Family Health Center of Benicia

Walter Zaks, M.D.
Aaron Zaks, D.O.
Laura Dalton, M.D.
Kristina Kim, D.O.
Rachel Kennedy, PA-C.

1440 Military West.
Benicia, CA 94510
Phone (707) 745-0711
Fax (707) 745-0788

Date: _____

Name: _____Date of Birth: _____

Male: ___Female: ___Marital Status: _____ SSN: _____

Race: _____ Ethnicity: _____ Religion: _____

If under 18, name of parent of guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone Number #: _____ Home/Cell/Work/Other

Secondary Phone Number #: _____ Home/Cell/Work/Other

Email Address: _____

Employed by: _____ Full Time/Part Time

Medical Insurance: _____ ID #: _____

Subscriber Name: _____

Subscriber D.O.B.: _____ Relation: _____

Subscriber Address: _____

Patient Primary Care Physician: _____

Person to contact in case of an emergency: _____

Phone #: _____ Relation: _____

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Name: _____ Date of Birth: _____

Consent

I authorize the providers of **Family Health Center of Benicia** to retain all of my medical records/information in an electronic format. These records will be maintained in a secured, confidential manner and shall be in compliance with HIPAA Regulations for patient confidentiality. These records shall not be released without consent of the patient or legal guardian. This authorization remains in effect until revoked in writing. I understand that I have access to a copy of the Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Insurance Authorization and Assignment

I hereby authorize **Family Health Center of Benicia** to furnish information to the insurance carrier(s) regarding my treatments. This authorization remains in effect until revoked in writing.

Signature: _____ Date: _____

Payment Obligations

I hereby assign, **Family Health Center of Benicia** all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by my insurance at the time of service to include co-pays, deductibles and non-covered services. I also understand that if I do not fulfill my payment obligations to **Family Health Center of Benicia**, my account will be subject to a full collections process. Any expenses related to the cost of collections and/or legal proceedings will be my responsibility.

Signature: _____ Date: _____

Medicare Patients Only

All Medicare patients must sign a lifetime beneficiary claim authorization. I request that payment of authorized Medicare benefits be made on my behalf to **Family Health Center of Benicia** for any service furnished services furnished by my doctor. I understand my signature requests that payment be made and authorizes release of the medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the electronically submitted claims, physicians or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

Signature: _____ Date: _____

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Name: _____Date of Birth: _____

Dear Patient,

In an attempt to give better and more coordinated health care, we have been mandated to switch to a computer system that is compliant with numerous new laws. Eventually, this will lead to a better, integrated health care system. However, in the short term there are some problems, such as our old computer program not communicating with our new system and the need to manually input tab results from Quest.

You can make your visit more efficient if you can fill out some of the data. Please fill out the parts you feel comfortable with and return this to the front desk.

Medical History

Allergies	Yes __ No __	COPD	Yes __ No __	Lung Cancer	Yes __ No __
Anemia	Yes __ No __	Dementia	Yes __ No __	Migraines	Yes __ No __
Anxiety	Yes __ No __	Depression	Yes __ No __	Myocardial Infarction	Yes __ No __
Arthritis	Yes __ No __	Diabetes Mellitus	Yes __ No __	Nerve/Muscle Disease	Yes __ No __
Asthma	Yes __ No __	Eye Disease	Yes __ No __	Osteoporosis	Yes __ No __
Autoimmune Disease	Yes __ No __	GERD	Yes __ No __	Prostate Cancer	Yes __ No __
Bipolar Disorder	Yes __ No __	Glaucoma	Yes __ No __	Seizures	Yes __ No __
Breast Cancer	Yes __ No __	Gout	Yes __ No __	Skin Cancer	Yes __ No __
Cancer	Yes __ No __	Heart Murmur	Yes __ No __	Sleep Apnea	Yes __ No __
Cardiovascular Other	Yes __ No __	Hyperlipidemia	Yes __ No __	Stroke	Yes __ No __
Celiac Disease	Yes __ No __	Hypertension	Yes __ No __	Substance Abuse	Yes __ No __
CHF	Yes __ No __	Kidney Disease	Yes __ No __	Thyroid Disease	Yes __ No __
Clotting Disorder	Yes __ No __	Kidney Stones	Yes __ No __	Tremors	Yes __ No __
Colon Cancer	Yes __ No __	Leukemia	Yes __ No __	Ulcers	Yes __ No __

If you marked yes on any of the above, please explain in detail and give approximate dates:

_____
_____
_____
_____

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Surgical History

Appendectomy	Yes __ No __	Dental Surgery	Yes __ No __	Ovary Removal	Yes __ No __
Brain Surgery	Yes __ No __	Ear Tubes	Yes __ No __	Small Intestine Surgery	Yes __ No __
Breast Surgery	Yes __ No __	Eye Surgery	Yes __ No __	Spine Surgery	Yes __ No __
CABG	Yes __ No __	Foot Surgery	Yes __ No __	Thyroid Surgery	Yes __ No __
Cholecystectomy	Yes __ No __	Fracture Surgery	Yes __ No __	Tonsillectomy	Yes __ No __
Colon Surgery	Yes __ No __	Hernia Repair	Yes __ No __	Tubal Ligation	Yes __ No __
Cosmetic Surgery	Yes __ No __	Hysterectomy	Yes __ No __	Valve Replacement	Yes __ No __
C-Section	Yes __ No __	Joint Replacement	Yes __ No __	Vein Surgery	Yes __ No __

If you marked yes on any of the above, please explain in detail and give appropriate dates:

_____

_____

_____

_____

_____

_____

Family History

Relationship	Name	Status	No Known Pro	Healthy	Alcohol/Drug A	Allergies	Anxiety/Depre	Arthritis	Asthma	Breast cancer	Clotting disorder	Colon cancer	COPD	Crohn's disease	Dementia	Diabetes	Glaucoma	Heart disease	Hyperlipidemia	Hypertension	Kidney disease	Learning disabi	Lung cancer	Macular degen	Mental retardat	Migraines	Osteoporosis	Ovarian cancer	Prostate cancer	Skin cancer	Stroke	Thyroid disease	Other
Mother																																	
Father																																	
Sister																																	
Brother																																	
Daughter																																	
Son																																	
Mat Aunt																																	
Mat Uncle																																	
Pat Aunt																																	
Pat Uncle																																	
MGM																																	
MGF																																	
PGM																																	
PGF																																	
	Neg Hx																																

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Social History

Alcohol Use Yes __ No __	**Tobacco Use** Yes __ No __
Comment Alcohol/Week _____	Quit Date _____
Drinks/Week ____ Glasses of Wine ____ Cans of Beer ____ Shots of Liquor ____ Drinks containing 0.5 oz of alcohol	Packs/day: 0.25 | 0.5 | 1 | 1.5 | 2 | 3 |0.00 Years: 5 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 0.0 **Smokeless Tobacco** Quit Date _____ Ready to Quit Yes __ No __ Counseling Given Yes __ No __

Preventative Care

Please list approximate dates for each of the following:

Colonoscopy Date: _____

Routine Eye Exam Date: _____

Immunization

Please list any immunizations received in the past at other facilities with approximate date:

(For example: shingles vaccines, travel vaccines, tetanus)

Vaccine: _____ Date Given: _____

Vaccine: _____ Date Given: _____

Women's Health

Last Mammogram Date: _____

Last PAP Date: _____

Menopause Date: _____

Pregnancy History

Contraception: _____

# of Pregnancies: _____ ____ Full Term/____ Pre Term ____ Ectopic ____ Multi Birth

# of Births: _____ Abortions: _____

Miscarriages: _____ # of Living Children: _____

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Please be advised that our office has changed or added new office policies. These policies are effective immediately. Please take the time to familiarize yourself with these policies:

1. **Office Hours** – Our clinic is open Monday through Thursday, 8:30 am to 4:30 pm and Friday, 8:30 am to 1:00 pm.

2. **Cancellation Policy** – We have a **24 hour cancellation policy**. Any appointment cancelled after 24 hours is treated as a missed appointment.

3. **Appointment Confirmations**: As a courtesy, our office will kindly call you **48 hours prior** to your scheduled appointment to confirm. If we are unable to reach or if our office is unable to confirm your appointment after (2) phone call attempts, you may experience a delay upon arrival for your appointment. In addition**, your appointment may be cancelled/rescheduled as our providers may need to use these time slots to fit in other patients who need immediate/same day urgent care**. If you are running late or need to cancel or reschedule (even on the day of your appointment), **please call 707-745-0711.**

4. **Missed Appointments** – **The charges for a missed appointment is $75**. We do not bill your insurance for missed appointments and **you are responsible for this fee**.

5. **Same Day Appointments** – Our office sets aside a certain number of appointments each day to be used as "same day" appointments. In order to obtain one of these appointments, you must call the night before you would like to be seen and leave a message after 5 pm. Messages are retrieved the morning of and patients are called back between 8 am and 9:30 am. Same day appointments are not guaranteed and are based on availability.

6. **Prescription Refills** – All prescriptions require a doctor's approval. You must allow **48 hours for refills** on maintenance medications. For **controlled substances, you must allow 72 hours for refills**. These prescriptions require a doctor's signature and ideally should be signed by the doctor who prescribed the medication to you. As you are aware, most doctors do not work every day, which is why we ask for an advance notice. Walk-ins will not expedite the process.

7. **Forms** – All medical forms that need to be filled out by our office and/or signed by a doctor will be a $25 charge (up to three forms). After three forms the charge is $35. Please allow three days for the completion of these forms. Please be advised that some of the forms will require an appointment with a doctor.

8. **Insurance Responsibility** – We are contracted with several insurance companies. It is your responsibility to make sure our physician is in your plan. It is also your responsibility to know your insurance policies and benefits. Before doing any laboratory tests, procedures, imaging tests, or seeing a specialist, we recommend you call your insurance to make sure the services are covered.

If you have any questions regarding these policies, you may ask any one of our staff. Your signature below, confirms your acknowledgement of these policies. We are excited to have you as a patient of **Family Health Center of Benicia**.

Name (please print): _____ Date: _____