PATIENT REGISTRATION FORM

NAME:_____DATE OF BIRTH_____

LIKES TO BE CALLED:_____SSN_____

ADDRESS:_____

APT:_____CITY:_____STATE:_____ZIP:_____

CELL: ( )_____ E-MAIL_____

Do we have permission to send you health information updates? YES_____ NO_____

PHONE: ( )_____ WORK: ( )_____

EMPLOYER:_____

BUSINESS ADDRESS:_____

SPOUSE:_____SPOUSE EMPLOYER:_____

REFERRED BY:_____PRIMARY CARE MD:_____

***PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE):**

NAME:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____ PHONE: ( )_____

NEAREST RELATIVE TO NOTIFY IN CASE OF AN EMERCENCY:

NAME:_____RELATIONSHIP:_____
ADDRESS:_____PHONE: ( )_____

INSURANCE:

1._____INSURED ID:_____GROUP #_____

2. _____INSURED ID:_____GROUP #_____

AUTHORIZATIONS:

I HEREBY AUTHORIZE PAYMENTS BY MY INSURANCE CARRIER BE MADE DIRECTLY TO THE PROVIDER OF THESE SERVICES.
YES_____NO_____

I UNDERSTAND I AM RESPONSIBLE FOR ANY PORTION OF THE BILL NOT COVERED BY MY INSURANCE CARRIER. I UNDERSTAND I AM RESPONSIBLE FOR GETTING ANY REQUIRED REFERRALS OR AUTHORIZATIONS FROM MY PRIMARY CARE PHYSICIAN, AS STIPULATED BY MY INSURANCE CARRIER, FOR MY TREATMENT AT THIS OFFICE.
YES_____NO_____

I HEREBY AUTHORIZE RELASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES
THE INFORMATION AUTHROIZED FOR RELASE MY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE INCLUDING HEPATITIS, SYPHILLIS, GONNORREA, HIV AND AIDS.
YES_____NO_____

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE:_____SIGNED:_____
(PATIENT)

Judy L Bourget MD

HEALTH QUESTIONNAIRE

Rev. 6/21/18

Name: _____ Age: _____ Date: _____

PAST MEDICAL HISTORY:

SS#: _____ Medical Record #: _____

Measles	NO	YES	Seizure	NO	YES	Peptic Ulcer	NO	YES
Mumps	NO	YES	Heart Disease	NO	YES	Kidney Disease	NO	YES
Chicken Pox	NO	YES	Hypertension	NO	YES	Diabetes	NO	YES
Polio	NO	YES	Tuberculosis	NO	YES	Thyroid Disease	NO	YES
Rheumatic Fever	NO	YES	Pneumonia	NO	YES	Venereal Disease	NO	YES
Scarlet Fever	NO	YES	Asthma	NO	YES	Anemia	NO	YES
Cancer	NO	YES	Hepatitis	NO	YES	Phlebitis/Blood Clot	NO	YES
Stroke	NO	YES	Liver Disease	NO	YES	Gout	NO	YES

Significant illnesses, injuries, or hospitalizations:

Year: _____	Illness: _____	Year: _____	Surgery: _____
Year: _____	Illness: _____	Year: _____	Surgery: _____
Year: _____	Illness: _____	Year: _____	Surgery: _____
Year: _____	Illness: _____	Year: _____	Surgery: _____

PAST SURGERIES:

Allergies: (Medication & Food)

1. _____	Reaction	_____
2. _____	Reaction	_____
3. _____	Reaction	_____
4. _____	Reaction	_____

Current Medications:

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

Immunizations:

Year:	
	Influenza
	Tetanus
	Pneumococcus
	Other

Social History:

Marital Status: S M Sep D W #_____ children

Occupation: **Hrs/Wk:** _____

Job Satisfaction: □ Yes □ No **Smoker:** □ Yes □ No **Pack/Day:** #_____ **Years:** #_____

Caffeine: □ Yes □ No **Cups/Drinks:** _____ Day

Alcohol: (Kind, Amount, Frequency)

Recreational Drugs:

Advance Directive/Living Will: □ Yes □ No

Family History	Age	If Living: Health Status	If Deceased: Age (at death) & Cause		Has any blood relative ever had: If so write which relative.		
Father					Cancer	NO	YES
Mother					Tuberculosis	NO	YES
Brother/Sister					Diabetes	NO	YES
					Heart Trouble	NO	YES
					High Blood Pressure	NO	YES
					Stroke	NO	YES
Husband/Wife					Convulsions	NO	YES
Son/Daughter					Suicide	NO	YES
					Mental Illness	NO	YES
					Bleeding Tendency	NO	YES
					Gout or Arthritis	NO	YES
					Osteoporosis	NO	YES

SYSTEM REVIEW

GENERAL

Do you eat a well balanced diet?	NO	YES
Approx. weight now_____ 1 yr ago_____		
Maximum weight_____		
Exercise? Frequently / wk _____		
Activities _____		
Any sexual concerns?	NO	YES
Year Last Complete Physical? _____		
Headaches	NO	YES
Glasses/contacts	NO	YES
Double Vision	NO	YES
Eye disease or injury	NO	YES
Last year checked for glaucoma_____		
Itching eyes or nose/hay fever	NO	YES
Septal deviation/ polyps (circle)	NO	YES
Nosebleeds	NO	YES
Sinus Trouble	NO	YES
Ear Disease	NO	YES
Impaired Hearing	NO	YES
Ringing in the ears	NO	YES
Hoarseness	NO	YES

NECK

Stiffness	NO	YES
Enlarged glands	NO	YES
Injury	NO	YES

RESPIRATORY

Coughing up blood	NO	YES
Chronic cough(incl. Smoker's cough)	NO	YES
Wheezing	NO	YES
Shortness of Breath	NO	YES
Skin test for tuberculosis	NO	YES
If yes, year and test results _____		
Year of last chest X-Ray		

CARDIOVASCULAR

Chest pain	NO	YES
Shortness of breath when lying flat	NO	YES
Pain in legs on walking, relieved by rest	NO	YES
Varicose Veins	NO	YES
Ankles often badly swollen	NO	YES
Heart Murmur	NO	YES
Rapid, hard or skipped heart beats	NO	YES
Year of last EKG? _____		
Have you had a stress treadmill? Year_____	NO	YES

GASTROINTESTINAL

Change in appetite	NO	YES
Heartburn or indigestion	NO	YES
Sour taste in throat or mouth	NO	YES
Intolerance to spicy foods, coffee or alcohol	NO	YES
Ever vomited blood?	NO	YES
Food stick in throat?	NO	YES
Gallbladder trouble/intol. to greasy foods	NO	YES
Intolerance to milk products	NO	YES
Pancreatitis	NO	YES
Do you often vomit?	NO	YES
Crampy abdominal pain	NO	YES
Chronic constipation	NO	YES
Frequent diarrhea	NO	YES
Change in bowel habits	NO	YES
Bloody or black bowel movements	NO	YES
Hemorrhoids or piles	NO	YES

GENITOURINARY

Loss of urine when cough or sneeze	NO	YES
Kidney or bladder infection (circle)	NO	YES
Burning or frequent urination (circle)	NO	YES
Feeling must go immediately?	NO	YES
Do you have to get up at night to urinate? #_____	NO	YES
Blood in urine	NO	YES
Kidney Stones	NO	YES
Swelling of hands and feet	NO	YES
Difficulty starting urination?	NO	YES
Decrease in strength of stream	NO	YES
Penile Discharge	NO	YES
Date of last prostate exam? _____		

MUSCULOSKELETAL

Joint Pain	NO	YES
Back Pain	NO	YES
Muscle weakness or tenderness	NO	YES
Difficulty walking	NO	YES

SKIN

Skin Disorders(list)	NO	YES

NEUROLOGIC / PSYCHIATRIC

Numbness / paralysis (circle)	NO	YES
Fainting spells	NO	YES
Memory spells	NO	YES
Dizziness	NO	YES
Do you have trouble sleeping?	NO	YES
Are you often depressed?	NO	YES
Are you often anxious or nervous?	NO	YES
Do you ever wish you were dead and away from it all?	NO	YES
Do you often worry?	NO	YES
Have you ever been under psychiatric care?	NO	YES

HEMATOLOGIC

Excessive bleeding or abnormal bruising	NO	YES

ENDOCTRINE

Night Sweats	NO	YES
Crave large amounts of fluids	NO	YES
Intolerance to slightly warm rooms	NO	YES
Intolerance to slightly cool rooms	NO	YES
Hair Loss	NO	YES
Diminished sex drive	NO	YES

GYNECOLOGICAL (This section for women only)

Age when periods started _____ years old		
Frequency: every _____ days; Last period _____		
Are they abnormal or irregular?	NO	YES
Menopausal _____ Age? _____	NO	YES
Number of pregnancies _____ C- Sections _____		
Term deliveries _____ Premature_____		
Miscarriages _____ Abortions _____		
Pelvic inflammatory disease	NO	YES
Pain with intercourse	NO	YES
Date of last cancer smear? _____ **Normal?**	NO	YES
Breast masses, lumps, cyst (circle)	NO	YES
Nipple discharge	NO	YES
Skin discoloration / dimpling	NO	YES
Family History of breast cancer	NO	YES
Date of last mammogram_____	NO	YES
Did someone other than the patient help fill this out?	NO	YES

Patient Signature:_____

Reviewing Physician:_____

Judy L Bourget, MD

No Show Policy

In order to be able to accommodate our other patients with appointments, we request that you please notify the office within 24 hours in advance to reschedule or cancel if you cannot be able to keep your appointment.

We will try our best to schedule your appointment at the most convenient time possible. As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time.

Cancellations must be received 24 hours in advance.

Patients who do not contact us prior to their appointment will be charged a $25.00 No-show charge.

Patients with frequently missed appointments will only be provided same day appointments.

I, _____ have reviewed the above policy.

Signed: _____ Date: _____
(Patient)

Judy L Bourget, MD.

PROTECT YOUR CREDIT

Effective January 1, 2012, we will mail you **only TWO statements** for our services, after we have billed your insurance company. If the payment is not received from you or your insurance company, the balance of the payment will be transferred to our collection agency after **90 days** from the date of service. *In addition, there will be a **30% service charge** on all accounts transferred to our collection agency*.

Please help us in keeping our expenses down by paying your copay at the time of service and providing us with your most recent and up-to-date insurance information.

Thank you,

Dr. Bourget & Staff

Patient acknowledges and agrees to the financial terms described above:

_____ _____

Patient Signature **Date**

Rev. 6/12/18

Judy L Bourget MD

NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF RECIEPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of Dr. Judy Bourget MD.

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 949-429-8760.

I acknowledge receipt of the ***Notice of Privacy Practices*** of Dr. Judy Bourget MD.

Signature: _____ Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature representative:_____ Date:_____

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (specify): _____