Jacqueline De Castro, MD
Jasper Basit, MD
1457 Bailey Dr., Hanford, CA 93230
Ph. 559.582.9100 Fax. 559.582.9103

REGISTRATION FORM

Section I: Patient Information

Name (Last, First, M.I.):_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip:_____

Phone (____)_____ Work Phone (____) _____ Cell Phone (____)_____

The best time to contact me is:_____ ☐A.M. ☐P.M. on my ☐Home phone ☐Work phone ☐Cell phone

Date of Birth:_____ Sex: _____ Social Security #:_____ Occupation: _____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Spouse/Parent's Name (encircle) :_____ Employer: _____ Work Phone: _____

Email Address: _____ Race/Ethnicity: _____

Person to contact in case of emergency_____ Phone:_____

Section II: Guarantor Information (Person responsible for payment of the account)

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other_____

Name:_____ Date of Birth: _____ Sex:_____

Address: _____City:_____ State:____ Zip:_____ Phone: (____)_____

Social Security #:_____ Occupation: _____ Employer: _____

Employer Address: _____ Work Phone (____)_____

Section III: For Insurance Information, please see Insurance Card

CONDITIONS OF TREATMENT:

1. *CONSENT TO TREATMENT:* The undersigned hereby consents to the administration and performance of all diagnostic procedures and treatment which, from the judgment of my physician, may be considered necessary or advisable. I further agree that if I decide to transfer care from this office without written consent from myself or my physician, Jacqueline G. De Castro, MD, Inc (referred to as "Dr De Castro") shall not be liable for the consequence of such decision.
2. *RELEASE OF INFORMATION:* To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize Dr De Castro to release portions of my records, including my medical records, to any person, organization, or agency which is or may be liable for all or any portion of my health information, including but not limited to insurance companies, health care service plans, worker's compensation, and government agencies.
3. *MEDICARE ASSIGNMENT:* I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct and that payment of authorized benefits be made in my behalf.
4. *ASSIGNMENT OF INSURANCE BENEFITS:* In the event I am entitled to outpatient benefits arising out of any policy of insurance insuring me or anyone liable to me, I hereby assign said benefits directly to Dr De Castro for application to my bill. I agree that Dr De Castro may issue a receipt for any such payments. I shall be responsible for payments not covered by this assignment.
5. *FINANCIAL AGREEMENT:* I hereby agree that in consideration for services to be rendered by Dr De Castro, I shall make prompt payments as bills are presented. I agree to pay interest at the legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney for collection, I shall pay the actual attorney's fees and collection expenses.
6. *GUARANTOR:* I hereby agree to assume the obligations imposed by the "Financial Agreement" above.
7. *TEACHING PROGRAM:* To the extent that the hospital conducts teaching programs to which the patient's condition or treatment is pertinent, students are permitted to participate in the care of the patient unless the hospital is notified to the contrary in writing.

Date	Signature of Patient/Parent/Guardian	Relationship to Patient (if applicable)	Witness
	X		

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MEDICAL HISTORY FORM

DATE: / /

NAME (LAST, FIRST, MI):	AGE:	SEX: ☐MALE ☐FEMALE	DATE OF BIRTH:
RELIGIOUS PREFERENCE:		PRIMARY LANGUAGE SPOKEN:	
MARITAL STATUS: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed		HIGHEST EDUCATIONAL ATTAINMENT:	
CURRENT OCCUPATION:		PREVIOUS OCCUPATIONS:	
IF MARRIED, SPOUSE'S NAME:			
CHILDREN'S NAME(S) AND AGE(S)			

OTHER DOCTORS WHO HAVE TAKEN CARE OF YOU IN THE PAST YEARS:

NAME	CITY	SPECIALTY

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES: ☐YES ☐NO
(IF YES, PLEASE LIST THE NAME OF THE MEDICATION OR SUBSTANCE AND TYPE OF REACTION):

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS
(PLEASE CHECK APPROPRIATE BOXES)

	NO	YES		NO	YES		NO	YES
HIGH BLOOD PRESSURE			INDIGESTION			DIFFICULTY URINATING		
DIABETES			NAUSEA			PAINFUL BOWEL MOVEMENT		
CANCER			VOMITING			BLOOD IN URINE		
HEART DISEASE			CONSTIPATION			NASAL DISCHARGE		
CHEST PAIN / CHEST TIGHTNESS			DIARRHEA			DEFORMITIES		
SHORTNESS OF BREATH			BLOOD IN STOOL			ARTHRITIS		
SWOLLEN ANKLES			ULCERS			LOW BACK PROBLEMS		
PALPITATIONS			URINATE AT NIGHT			SKIN DISEASES		
LIGHTHEADEDNESS			WEAKNESS			BLOOD DISORDERS		
FREQUENT URINATION			URINARY INCONTINENCE			SEXUALLY TRANSMITTED DISEASE		
RHEUMATIC FEVER			POST NASAL DRIP			ANXIETY		
ASTHMA			DIFFICULTY SWALLOWING			DEPRESSION		
BREAST MASSES / DISCHARGE			CHANGE IN BOWEL HABITS			ANEMIA		
DEAFNESS			ABDOMINAL DISCOMFORT			ALCOHOL ABUSE		
MUSCLE PAIN			HEMORRHOIDS			DRUG ABUSE		
URINARY INFECTIONS			GALL BLADDER DISEASE			GOUT		
NECK STIFFNESS			COLITIS			COUGHING BLOOD		
BRONCHITIS			HEPATITIS OR JAUNDICE			CHANGE IN APPETITE		
PNEUMONIA			THYROID DISEASE			INSOMNIA		
PERSISTENT COUGH			HEAD OR NECK RADIATION			RINGING IN EARS		
TUBERCULOSIS			HEADACHE			TINGLING/NUMBNESS		
HAY FEVER			KIDNEY DISEASES			SORENESS OF THROAT		
UNEXPLAINED WEIGHT GAIN /LOSS			KIDNEY STONES			OTHER (SPECIFY)		

PLEASE LIST AND GIVE DATES OF THE FOLLOWING:			
Date	Surgery	Hospital/City:	Doctor:

Hospitalizations (Other than for Surgery):		
Date	Reason	Hospital/City:

Injuries:			Date
Back Injuries	☐No	☐Yes	
Dislocation	☐No	☐Yes	
Fractures	☐No	☐Yes	
Soft Tissue Injuries	☐No	☐Yes	
Concussion/Head Injury	☐No	☐Yes	

Immunization History – Have you ever had:							
Pneumovax immunization?	☐No	☐Yes	When?	Flu Immunization	☐No	☐Yes	When?
Tetanus immunization	☐No	☐Yes	When?	H1N1 Immunization	☐No	☐Yes	When?
Other (specify):			When?				

When was your last:		
Cholesterol Check:	Pap Smear:	Colonoscopy:
Stool Check for Blood:	Breast Exam:	Prostate Exam:

FAMILY HISTORY

HAS ANY MEMBER OF YOUR FAMILY (INCLUDING PARENTS, GRANDPARENTS, AND SIBLINGS) EVER HAD THE FOLLOWING?

ILLNESS	WHICH FAMILY MEMBER	AGE DIAGNOSED
Cancer (Type:_____)		
Hypertension (High Blood Pressure)		
Diabetes		
Heart Disease		
Stroke		
Epilepsy/Seizures		
Mental Disease (Anxiety, Depression, Bipolar, etc)		
Drug or Alcohol Addiction		
Bleeding Problems		
Asthma/Allergies		

MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER, VITAMINS, HERBS, ETC)

DRUG NAME	DOSE	DRUG NAME	DOSE

FOR FEMALE PATIENTS

Age at onset of Periods:	Regular? ☐No ☐Yes Frequency: _____	Length of Period:
Pregnancies: Births:	Miscarriages: Abortions:	Birth Control Method:
# Cesarean Sections:	# Premature Deliveries :	Sexually Active? ☐No ☐Yes
Pelvic Pain? ☐No ☐Yes (Explain.)		Previous Abnormal PAP: ☐No ☐Yes (Explain.)

Patient Name:	DOB:	Today's Date:

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Authorization to Release Medical Records

Patient's Name: _____ DOB: _____

Address: _____ Phone: _____

Please OBTAIN Information FROM:

_____
Name of Physician, Hospital or Other

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number/Fax Number

For the purpose(s) of:

- ☐ Patient Claim
- ☐ Insurance Claim
- ☐ Continuity/Transfer of Care

Specified dates of records to be released:

_____

_____

This authorization shall start immediately and end on : _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:

_____

_____

_____

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. (Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code, Sect. 56 may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signature: _____
(Patient/Legal Representative) Date: Time:

If signed by other than patient, please indicate relationship: _____

Witness: _____

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Family Medicine
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Permission To Discuss Medical Information

I, _____, hereby grant Dr. De Castro / Dr. Basit and their staff to discuss my medical information and medical history with _____ for the purpose of making decisions about healthcare and related services.

_____ Date _____
Signature

Statement of Patient Financial Responsibility

Patient Name: _____ DOB:_____

Jacqueline G. De Castro, MD, Inc. appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as predetermined by your contact with your insurance carrier. We expect these payments at the time of your service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim or if you or your physician elect to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Jacqueline G. De Castro, MD. Inc., for providing primary healthcare services to me or the above-named patient. I certify that the information provided is to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Jacqueline G. De Castro, MD, Inc., the full and entire amount of bill incurred by me or the above-named patient; or if applicable amount due after payment has been made by my insurance carrier.

Signature _____Date_____

Co-Pay Policy

Some Health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time of service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient Signature: _____ Date_____

Consent for Treatment and Authorization to Release Information

I hereby authorize The Jacqueline G. De Castro. MD, Inc, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize The Jacqueline G. De Castro. MD, to release to appropriate agencies, any information acquired during my or the above-named patient's examination and treatment.

Patient Signature: _____Date_____

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel a total of four appointments, I may be discharged from care.

The Practice will notify you in writing via U.S. Mail, if you are discharged from care.

I have read and understand the above information, and agree to the terms described.

Patient Signature: _____ Date_____