PATIENT INFORMATION First Primary Care and Family Medicine (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ______________ (First) __________ (MI) _____ Previous Name ______________

Address Line 1 ______________________________

City, State ______________ ZIP __________

Home Phone ______________ Cell No. ______________ Work Phone ______________ Ext. __________

Primary Care Provider (PCP) ______________ Referring Provider ______________

Rendering Provider Name (this practice) ______________ E-Mail Address: ______________

Date of Birth MM _______/DD _________/YYYY ____________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other __________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number ______-_______-_________ Employer Name ______________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ______________ First Name ______________

Phone Number ______________ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ______________ ☐ Guardian

Address Line 1 ______________________________

City, State ______________ ZIP __________

Home Phone ______________ Work Phone ______________ Ext. __________

Referring Provider Name ______________________________

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ______________ (First) ______________ (MI) __________

Guarantor Account Number ______________ Date of Birth MM _________/DD ________/YYYY ___________

Social Security Number _______-_____-________ Telephone ______________

E -Mail Address ______________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ______________________________

City, State ______________ ZIP __________

Employer ______________ Employer Phone Number ______________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ______________ (_______)______________

Name of Insured ______________ Patient Relationship to Insured ______________

Subscriber ID (Policy Number) ______________ Group ID ______________ Copay Amount ______________

Effective Date ______________ Termination Date ______________ Date of Birth MM _______/DD _______/YYYY ______

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ______________ (_______)______________

Name of Insured ______________ Patient Relationship to Insured ______________

Subscriber ID (Policy Number) ______________ Group ID ______________ Copay Amount ______________

Effective Date ______________ Termination Date ______________ Date of Birth MM _______/DD _______/YYYY ____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature ______________________________ ***Date*** ______________

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Medical History

Do you have or have you had any of the following conditions:

Yes	No		Yes	No	
		AIDS/HIV			Hernia(s)
		Alcohol problem			High Blood Pressure
		Anemia			High Cholesterol
		Blood Clots			Bladder/Kidney problems
		Cancer (Type: ______)			Liver Disease
		Cataracts			Mental Trouble: Anxiety
		COPD/Emphysema			Mental Trouble: Depression
		Diabetes			Seizures/Epilepsy
		Eating Disorder			Sickle Cell Anemia
		Eczema			Skin Disorder
		Genital Herpes			Stroke
		Genital infections			Thyroid issue: hypothyroidism
		HPV/Genital Warts			Thyroid issue: hyperthyroidism
		Glaucoma			Transfusion
		Gout			Tuberculosis (TB)
		Pollen Allergies			Ulcers
		Headaches			Heart attack
		Hearing loss			Heart Disease
		Heart Murmur			Easy bruising
		Hemorrhoids			Easy bleeding
		Hepatitis			Blood in stools

Allergies

Please list any drug allergies and the type of reactions you experience with each drug

Drug	Reaction

Medications

Please list all the medications you are currently taking, along with the dosage and frequencies

Medication	Dosage	Frequency

Family History

Relative	Year born	If deceased, age of death	Medical problems/Cause of death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Relative	Age/Female Or Male	If deceased, age of death	Medical problems/Cause of death
Sibling(s)	/		
	/		
	/		
Children	/		
	/		
	/		
Spouse	/		

Surgery/Hospitalization/Accident/Injury History

Please list any surgeries/hospitalizations/accidents/injuries

Surgery/Hospital/Accident/Injuries	Year

First Primary Care & Family Medicine

Dr. Tang, Hui

Date: ______________________

Patient name: ______________________

Name/Location of your primary Pharmacy: ______________________

Who referred you to this practice? ______________________

List any other Physicians that you are currently under the care of: (ex: cardiologist, orthopedic)

____

____

Instructions: Please complete the following questionnaire before you see the doctor. Answer the question in as much detail as possible. The more information you provide will help your doctor to more accurately understand you and your medical history. Thank you.

Personal Habits

Do you drink alcohol regularly? Yes No If yes, what amount per week? ______________

Do you drink caffeinated beverages? Yes No If yes, how much per day? ______________

If yes, what type? (Ex: coffee, tea, soda): ______________

Do you smoke? Yes No If yes, how many packs per day? ______________

If yes, for how many years? ______________

Are you a former smoker? Yes No If yes, what year did you quit? ______________

Do you exercise? Yes No If yes, how many times per week? ______________

Do you currently use street drugs? Yes No

If yes, please circle: (A) Cocaine (B) Marijuana (C) recreational (D) other (Specify): ______________

Occupation: ______________________

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

IMPORTANT

PLEASE fill out all paper work, initial and sign.

Dr. Tang needs The Pain Management/Controlled Substance Agreement form to be completed by all patients once a year.

This helps Dr. Tang to comply with the LAW regarding controlled pharmaceuticals.

If you are not taking these types of medications we still need the form initialed, signed and kept on file.

Thank you in advance for your help in this matter.

PAIN MANAGEMENT/CONTROLLED SUBSTANCE AGREEMENT

• **The purpose of this Agreement is to prevent misunderstandings** about certain medicines you will be taking for pain management or controlled substance such as anti-anxiety medication (Examples-Valium, Xanax) or ADD/ADHD medications. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. ______ Pt. Initials

• **I understand that this Agreement is essential to the trust and confidence** necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement. ______ pt. Initials

• **Because these medicines have the potential for abuse or diversion, strict accountability is necessary**.

• **I understand that if I break this Agreement**, my doctor will stop prescribing these pain-control medications/controlled substances _______Pt. initials

• **I agree to notify my doctor of any and all pain medications or prescriptions that I receive from other providers** (effective from date of this agreement and ongoing). Such notification should occur by next business day following receipt of prescription. If I fail to alert my doctor I understand I may be discharged from the practice. ______Pt. initials

• **I understand that someday my doctor may wean me partially or totally from narcotics** if he/she determines that, in the long run, this is likely to be in my best interests. In such situations other meds or therapies will likely be suggested as part of my new treatment plan. I agree to respect my doctor's opinion in such circumstances and comply with the new treatment plan ____Pt. Initials

• **I understand that if I am suspected of diverting or distributing my pain medications/controlled substances, my doctor will immediately cease prescribing** these medications. In this case, my doctor will be required to comply with local state and/or federal reporting requirements and investigation.______ Pt. initials

• **I would also be amenable** to seeking psychiatric treatment, psychotherapy and/or psychological treatment if my doctor deems necessary. ____ Pt initials

• **I agree to l communicate fully and honestly with my doctor** about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. ____ Pt initials

• **If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.** I also understand that my state may have regulations concerning driving while under the influence of drugs and accept responsibility for adhering to those regulations. ____ Pt. Initials

• **I understand the use of opiates or pain medications in combination with anti-anxiety medications such as Valium or Xanax may cause me to stop breathing and abnormal heart rhythms resulting in injury or death**. ____Pt. initials

• **I understand that strong medications, which may include opiates and other controlled substances, which I may be prescribed, have potential risks and side effects, including the risk of addiction**. An over-dosage with an opiate medication may cause injury or death. Other possible complications include, but are not limited to, constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. ____Pt. Initials

• **I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances**. Use of alcohol will be limited to a time when I am not driving, operating machinery and will be infrequent. ____Pt. Initials

• **I will not share, sell or trade my medication with anyone**. ___Pt. Initials

• **I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor**. ______ Pt. Initials

• **I will inform my doctor of ALL current medications** including herbs, vitamins, supplements, and over-the-counter medications. I will provide an updated medication list during every visit. ______ Pt. Initials

• **I will not alter my medicine in any way or use any other administrative method other than what has been prescribed**.
Long-term agents (MS Contin, Oxycontin, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected and/or snorted. Potential toxicity could occur due to rapid absorption if taken inappropriately, which may lead to death. _____Pt. Initials

• **I understand that suddenly stopping some medications** (including opioids and sedatives) can cause substantial discomfort over and above any increase in my chronic pain causing psychological distress, extreme achiness and fatigue, nausea, trembling, etc. ______Pt. Initials

• **I will avoid withdrawal symptoms** by budgeting my pills, not taking more medications than prescribed, and keeping my appointments for refills. I understand that ‘running out’ of itself is not grounds for insisting on an ‘emergency or urgent appointment’. ____Pt. initials

• **I will safeguard my pain medicine/controlled substances from loss or theft**. Lost or stolen medicines will not be replaced. _____Pt. Initials

• **I agree that refills of my prescriptions for pain medicine/controlled substance will be made only at the time of an office visit or during regular office hours**. No refills will be available during evenings or on weekends. _____Pt. Initials

• **I agree that prescriptions for pain medicine/controlled substances will not be refilled earlier than the agreed upon renewal date**. _____Pt. Initials

• **(Males Only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance**. I understand that my prescriber/provider may check my blood or request that my primary care provider do routine testing to see if my testosterone level is normal. Please be aware your insurance may not cover this test, therefore if deemed medically necessary you agree to be responsible for any costs not covered by your insurance. ____ Pt. Initials

• **(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and prescribing prescriber/provider to inform them**. I am aware that should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. Infant drug withdrawal can be life threatening. If a female of childbearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with opioids/controlled substances. ____ Pt. Initials

I agree to use ____Pharmacy, Located

at____,

Telephone number ___________________________________, for filling prescriptions for all of my pain

medicine/controlled substance.

• **If I chose to have my medications filled by a new pharmacy not listed above**, I will be required to sign an amendment to this agreement with my updated pharmacy information. ______ Pt. Initials

• **I understand that changing date, quantity, or strength of medicines or altering a prescription in any way is against the law**. Forged prescriptions and/or forged provider's signatures are also against the law. If any of these instances occur, it will result in an immediate termination from this practice._____Pt. Initials

• **I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine or other controlled substances.** I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. ______ Pt. Initials

• I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine/controlled substance. Tests may include screens for illegal substances, and your cooperation is required. **Refusal of such testing may subject you to an abrupt / rapid wean schedule in order for the medication to be discontinued or prompt termination from care. ____Pt. Initials**

• **I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time**. _____Pt. Initials

• I will bring all unused pain medicine or controlled substance to every office visit related to the management of my pain treatment program _____Pt. Initials

• I understand that any serious misbehavior such as yelling, threatening, cursing, etc will likely be cause for dismissal from the practice. _____________Pt. Initials

• **I agree to follow the guidelines that have been fully explained to me**. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. ______Pt. Initials

This agreement is entered into on this ___________day of ____________________, ____________.

Patient signature:
____

Prescriber/provider signature:
____

Witnessed by:
____