Date_____ **Joshua Medical Group** **Account#**_____

Patient Information

Patient's Name_____ **Date of Birth**_____ **Age**_____

Last First Middle

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Social Security # _____-_____-_____ **E-Mail**_____ **Gender**____**M**____**F**

Please check appropriate Race and Ethnicity:

Race:____**American Indian/Alaska Native**____**Asian**___**Black or African American**____**Native Hawaiian or Pacific Islander**
___**White**___**Undetermined**

Ethnicity:____**Hispanic or Latino** ___**Non-Hispanic or Latino** ___**Other or Undetermined**

Marital Status____**Married**____**Single**___**Divorced**___**Widowed** **Spouse/Partner's Name**_____

Employer_____ **Address**_____

Emergency Contact_____ **Phone #**_____

Guardian Name_____ **Relationship to Patient**_____

Guardian Address_____ **Phone #**_____ **Work Phone #**_____

Social Security #_____ **Date of Birth**_____

Primary Insurance Information

Name of Insurance_____

Policyholder Name_____

Birth Date_____ **Effective Date**_____

Social Security # _____

Insurance Phone #_____ **Group#**_____

ID #_____ **Copay $**_____

Secondary Insurance Information

Name of Insurance_____

Policyholder Name_____

Birth Date_____ **Effective Date**_____

Social Security # _____

Insurance Phone #_____ **Group #**_____

ID #_____ **Copay $**_____

Previous Insurance Plan_____ **Is it still in effect?**_____

Preferred Laboratory for Blood Work_____

How were you referred to our office? Please circle one.

Yellow Pages **Friend** **Other Physician**_____ **Newspaper** **Other**_____

We ask for payment at the time of services, unless other arrangements have been made (Insurance or special arrangements). I authorize the staff of Joshua Medical Group to perform necessary services during diagnosis and treatment. I have read and understood the above questions and statements.

Signature_____ **Date**_____

Joshua Medical Group-Patient History

Note: This is a confidential record and will be kept in our office. Information contained here will not be released to anyone without your permission.

Today's Date_____ **Date of your last physical First Name**
Last Name_____ **Name Date of Birth** _____
Social Security #_____

Chief Complaint-Reason for your visit today?_____

History of Present Illness/Problem

Location of the problem
Abdomen Back Leg
Other_____
On a scale of 1-10, with 10 being the most severe, Circle the number that best describes you problem

1 2 3 4 5 6 7 8 9 10

How long does the problem last?
30 minutes 1 hour constant
Other_____
Is there anything else occurring at the same
_____
_____

When did you first notice the problem?

Today 1 week ago 1 month ago
Other_____

Is the problem constant or variable?

Dull the sharp Very sharp then stops Always there
Other_____

Does anything help or make it worse?

Moving around Standing up Lying down
Other_____

Does the problem interfere with your normal? activity?
Yes_____**No**_____**Explain**_____
_____

Past Medical, Family & Social History

Please list all serious illness in your immediate family (Example: diabetes, heart disease, high blood pressure, cancer, TB, depression, etc.

_____
_____
_____

List any personal past illness and/or surgeries:

_____ **Date**_____
_____ _____
_____ _____

Any special diet? No_____**Yes**____**Explain**_____
Any allergies? No_____**Yes**_____**Please list**_____

Do you smoke? No____**Yes**____**How long**_____
Do you drink? No____**Yes**____**How much** _____

Do you exercise regularly? No____**Yes**____**How much**_____

Please list all current medications and vitiamins/supplements_____
_____
_____
_____
_____

Please continue on the reverse side

Review of Systems

Do you now have, or have you recently had any of the following symptoms? Please circle **YES** or **NO.**

Constitutional Symptoms
Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes
Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

Allergic/Immunologic
Hay Fever Y N
Drug allergies Y N
Other _____

Neurological
Tremors Y N
Dizzy spells Y N
Numbness/Tingling Y N
Other _____

Endocrine
Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Gastrointestinal
Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other _____

Cardiovascular
Chest pain Y N
Varicose veins Y N
High blood pressure Y N

Integumentary
Skin rash Y N
Boiles Y N
Persistent itch Y N
Other _____

Musculoskeletal
Joint pain Y N
Neck pain Y N
Back pain Y N
Other _____

Ear/Nose/Throat/Mouth
Ear Infection Y N
Sore throat Y N
Sinus problem Y N
Other _____

Genitourinary
Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other _____

Respiratory
Wheezing Y N
Frequent coughs Y N
Shortness of breath Y N
Other _____

Hematological/Lymphatic
Swollen glands Y N
Blood clotting problem Y N
Y N
Other _____

Psychological
Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N

OUR FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment. Therefore, if you have any questions or concerns about our payment policies, our staff will be happy to address them.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the physician.

☐ **For Cash Patients: Payment for services is due at the time they are rendered.** We accept cash, check and credit cards. **(There is a $25.00 additional charge for returned checks.)**

I have read and understand Joshua Medical Group's Financial Policy.

PATIENT'S SIGNATURE_____DATE _____

☐ **For Patients with Medical Insurance:**

1. **As a courtesy, we will be happy to process your insurance claim for you. To properly bill your Insurance we require a legible copy of both sides of your Insurance cards, including the billing address (6 month updates require a new copy of your current Insurance card). *Appointments will be rescheduled if this information is not available.***

2. **However, all charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all insurance contracts.**

3. **We accept assignment of insurance benefits which means your insurance company sends payment for our services directly to our office.**

4. **Co-payments are due at the time of treatment.**

5. **If your insurance company does not pay within a reasonable amount of time, and after we have made numerous attempts to collect, we will ask that you contact your insurance carrier and inquire as to why the claim has not been paid.**

6. **We try to work with all our patients regarding their balances. If, however, your account is assigned to our Collection Agency there will be a $50.00 fee added to your balance for processing. You will receive a letter regarding your final notice giving you 10 days to pay your bill before your account is sent to collections and we add the process fee.**

I,_____hereby authorize _____
(Patients Name) (Name of Insurance Company)

To pay and hereby assign directly to Joshua Medical Group all benefits, if any, otherwise payable to me for his/her services as described. I understand that I am financially responsible for all charges incurred in the event that my insurance company does not make payment. I further acknowledge that any insurance benefits, when received by and paid to Joshua Medical Group will be credited to my account in accordance with the above said agreement. I authorize release of any medical information necessary to process all claims for Joshua Medical Group and/or its affiliated providers.

_____ _____
(Authorized signature of subscriber/patient) Date

We understand that temporary financial problems may affect timely payment on your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your health care provider

24 Hour Cancellation & Rescheduling Policy

At Joshua Medical Group, your appointment is reserved especially for you. We value your time and ask for your cooperation in following our cancellation and rescheduling policy to ensure all patients receive the care they need in a timely manner.

Please note the following:

- We require at least 24 hours' notice for cancelling or rescheduling any appointment.
- Appointments that are missed, cancelled late, or rescheduled with less than 24 hours' notice will incur a $25 fee.
- Repeated or multiple rescheduling may also result in a $25 fee.

Missed appointments reduce availability for other patients who may need urgent care. It is your responsibility to remember your scheduled appointments.

As a courtesy, we will attempt to confirm your appointment by phone the day before. However, you are still responsible for keeping track of your appointment time, regardless of whether or not you receive a reminder call.

Thank you for your understanding and support in helping us provide timely care to all our patients.

Patient Information:

First Name _____ Last Name _____ Date of Birth _____

By signing below, you acknowledge that you have read and understand the above policy.

_____

Signature of Patient or Authorized Date

Joshua Medical Group

A FAMILY PRACTICE GROUP

TO ALL PATIENT'S WITH INSURANCE COVERAGE

PLEASE READ AND SIGN

If you have insurance coverage, it is your responsibility to know the policy and guidelines of that company. What this means is:

- **You are responsible to know your deductible.**
- **You are to know your co-pay.**
- **Understand the type of coverage your insurance has.**
- **Telehealth appointments are treated as in-office visits, and your insurance will be billed for the services provided.**

With so many different insurance policies in effect it is virtually impossible for this office to know the details of every insurance policy. We will try to help you as much as possible…

- If your insurance denies your bill, you will be held liable for any charges.

We will be happy to answer any questions, or assist you in any way.

Thank you,

Gonzalo Martinez, MD

_____ _____

Patient Name D.O.B

_____ _____

Patient Signature Date

Joshua Medical Group

A FAMILY PRACTICE GROUP

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information to be used or disclosed by us, whether electronically, paper, or orally, are kept confidential, This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal and protected health information.

As required by HIPAA, we have prepared this explanation of how we maintain the privacy of your health information and how we may use and disclose this information.

We may use or disclose your medical records only for each of the following purposes: treatment, payment, and health care operations, and only to those entities that you approve.

Today's Date

I,_____, authorize Joshua Medical Group
First Name **Last Name** **Date of Birth**
to contact the following person(s) in regards to my protected health information.

Name	**Relationship**
Name	**Relationship**

INSTRUCTIONS:
Please leave the phone number(s) you would like to be contacted at and mark in the provided area whether or not we can leave detailed messages in the box next to the phone number.

Contact Numbers	Leave message with call back # ONLY	OK to leave detailed message
( )		
( )		

Patient Signature or Legally Authorized: _____