Registration

West Point Medical Center

☐ Rancho Cucamonga 8520 Archibald St. Ste. B Bldg. #20 ☐ Fontana Urgent Care 7774 Cherry Ave. ☐ Fontana Family Practice 7798 Cherry Ave. ☐ San Bernardino 1800 Medical Center Dr. Ste. 99

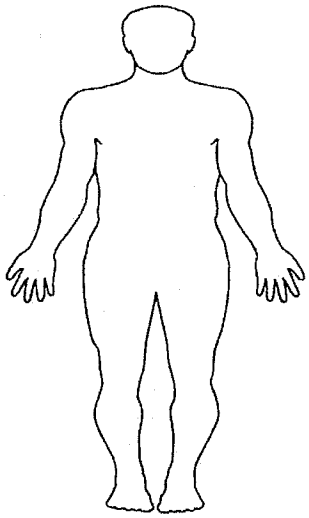
DATE/FECHA:	**SSN#:** - -
Last/Apellido **First/Nombre** Middle Title	Marital Status / Estado Civil
Street Address / Direcion De Casa	**DOB** Fecha de nacimiento / / ☐ **M** ☐ **F** **Gender H/M**
City/Ciudad **State/Estado** **ZIP/ Codigo Postal**	**Home # (Numero de telefono)** ( )
I wish to be contacted in the following manner: ☐ Written Communication ☐ Verbal Communication ☐ Other :	**Mobile #** ( )
Email: **Pharmacy:**	
Occupation / Ocupacion / **Employer / Trabajo**	**Employer Ph** (Numero De Trabajo) ( )

DESCRIBE THE INJURY / DESCRIBE EL ACCIDENTE/OR SINTOMAS

Where was the accident? /Donde se lastimo

Date & Time of Injury (Fecha y Hora de Accidente)

MARK THE BODY PART INJURED & LEVEL OF PAIN
From 0 to 10. Zero means no pain and 10 means very severe pain.
MARQUE LA PARTE DEL CUERPO QUE SE LASTIMO.
Del 0 al 10. 0 ciendo no tanto dolor 10 ciendo mucho dolor.



Anatomical Position

IN CASE OF EMERGENCY CONTACT (EN CASO DE EMERGENCIA)

Name / Nombre	Relationship / Relacion	Home#(casa)	Work #(Trabajo)
1)		( )	( )
2)		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to WPMC. I understand that West Point Medical Center will bill my insurance company or your employer for the services provided. However if insurance company denies the payment for any reason, injury is determined not to be work related, or the claim is denied I will be responsible for the full payment. I authorize my medical records to be released to my employer, insurance company, 3rd party administrator, and/or PCP.

Según mi conocimiento la información anteriormente mencionada es correcta. Yo autorizo que los beneficios de mi seguro sean pagados directamente a WPMC. Yo comprendo que el Centro Médico Westpoint le enviará el cobro directamente a mi empleador por los servicios rendidos. Sin embargo, si por alguna rason la aseguranza no paga yo sere responsable de pagar la cuenta, si se determina que mi lesión no es relacionada con el trabajo, o si la demanda es rechazada, yo seré responsable de pagar la cuenta. Yo autorizo que mis archivos medicos estén disponibles para mi empleador, mi aseguranza, alguna tercer persona administrativa, y/o Provedor.

Signature (Firma)	**Date / Fecha**
Parent/Guardian (Padres/Guardian)	**Date / Fecha**

West Point Medical Center Health History Questionaire

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Name (*Last, First, M.I.*): _____ ☐ **M** ☐ **F** **DOB:** _____ **Date**_____

1. Reason For Your Visit **How many days?**

_____ _____

_____

_____

2. Describe any medical problems for which you are being currently treated

_____

3.Describe any surgeries you may have had

_____

4.List all the medications you are now taking, including those you have bought without a prescription (such as Aspirin, cold medicines, vitamins, herbs, supplement)

_____

5. List any ALLERGIES and SENSTIVITIES to medications, soaps, pollens, bee stings, etc.

Allergic To	Reaction	Allergic To	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

6. Childhood illnesses ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Polio ☐ Rheumatic Fever

7. Immunizations ☐ Tetanus Booster _____ yrs ago ☐ Hepatitis ☐ MMR ☐ Polio ☐ HIB ☐ Pneumonia

9. Family History: ☐ Diabetes ☐ High Blood pressure ☐ Heart Dz ☐ Cancer _____ Other _____

10. Do you drink, smoke or abuse any other substance and how much?

_____

Health History

Yes	No	Do you have?	Yes	No	Do you have?
		Weakness, weight change night sweats?			Painful / frequent urination, urgency, blood in urine?
		Headaches, dizziness, visual problems?			Incontinence or change in urine stream?
		Ear pain, discharge, infection, impaired hearing?			Increased menstrual bleeding or pain?
		Runny nose, congestion, sore throat?			History of neck, back pain, hands or other joint pain?
		Swollen lymph nodes or neck pain?			History of any work injuries accidents or disabilities?
		Shortness of breath, wheezing, asthma, emphysema?			Arthritis or family history of arthritic disorders?
		Cough, blood in sputum, or chest congestion?			Missing or impaired hand, arm, foot, leg, finger, toe?
		Other Lung disease, TB, or exposure to it?			History of seizures, stroke, or spinal injury?
		Chest pain, tightness, or sweating with chest pain?			History of head trauma or concussion?
		Hypertension, murmurs, heart disease?			Seizures, loss of consciousness, or dizziness?
		Heart surgery, angioplasty, pace maker?			Paralysis, tremor, in-coordination?
		Difficulty swallowing, acid reflux, gastritis, or ulcers?			Difficulty with memory or speech?
		Nausea, vomiting or diarrhea?			Sensory or motor disturbance?
		Abdomen pain, bloated ness, gas, or indigestion?			Depression anxiety or nervous ness?
		Blood in stool, or changes in bowel habits?			History of suicide attempt?
		Liver Disease, diverticulitis, or colitis?			Rash, itching. abnormal moles
		Diabetes, kidney disease or dialysis?			Anemia, easy bleeding or bruising?
		Venereal diseases?			Thyroid or other hormonal disorders?

For any yes answer, indicate onset date, diagnosis, and current treatment _____

_____

_____

_____

WPMC Financial Policy

Basic Policy: I understand that West Point Medical Center will bill my Insurance company for services provided. However, if my insurance company denies payment for any reason, including but not limited to; deductible not met, out of network services, denial of pre-authorized, or unauthorized service, I will be responsible for payment. Payment for service is due at the time service is provided in our office or upon notice of insurance claim denial. **No refunds.**

For Patients with insurance: We bill most insurance carriers for you if proper paperwork is provided to us. Co-payments and deductibles are due at the time of service.

Medicare Patients: We will bill Medicare for you. All co-payments or deductibles are due and payable at the time of service is provided.

Surgery Fees: All co-pays, deductibles and payment for non-covered surgical procedures are due prior to surgery. Your insurance carrier may require prior authorization.

Non-covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Workers Compensation: If your injury is work related we will need authorization to treat from your employer, the case number and carrier name prior to your visit in order to bill the workers compensation insurance company.

Yearly Health checks: Periodic preventative health checks may or may not be covered under you health insurance policy. It is your responsibility to verify with your insurance company that these services are covered under your health insurance policy prior to scheduling the exam, as you will be responsible for all non-covered services.

HMO Insurance: We do participate with some, but not all, Heath Maintenance Organizations. In most cases, you need a referral from your primary care physician, or an authorization number from your HMO, which allows us to treat you. It is your responsibility to verify with your insurance carrier that these services are covered under your plan prior to your being seen, as you will be responsible for all non-covered services.

Late Fees: Interest at 18% and $30.00 late fee will be charged for all bills 30 days past due from the date of the statement. Courtsey discount is only valid if bills are paid within 15 days.

Signature: _____

"We require copies of a photo identification and your insurance card(s)"

Medicare Patients: Signature on File: I request payment of authorized Medicare benefits be made directly to West point Medical Center for any services furnished either to me or on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay any claims. If "other health insurance: is indicated in Item 9 of the HCFA-1500 form or else were on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible and/or coinsurance and the deductible are based upon the charge determination of the Medicare Intermediary.

Patient's Name: _____Medicare# _____Date_____

MEDICARE Patient's Signature: _____

Notice of Privacy Practices

West Point Medical Center
7774 Cherry Avenue. Fontana, Calif. 92336
Privacy Officer 909-355-1296

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

Name and Address of Patient:

Notificación de Prácticas Privadas

Por la presente reconozco que e recibido una copia del Aviso de esta práctica médica sobre la información Práctica de Privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Telefono: _____

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o cuidador de un paciente incompetente

Nombre y dirección del paciente: