CHRISTI C. CHENG, M.D.

13847 East 14h Street #108
San Leandro, Ca 94578

Account No.	Dr. No.

PATIENT REGISTRATION RECORD

Patient Name: _____ (Last / First / Middle)
Address: _____
City_____ State_____ Zip_____
Employer Name: _____
Employer Address: _____
City_____ State_____ Zip_____
Spouse Name: _____ (Last / First / Middle)
Spouse Employer: _____
Home Phone: (_____) _____-_____ DOB: ___/___/____

Date of Birth: _____/_____/_____ Age_____
Driver's License#_____ State_____
Social Security Number: _____-_____-_____
Sex: M / F (Circle)Single/Married/Divorced/Widowed/Minor
Home Phone: (_____) _____-_____
Work Phone: (_____)_____-_____
Cell Phone: (_____)_____-_____
Email Address: _____
Spouse Work Phone: (_____)_____-_____

WHO TO CALL FOR AN EMERGENCY:

Name: _____
Address: _____
City_____ State_____ Zip_____

Home Phone: (_____) _____-_____
Work Phone: (_____) _____-_____
Relationship: _____
How did you hear about our clinic?
_____

RESPONSIBLE PARTY FOR PAYMENT:

Guarantor Name: _____
Relationship to Patient: (please check): ( ) self ( ) spouse ( ) parent
Home Address: _____
City_____ State_____ Zip_____

Social Security Number: _____-_____-_____
Date of Birth: _____/_____/_____
Home Phone: (_____)_____-_____
Work Phone: (_____)_____-_____

PRIMARY INSURANCE:

Insurance Name: _____
I.D. Number: _____

Effective Date: _____
Group Number: _____
Policy Holder: _____

SECONDARY INSURANCE:

Insurance Name: _____
I.D. Number: _____

Effective Date: _____
Group Number: _____
Policy Holder: _____

I authorize Dr. Christi C. Cheng to act as my agent in helping me obtain from my insurance company which includes authorizing the release of any and all information required by my insurance company to process my claims. I authorize my insurance company to make payment directly to Dr. Christi C. Cheng for these services. I understand that I am ultimately responsible for my bill. I permit a copy of this authorization to be as valid as the original. This authorization is valid until it is rescinded in writing.

I understand that this medical office cannot control not take responsibility for the personal and medical information which the office is required to furnish to my insurance company that company may release such information to another insurance company, to my employer or to a national data bank.

I authorize you to render me reasonable and proper medical care by current standards.

Signature: _____ **Date:** _____

Office Use	Date	Initial	Date	Initial	Date	Initial	Date	Initial
Updated								

PLEASE FILL OUT COMPLETELY

HEALTH QUESTIONAIRE

SYSTEMIC REVIEW:

Respiratory (Cont'd)

Asthma or Wheezing	No	Yes
Difficulty breathing	No	Yes
Any trouble with lungs	No	Yes
Pleurisy or Pneumonia	No	Yes

Cardiovascular:

Chest pain angina pectoris	No	Yes
Shortness of breath with walking or lying down	No	Yes
Difficulty walking two blocks	No	Yes
Heart trouble or heart attacks	No	Yes
High blood pressure	No	Yes
Swelling of hands, feet or ankles	No	Yes
Awakening in the night smothering	No	Yes
Heart murmur	No	Yes

Gastrointestinal:

Peptic ulcer (stomach or duodenal)	No	Yes
Vomiting blood or food	No	Yes
Gallbladder disease	No	Yes
Liver trouble	No	Yes
Hepatitis	No	Yes
Painful bowel movements	No	Yes
Bleeding with bowel movements	No	Yes
Black stools	No	Yes
Hemorrhoids or piles	No	Yes
Recent change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Heartburn or indigestion	No	Yes
Cramping or pain in the abdomen	No	Yes
Does food stick in throat	No	Yes

Genitourinary

Loss of urine	No	Yes
Frequent urination	No	Yes
Night time urinating	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Kidney trouble	No	Yes
Kidney stones	No	Yes
Bright's Disease	No	Yes

Gynecological

Age periods started _____

How long do periods last? _____ Days

Gynecological (cont'd)

Number of pregnancies _____

Number of miscarriages _____

Date of last cancer smear and results _____

_____

Frequency of periods, every _____ days.

Any Pain with your periods	No	Yes

Number of children _____ Ages _____

Date of first day of last period _____

Locomotor-Musculoskeletal:

Varicose veins	No	Yes
Weakness of Muscles or joints	No	Yes
Any difficulty in walking	No	Yes
Any pain in calves or buttocks on walking relieved by rest	No	Yes

Neuro-Psychiatric:

Have you ever had psychiatric care?	No	Yes
Have you been advised to see a psychiatrist?	No	Yes
Do you ever have, or have you had, fainting spells?	No	Yes
Convulsions	No	Yes
Paralysis	No	Yes

Hematologic:

Are you slow to heal after cuts	No	Yes
Blood disease	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery?	No	Yes
Have you had abnormal bruising or bleeding?	No	Yes

Allergic:

Any allergies, including medication	No	Yes

Endocrine

Thyroid disease	No	Yes
Hormone therapy	No	Yes
Any change in hat or glove size	No	Yes
Any change in hair growth	No	Yes
Have you become colder than before or skin become dryer	No	Yes

HEIGHT _____

WEIGHT _____

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

	Circle One			What Drug or Food?
Penicillin or other antibiotics	Yes	No	Don't know	_____
Morphine, Codeine, Demerol or other narcotics	Yes	No	Don't know	_____
Novocain or other anesthetics	Yes	No	Don't know	_____
Asprin, empirin or other pain remedies	Yes	No	Don't know	_____
Sulfa drugs	Yes	No	Don't know	_____
Tetanus antitoxin or other serums	Yes	No	Don't know	_____
Adhesive tape	Yes	No	Don't know	_____
Iodine or merthiolate	Yes	No	Don't know	_____
Any other drug or medication	Yes	No	Don't know	_____
Any foods, such as egg, milk or chocolate	Yes	No	Don't know	_____

2. Drugs Recently Taken: Within the past six months has patient taken:

Cortisone	Yes	No	Don't know
ACTH	Yes	No	Don't know
Anticoagulants	Yes	No	Don't know
Tranquilizers	Yes	No	Don't know
Hypotensives (high blood pressure medicines)	Yes	No	Don't know
Has the patient ever received treatment for:			
Asthma, rheumatism or rheumatic fever?	Yes	No	Don't know
Aspirin	Yes	No	Don't know

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

_____ _____ _____

Doctor Date Signature of Patient

HEALTH QUESTIONAIRE

NAME _____ AGE _____ DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

Measles	No	Yes	Rheumatic Fever or Heart Disease	No	Yes
Mumps	No	Yes	Tuberculosis	No	Yes
Chickenpox	No	Yes	Venereal disease	No	Yes
Diabetes	No	Yes	Congenital Abnormalities	No	Yes
Strokes	No	Yes	Other serious diseases	No	Yes
Cancer	No	Yes			

Adult:

Have you had any serious illness? No Yes

Have you ever been hospitalized or been under medical care for very long? No Yes

If yes, for what reason? _____

Operations:

Have you had any surgery? No Yes

List _____

Injuries:

Have you had any broken bones? No Yes

Have you had any head concussions or injuries? No Yes

Have you ever been knocked unconscious? No Yes

FAMILY HISTORY:	If Living: Age	If Living: Health	If Deceased: Age (at death) & Cause		Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother/Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High blood pressure	No	Yes
Husband/Wife					Stroke	No	Yes
Son/Daughter					Convulsions	No	Yes
					Suicide	No	Yes
					Insanity	No	Yes
					Bleeding tendency	No	Yes
					Gout or other arthritis	No	Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed

Are you living with your husband or wife? No Yes

Is your sex life satisfactory? No Yes

Do you have dependents at home? No Yes

Alcoholic Beverages: Never_____Rarely_____Moderatley_____Daily_____Ever?_____ No Yes

Tobacco: Cigarettes Packs a day_____Don't Smoke_____Ever smoked?_____ No Yes

Are you employed? Full Time_____Part Time_____

What is your job? _____

Are you exposed to fumes, dust or solvents? _____

Education: (Years)

Grade School _____

High School _____

College _____

Postgraduate _____

How much time have you lost from work because or your health during the past?

Six Months _____

One Year _____

Five Years _____

SYSTEMIC REVIEW: Do you have any of the following?

General:

Recent weight change?	No	Yes
Have you been in good general health most of your life?	No	Yes

Skin:

Skin Disease	No	Yes
Jaundice	No	Yes
Hives, eczema or rash	No	Yes
Frequent infection or boils	No	Yes
Abnormal pigmentation	No	Yes

Head or Eyes-Ears-Nose-Throat:

Eye disease or injury?	No	Yes
Do you wear glasses?	No	Yes
Double vision	No	Yes
Headaches	No	Yes
Glaucoma	No	Yes
Itching eyes or nose	No	Yes

Head-Eyes-Ears-Nose-Throat (cont'd)

Sneezing or runny nose	No	Yes
Nosebleeds	No	Yes
Chronic sinus trouble	No	Yes
Ear disease	No	Yes
Impaired hearing	No	Yes
Dizziness or transient episodes of unconsciousness	No	Yes

Neck:

Stiffness	No	Yes
Thyroid trouble	No	Yes
Enlarged glands	No	Yes

Respiratory:

URI (cold) now	No	Yes
Spitting up blood	No	Yes
Chronic or frequent cough	No	Yes

PLEASE COMPLETE OTHER SIDE

Authorization for Release of Medical Information

Patient's Name: _____ **DOB:** _____

I hereby authorize: _____ *(Name of Disclosing Party)*

Address: _____

_____

Telephone No.: _____

to use and/or disclose my protected health information ("Health Information") as defined by Federal and state law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health-care provider, then the disclosed Health Information may no longer be protected from further disclosed by state or federal law.

This Health Information may be disclosed to: Christi C. Cheng, M.D. *(Name of Receiving Party)*

Mailing Address: 13847 East 14h Street #108

San Leandro Ca 94578

Tel: 510-912-0105

Telephone No.: Fax: 510-576-7921

Any and all of the following Health Information may be disclosed by Dr. Christi C. Cheng:

- ☐ Medical Records
- ☐ Claims/Billing Information
- ☐ Mental Health Records (which may be retrieved from your provider)
- ☐ Drug/Alcohol Abuse Records
- ☐ HIV Test Results

Relationship to Individual: ☐ Personal Representative ☐ Attorney ☐ Spouse/Relative ☐ Other _____

The Health Information will be used only for the purpose of allowing: _____

_____

- I understand that my health care will not be affected if I do not sign this form.
- I understand that this authorization will expire on _____ or **one (1) year** from the date of my signature below whichever is earlier.
- I also understand that I may revoke this authorization at any time by notifying Dr. Christi C. Cheng in writing. I understand that my revocation of this authorization will not affect any actions taken by Dr. Christi C. Cheng in reliance on this authorization prior to the time it received my revocation.
- I understand that I have the right to receive a copy of this authorization.

Signed: _____ **Dated:** _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care).
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.

Dr.Christi
CHRISTI CHENG, M.D.
FAMILY MEDICINE

HIPAA Acknowledgement

We Want You to Know How We Will Protect Your Private Health Information

When you visit Christi Cheng, MD Family Medicine Practice it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 13, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staff. In general, HIPAA was enacted to establish national standards to:

1. Give patients more control over their health information.
2. Set boundaries for the use and release of health records.
3. Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information.
4. Hold violators accountable with civil and criminal penalties.
5. Try to balance the need for individual privacy with requirements for public responsibility that requires disclosure to protect public health.

The **HIPAA** rules require that Christi Cheng, MD Family Medicine Practice provide all of our patients with our Notice of Privacy Practices. The notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information. A copy of this notice is available by request. Please sign below that we have made available a copy of the Notice for you to review. At your request we will gladly provide a personal copy of the Notice to you at any time. If you have any questions about our Privacy Practices please feel free to contact our Office Manager.

Thank you for your cooperation.

I acknowledge that I have received a copy of Christi Cheng, MD Family Medicine Practice Notice of Privacy Practices and have been given an opportunity to ask questions concerning the Privacy Practices of Christi Cheng, MD Family Medicine Practice.

Patient Name: _____
(Please Print)

Signature of Patient or Guardian: _____

Date: _____

If Guardian, explain relationship to patient: _____