Grove Internal Medicine **History Form**

Name: ______________________________ DOB: _______________ Age: __________ Date: _____________

Address: ____ Occupation: ____________________

Phone (home): _______________ (cell): ________________ (work): _____________ SS# ________________

Chief Complaint: ____

DRUG ALLERGIES

1)

2)

3)

CURRENT MEDS/DOSAGE

1)

2)

3)

4)

5)

FAMILY HISTORY

Indicate Yes or No	Father	Mother	Siblings	Children
Heart disease				
High Blood Pressure				
Stroke				
Cancer				
Glaucoma				
Diabetes				
Epilepsy/Convulsion				
Bleeding Disorder				
Kidney Disease				
Thyroid Disease				
Mental Illness				
Other (please indicate illness)				

HOSPITALIZATION/SURGERIES

DATE	REASON

MEDICAL HISTORY: Circle all that apply

Headache
Shortness of Breath
Heart palpitations
Heart Murmurs
Chest Pain
Dizziness/Fainting
Nervousness

Allergies/Hay fever
Asthma
Bronchitis
Pneumonia
Ulcer
Osteoporosis
Peripheral Vascular Disease

GI Disorder
Lactulose intolerance
Gallbladder Disease
Prostate Disease
Bowel Irregularity
Incontinence

Venereal Disease
Gout
Hepatitis
Anemia
Arthritis
Depression
Sexual/Menstrual Problems

Scarlet Fever
Frequent Infection
Chronic rashes
Rheumatic fever
Mumps
Measles

Tetanus
Diphtheria
Polio
Rubella

HABITS

Smoke: Packs daily: How long: Interest in stopping?:

Alcohol: Type(s): Amount:

Diet: Salt intake: Fat intake:

Exercise routinely: **Coffee**: Cups daily: Other Caffeine:

Sleep: Difficulty falling asleep: Continuity disturbances: Snoring:

Early morning awakening: Daytime drowsiness:

WOMEN ONLY Pregnant: Planning pregnancy:

GROVE INTERNAL MEDICINE, INC.
A PROFESSIONAL CORPORATION

Grove Professional Plaza
8283 Grove Ave, Suite 201
Rancho Cucamonga, CA 91730
(909) 981-6644

PATIENT HISTORY

PATIENT NAME LAST FIRST MIDDLE INITIAL DATE

ADDRESS CITY ZIP CODE TELEPHONE

DATE OF BIRTH AGE SEX SOCIAL SECURITY NUM. CELL PHONE NUMBER

EMPLOYER ADDRESS

TELEPHONE DEPARTMENT HOURS

SPOUSE LAST FIRST MIDDLE INITIAL

EMPLOYER ADDRESS TELEPHONE

INSURANCE COMPANY ADDRESS CITY ZIP CODE

POLICY HOLDER LAST FIRST MIDDLE INITIAL

RELATIONSHIP TO PATIENT SOCIAL SECURITY NUMBER CERTIFICATE NUMBER

POLICY NUMBER TELEPHONE

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU RELATIONSHIP

ADDRESS CITY ZIP CODE

TELEPHONE

GROVE INTERNAL MEDICINE
AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Name:

Date of Birth:

Grove Internal Medicine will only disclose the personal health information you want disclosed.

Fill in the name of the person(s) to whom you want Grove Internal Medicine to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

What personal health information would you like disclosed:

Expiration of authorization: (date or event).

Signature of Member/Participant, Personal Representative, Parent/Guardian who is authorizing the Release:

Date:

GROVE INTERNAL MEDICINE, INC.

8283 GROVE AVE. STE. 201
RANCHO CUCAMONGA CA 91730
(909) 981-6644 fax (909) 981-5048

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE TO DISCLOSE MY PROTECTED HEALTH INFORMATION IN THE MANNER DISCRIBED BELOW. I UNDERSTAND THAT THE RECIPIENT OF MY PHI MAY NOT FURTHER DISCLOSE THE INFORMATION UNLESS THE RECIPIENT OBTAINS ANOTHER AUTHORIZATION FROM ME OR UNLESS THE DISCLOSURE IS SPECIFICALLY REQUIRED OR PERMITTED BY LAW. I FURTHER UNDERSTAND THAT THE HEALTH CARE PROVIDER WILL NOT CONDITION THE PROVISION OF CARE OR THE RECEIPT OF BENEFITS ON THE SIGNING OF THIS AUTHORIZATION.

PATIENT INFORMATION

NAME: DOB: PHONE #:

STREET ADDRESS: CITY:

STATE: ZIP CODE:

CATEGORY OF PHI:

MEDICAL RECORD

CLAIMS/BILLING INFORMATION

DRUG/ALCOHOL ABUSE INITIAL

MISC INFORMATION SPECIFY BELOW:

AMOUNT OF PHI:

LAST 2 YEARS OF PHI IN THE CHOSEN CATEGORY

LIMIT USE/DISCLOSURE OF MY PHI

TO:

RECIPIENT:

GROVE INTERNAL MEDICINE, INC.

8283 GROVE AVE. STE. 201

RANCHO CUCAMONGA CA 91730

REASON FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION:

THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE SIGNED, UNLESS SPECIFIED: I UNDERSTAND THAT I WILL BE PROVIDED WITH A COPY OF THIS AUTHORIZATION AND THAT I MAY REVOKE OR MODIFY THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE HEALTH CARE PROVIDER IN WRITING. 1 MUST SIGN MY WRITTEN REQUEST AND SEND IT TO:

SIGNED: DATED: WITNESSED:

IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE RELATIONSHIP:

PARENT OR GUARDIAN/CAREGIVER OF A MINOR CHILD

GUARDIAN OR CONSERVATOR OF AN INCOMPETENT PATIENT

BENEFICARY OR PERSONAL REPRESENTATIVE OF DECEASED PATIENT

ADVANCE BENEFICIARY NOTICE

NOTICE: YOUR NEED TO MAKE A CHOICE ABOUT RECEIVING THESE HEALTH CARE ITEMS OR SERVICES:

SOMETIMES YOUR INSURANCE MAY NOT PAY FOR ALL ITEMS OR SERVICES RECOMMENDED FOR YOU. INSURANCE DOES NOT PAY FOR ALL OF YOUR HEALTH CARE COSTS. INSURANCE ONLY PAYS FOR COVERED ITEMS AND SERVICES WHEN INSURANCE RULES ARE MET. THE FACT THAT INSURANCE MAY NOT PAY FOR A PARTICULAR ITEM OR SERVICE DOES NOT MEAN THAT YOU SHOULD NOT RECEIVE IT. THERE MAY BE A GOOD REASON YOUR DOCTOR RECOMMENDED IT.

ITEM OR SERVICE RECOMMENDED

MEDICAL SERVICES/ XRAY AND/OR LABORATORY

I UNDERSTAND THAT MY INSURANCE WILL NOT DECIDE WHETHER TO PAY UNLESS I RECEIVE THESE ITEMS OR SERVICES. PLEASE SUBMIT MY CLAIM TO MY INSURANCE COMPANY. I UNDERSTAND THAT I MAY BE PERSONALLY AND FULLY RESPONSIBLE FOR ANY SERVICES NOT COVERED.

DATE

SIGNATURE OF PATIENT OR PERSON ACTING ON PATIENT'S BEHALF

GROVE INTERNAL MEDICINE, INC.
8283 GROVE AVE. STE. 201
RANCHO CUCAMONGA CA 91730

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR HEALTHCARE OPERATIONS

I, , UNDERSTAND THAT AS PART OF MY HEALTHCARE, THIS PRACTICE ORIGINATES AND MAINTAINS HEALTH RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS, DIAGNOSES, TREATMENT , AND ANY PLANS FOR FUTURE CARE OR TREATMENT. I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A BASIS FOR PLANNING MY CARE AND TREATMENT
- A MEANS OF COMMUNICATION AMONG THE MANY HEALTH PROFESSIONALS WHO CONTRIBUTE TO MY CARE
- A SOURCE OF INFORMATION FOR APPLYING MY DIAGNOSIS AND SURGICAL INFORMATION TO MY BILL
- A MEANS BY WHICH A THIRD-PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED, AND
- A TOOL FOR ROUTINE HEALTHCARE OPERATIONS SUCH AS ASSESSING QUALITY AND REVIEWING THE COMPETENCE OF HEALTHCARE PROFESSIONALS
- AUTHORIZES PAYMENT BE MADE TO ME OR ON MY BEHALF TO GROVE INTERNAL MEDICINE, INC.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS AND THAT THE ORGANIZATION IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING.

I WISH TO HAVE THE FOLLOWING RESTRICTIONS TO THE USE OF DISCLOSURE OF MY HEALTH INFORMATION:

I HAVE BEEN PRESENTED WITH A COPY OF THIS PRACTICE’S NOTICE OF PRIVACY POLICIES, DETAILING HOW MY INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FEDERAL AND STATE LAW. I UNDERSTAND THE CONTENTS OF THE NOTICE. I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS CONSENT/ ACKNOWLEDGEMENT

NAME DATE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

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FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your loca-tion, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.