISTORY	Yes	No		Yes	No		Yes	No
Serious Illness	☐	☐	Breast Disease	☐	☐	Breast Cancer	☐	☐
Serious Injuries	☐	☐	Stomach/Bowel Problems	☐	☐	Other Cancer	☐	☐
Bleeding Problems	☐	☐	Liver/Kidney Disease	☐	☐	Heart Attack	☐	☐
Anesthesia Problems	☐	☐	Bladder Infections	☐	☐	Stroke	☐	☐
Scarring Problems	☐	☐	Eye Problems	☐	☐	Bronchitis	☐	☐
Diabetes	☐	☐	Nervous Disorder	☐	☐	Pneumonia	☐	☐
Asthma	☐	☐	Nerve Injury/Paralysis	☐	☐	Alcoholism	☐	☐
High Blood Pressure	☐	☐	Fainting Spells	☐	☐	Drug Addiction	☐	☐
Heart Disease	☐	☐	Seizures	☐	☐	AIDS	☐	☐
Lung Disease	☐	☐	Arthritis	☐	☐	Other	☐	☐

Explain and give dates for each of above "Yes" response: _____

_____

_____

Do/Have You Smoked?: _____ Avg # packs per day: _____ # of years ___ Date Quit: ____

Do You Drink Beer or Alcohol?: _____ How Much?: _____ Date of last Chest X-ray: ____

Date/Result Last Mammogram: _____ Date Last Menstrual Period: _____ Are you pregnant?: _____

MEDICATIONS	Yes	No		Yes	No		Yes	No
Aspirin Products	☐	☐	Diabetic Pills	☐	☐	Weight Loss Pills	☐	☐
Headache Pills	☐	☐	Insulin	☐	☐	Water Pills	☐	☐
Arthritis Pills	☐	☐	Thyroid Pills	☐	☐	Tranquilizers	☐	☐
Blood Thinners	☐	☐	Digitalis	☐	☐	Sleeping Pills	☐	☐
Anticoagulants	☐	☐	Dilantin	☐	☐	Laxatives	☐	☐
Cortisone/Steroids	☐	☐	Phenobarbital	☐	☐	Antibiotics	☐	☐
Hormones	☐	☐	Barbiturates	☐	☐	Birth Control Pills	☐	☐

List all names of meds (with amounts and how often) taken during the past 6 months: _____

_____

ALLERGIES/SENSITIVITIES	Yes	No		Yes	No		Yes	No
Penicillin	☐	☐	Aspirin	☐	☐	Iodine	☐	☐
Sulfa Drugs	☐	☐	Aspirin Substitutes	☐	☐	Phisohex/Betadine	☐	☐
Other Antibiotics	☐	☐	Novacaine	☐	☐	Adhesive Tape	☐	☐
Tetanus	☐	☐	Other Anesthetics	☐	☐	Other	☐	☐

List reactions which have occurred for each above "Yes" response: _____

_____

FAMILY HISTORY	Yes	No		Yes	No		Yes	No
Bleeding Problems	☐	☐	Diabetes	☐	☐	Breast Cancer	☐	☐
Anesthesia Problems	☐	☐	Stroke	☐	☐	Other Cancer	☐	☐
High Fever from Surgery	☐	☐	Heart Disease	☐	☐	Arthritis	☐	☐
Scarring Problems	☐	☐	High Blood Pressure	☐	☐	Other	☐	☐

List family member and explanation if necessary for each above "Yes" response: _____

_____

_____

Patient Signature: _____ Physician Signature: _____

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Patient's Name: _____ **Chart #:** _____

Advanced Beneficiary Notice (ABN)

Note: **You will need to make a choice about receiving health-care services.**

Your health insurance may not pay for certain item(s) or service(s). The plan you have chosen as your health insurer does not necessarily cover all of your health-care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your medical provider recommends the service(s).

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services, knowing that you might have to pay for them yourself. We recommend that you contact your insurance company for further policy details if you have any questions regarding a service. It is essential that you are aware of your insurance benefits such as your deductible, out-of-pocket, and co-insurance, as these are to be met in order for your insurance to pay an item or service. Most insurances do not apply the deductible for an annual physical.

By signing below you agree to take financial responsibility for the cost of the item(s) or service(s), if your health insurance does not include this as a covered item(s) or service(s) or if the cost is applied to your deductible, out-of-pocket, or co-insurance.

_____ _____

Print responsible party name **Authorized representative's name**

_____ _____

Responsible party signature **Representative's signature**

Date: _____ **Date:** _____