

**Tony Pham M. D.**

*Internal Medicine*

2500 Alton Parkway, Suite 100 Irvine, CA 92606

Patient Name: \_\_\_\_\_  Male  Female  
Last Name First Name Middle Initial

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employers Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

**Emergency Contact Person**

Name of Person To Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last Name First Name

Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

**Primary Insured Information**

Insurance Co. Name: \_\_\_\_\_  HMO  PPO  Medicare  Other

Name of Insured: \_\_\_\_\_ Insured's D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship To Patient:  Self  Spouse  Other

**Patient Notice of Fees and Payments**

If you wish to have us file insurance claims for you, it is your responsibility to provide us with necessary insurance information. Not all services are covered by all insurance policies. Any services that are not covered by your insurance are your responsibility. For those patients belonging to a pre-paid HMO, it is your responsibility to inform the Doctor of any limitations of referrals for services outside this facility before the procedures are ordered. Charges which have not been paid by your insurance will be the patient's responsibility. The patient will receive a statement for any unpaid charges. All patient due balances are expected to be paid upon receipt of statement.

**\*\*For each month the statement is past due a \$35.00 late charge will be added to the balance indicated on the statement.**

**\*\*Co-Payments for services are due at the time of treatment rendered.**

**\*\*There will be a \$25.00 service charge for ALL returned checks.**

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians for services rendered. I am responsible for knowing my benefit/coverage. I will be financially responsible for All charges that are not covered by my insurance company. I hereby acknowledge that I have read, understand, and agree to hereby give consent for treatment.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## ***Internal Medicine***

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### **Patient Health History**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL MAIDEN Month Day Year

Sex:  F  M Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Referred here by:** (Check One)  Self  Family  Friend  Doctor  Hospital  Other: \_\_\_\_\_

#### **Past Medical History**

Do you now or have you ever had any of the following? (if Yes, check box)

- Cancer  Anemia  Jaundice  Epilepsy  Goiter  Emphysema  Pneumonia  
 Cataracts  Colitis  HIV/AIDS  Psoriasis  Heart Problems  Arthritis  Rheumatic Fever  
 Leukemia  Glaucoma  Diabetes  Kidney Disease  Tuberculosis  Stroke  Nervous Breakdown  
 Asthma  Gout  Bad Headaches  High Blood Pressure  Stomach Ulcers  Childhood Arthritis

List any other conditions you have had that are not already noted: \_\_\_\_\_  
\_\_\_\_\_

**Current Medications:** ( List any medications you are taking. Include items such as aspirins, vitamins, laxatives, calcium and supplements)

**Drug/Food Allergies:** Yes: \_\_\_\_\_ No: \_\_\_\_\_ To What: \_\_\_\_\_

**Type of Reaction:** \_\_\_\_\_

<b>Name of Drug</b>	<b>Dose (include strength &amp; quantity daily)</b>	<b>How long have you taken medication?</b>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Date of last EKG \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Last Blood Draw: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last Chest x-Ray: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### **Past Medical Surgeries**

<b>Year</b>	<b>Illness</b>	<b>Surgery</b>	<b>Reason</b>
1.			
2.			
3.			
4.			

**Social And Family History**

Marital Status:  Single  Married  Separated  Divorced  Widowed \* Number of Children:\_\_\_\_\_

Smoker:  Yes  No Packs Per Day:\_\_\_\_\_ Number of Years:\_\_\_\_\_

Caffeine:  Yes  No Cups per Day:\_\_\_\_\_ Alcohol: (Kind, Amount, Frequency):\_\_\_\_\_

Do you use recreational drugs, such as marijuana, cocaine, meth?  Yes  No If yes, please list:\_\_\_\_\_

**Has any blood relative had or has any of the following? (Check and indicate relationship)**

- Cancer\_\_\_\_\_  Colitis\_\_\_\_\_  Psoriasis\_\_\_\_\_  Goiter\_\_\_\_\_  Stroke\_\_\_\_\_  Asthma\_\_\_\_\_  Diabetes\_\_\_\_\_
- Gout\_\_\_\_\_  High Blood Pressure\_\_\_\_\_  Arthritis\_\_\_\_\_  Tuberculosis\_\_\_\_\_  Heart Problems\_\_\_\_\_
- Convulsions\_\_\_\_\_  Suicide\_\_\_\_\_  Mental Illness\_\_\_\_\_  Bleeding Tendency\_\_\_\_\_  Hereditary Defects\_\_\_\_\_
- Leukemia\_\_\_\_\_  Alcoholism\_\_\_\_\_  Osteoarthritis\_\_\_\_\_  Autoimmune Disease\_\_\_\_\_

**System Review**

As you review the following list, please check any of those problems, which have significantly affected you.

<p><b>Constitutional</b></p> <p><input type="checkbox"/> Recent Weight Gain Amount:_____</p> <p><input type="checkbox"/> Recent Weight Loss Amount:_____</p> <p><input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Fever</p> <p><b>Eyes</b></p> <p><input type="checkbox"/> Loss of Vision</p> <p><input type="checkbox"/> Double or Blurred Vision</p> <p><input type="checkbox"/> Itching Eyes</p> <p><b>Ear-Nose-Mouth-Throat</b></p> <p><input type="checkbox"/> Bleeding Gums</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Dryness of mouth</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Runny Nose</p> <p><input type="checkbox"/> Sores in mouth</p> <p><input type="checkbox"/> Loss of taste</p> <p><input type="checkbox"/> Frequent sore throats</p> <p><input type="checkbox"/> Difficulty in swallowing</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> Pain in Chest</p> <p><input type="checkbox"/> Heart Murmurs</p> <p><input type="checkbox"/> Irregular heart beat</p> <p><input type="checkbox"/> Sudden changes in heart beat</p> <p><input type="checkbox"/> High blood pressure</p> <p><b>Musculoskeletal</b></p> <p><input type="checkbox"/> Morning stiffness Lasting how long?_____</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Muscle tenderness</p> <p><input type="checkbox"/> Joint swelling -List joints affected within last 6 months: _____</p>	<p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting of blood or coffee ground material</p> <p><input type="checkbox"/> Stomach pain relieved by food/milk</p> <p><input type="checkbox"/> Blood in stools</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Persistent Diarrhea</p> <p><input type="checkbox"/> Black stools</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Increasing constipation</p> <p><b>Genitourinary</b></p> <p><input type="checkbox"/> Difficult urination</p> <p><input type="checkbox"/> Pain or burning on urination</p> <p><input type="checkbox"/> Rash/Ulcers</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Pus in urine</p> <p><input type="checkbox"/> Cloudy, "smoky" urine</p> <p><input type="checkbox"/> Discharge from penis/vagina</p> <p><input type="checkbox"/> Getting up at night to pass urine</p> <p><input type="checkbox"/> Sexual difficulties</p> <p><input type="checkbox"/> Vaginal dryness</p> <p><b>Respiratory</b></p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Difficulty in breathing at night</p> <p><input type="checkbox"/> Wheezing (asthma)</p> <p><input type="checkbox"/> Swollen legs or feet</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><b>Integumentary (Skin &amp; or Breast)</b></p> <p><input type="checkbox"/> Easy Bruising <input type="checkbox"/> Redness <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Hives <input type="checkbox"/> Hair Loss</p>	<p><input type="checkbox"/> Tightness</p> <p><input type="checkbox"/> Nodules/bumps</p> <p><input type="checkbox"/> Color changes of hands/feet in the cold</p> <p><b>Neurological System</b></p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Sensitivity or pain of hands and or feet</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Muscle Spasms</p> <p><input type="checkbox"/> Loss of consciousness</p> <p><b>Hematologic/Lymphatic</b></p> <p><input type="checkbox"/> Transfusion? When:_____</p> <p><input type="checkbox"/> Swollen glands</p> <p><input type="checkbox"/> Tender glands</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Bleeding tendency</p> <p><b>Psychiatric</b></p> <p><input type="checkbox"/> Excessive worries</p> <p><input type="checkbox"/> Easily losing temper</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Difficulty falling asleep</p> <p><input type="checkbox"/> Difficulty staying asleep</p> <p><b>Endocrine</b></p> <p><input type="checkbox"/> Excessive thirst</p> <p><b>Allergic/ Immunologic</b></p> <p><input type="checkbox"/> Frequent sneezing</p> <p><input type="checkbox"/> Increased susceptibility to infection</p>
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Patient's Name:\_\_\_\_\_ Date:\_\_\_\_\_ Reviewing Physician:\_\_\_\_\_

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**PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I have received a copy of Tony Pham M.D.'s Notice of Privacy Practices.**

**Please Initial Next To The Communication Method You Prefer:**

I authorize Dr. Pham and /or Staff to leave confidential messages at the following phone number with whomever or whatever device that picks up the phone. ( )

I authorize Dr. Pham and /or Staff to communicate confidential information to me by mail only and I accept liability for delay.

I do not wish Dr. Pham or Staff to call or send me mail, I am willing to accept the liability due to lack of communication on my part.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

**Record of Disclosures of Protected Health Information**

<b>Date</b>	<b>Disclosed to Whom Address or Fax Number</b>	<b>(1)</b>	<b>Description of Disclosure/ Purpose of Disclosure</b>	<b>By Whom Disclosed</b>	<b>(2)</b>	<b>(3)</b>

- (1) Check this box if the disclosure is authorized
- (2) Type Key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
- (3) Enter how disclosure was made: F=Fax; E=Email; M=Mail; O=Other