Redlands Yucaipa Medical Group

Rafael Villarosa, M.D.
www.drvillarosa.com
255 Terracina Blvd. #207
Redlands, CA 92373
(909) 793-2226
Fax (909) 793-3336

Welcome!

Please find enclosed the new patient forms to complete and bring to your new patient appointment on _____@_____. We ask that in addition to your paperwork that you also bring in your insurance card(s), photo ID (driver license/ID card) and a **complete/detailed medication list (to include: medication name, strength and directions) *or* your prescription bottles** to your appointment. **Please arrive 15-20 minutes BEFORE your scheduled appointment for registration purposes.**

If you would like us to obtain a copy of your records from your previous doctor; please complete the attached records release and forward it to them or bring it to your appointment with our office and we will fax it to them.

Our office is located at 255 Terracina Blvd. #207

From the San Bernardino area: Exit California St. Go right onto California St. Stay on California (it will jog slightly to the right at Redlands Blvd.) until the end. You will make a left on Barton Rd. Continue east until (the second light) Terracina Blvd. and make a right. Go up Terracina approximately 1 mile, we will be on the left had side just before the hospital.

From the Palm Springs area: Exit Cypress Ave. Go left on to Cypress. Follow Cypress approximately 3 miles, it will curve to the right and turn into Terracina. After the stop sign we are the first two story building on the right hand side.

From the 30 freeway/mountain areas: 30 freeway south, exit on San Bernardino Ave. Go straight when you exit the freeway. At Lugonia Ave make a right. At Alabama (stop light) make a left. Stay on Alabama until it ends at Barton Rd. Make a right on Barton Rd. The next light is Terracina make a left, we are approximately 1½ miles up on the left hand side. Just before the hospital (directly across from the hospital parking lot).

If you have any questions, please free to call the office.

****If for any reason you are unable to keep your appt. please call our office 24 hours a day to cancel, even if it is the same day (you can leave a message with the answering service). This will allow us to work in patients who call in for a same day appointment****

WHAT IS THE DIFFERENCE BETWEEN INTERNAL MEDICINE AND FAMILY PRACTICE/GENERAL PRACTICE

Family medicine and internal medicine have a lot of similarities but also a lot that separates them into two different fields of medicine.

Family medicine doctors see all ages of people are trained in the general care of adults, newborns and children; a good choice if you want to have the same doctor for your entire family. They treat chronic illnesses and common problems and provide preventive care and health education for all ages and both sexes.

Internal medicine doctors generally see adults, usually age 18 and older. Internists are trained to solve diagnostic problems and handle chronic/long term illnesses such as hypertension, thyroid problems and diabetes. Many older adults in the United States see an internist as their primary physician.

As an internist, I am able to treat almost all of your medical needs without having to send you to a specialist. There are, of course, certain ailments that may require surgical procedures, testing and treatment that I certainly would refer you to a specialist if necessary.

PATIENT REGISTRATION

Patient Information

Patient Name (first, middle, last) Date of Birth

Address City, State Zip

Day time Phone # Home Phone FULL Social Security # (WE DO NOT DISCLOSE THIS)

Cell Phone # Gender (M/F) Driver License #

Employer Name Occupation Work Phone #

Employer Address

LOCAL PHARMACY NAME ***CITY*** ***PHONE***

Who can we thank for referring you:_____

Emergency Contact Information

Spouses Name (if Applicable) Cell Phone/ Daytime Phone #

Person to contact in case of emergency (if other than spouse) Relationship to patient

Emergency contact daytime phone # Emergency contact home phone #

Responsible Party Information (Person who carries the insurance or who will pay the bill)

Name (if other than patient) Date of Birth

Address (if other than patient) City, State Zip

Daytime Telephone # Social Security #

Relationship to patient

Employer Name Employer Phone #

Employer Address, City, State, Zip

Insurance Information (*not necessary if card available*)

Insurance Company ID/Group # Group #

Insurance Company ID/Group # Group #

Assignment of Benefits

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance/co-payment or any other balance not paid for by your insurance.

In order to control your cost of billings, we request that our charges for office visits be paid at the time of each visit.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to the reasonable attorney's fee and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portion of the patient's record.

I hereby assign all medical and/or surgical benefits; to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans to Rafael Villarosa, M.D. (aka RH Villarosa, MD, Inc.)

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release any/all information to secure the payment.

Additional charges may be billed form other providers for services rendered.

Signed_____Date_____

Consent for Treatment

1. I hereby to voluntarily consent to such care including routine procedures and other treatment by Redlands Yucaipa Medical Group professional and their assistants, appointee, or consultants as is necessary in their judgment.
2. I am aware that the practices of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in Redlands Yucaipa Medical Group.
3. I understand that for certain procedures deemed necessary by my physician I will be required to sign a special consent form. Further, if I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.
4. I understand that Redlands Yucaipa Medical Group shall not be responsible or liable for the loss of/or damage to any personal property.
5. I authorize the release to any party responsible for my care, such information from my records as is required in order for the clinic and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

I have read the above statement and my quests have been adequately answered and I certify that I understand its contents.

PRINTED NAME_____Date of Birth_____

Signature of Patient_____Date_____

Signature of parent/guardian_____

Relationship_____

Witness_____

RAFAEL VILLAROSA, M.D.

PATIENT ACKNOWLEDGEMENT of NOTICE OF PRIVACY PRACTICES

I, _____ have received the
Patient Name (Please Print)

Notice of Privacy Practices and understand that my physician office has certain legal duties to protect my Protected Health Information. (PHI) I also understand that I have certain rights in regard to my (PHI).

_____ _____
Signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

I hereby authorize this office to release my medical information regarding my case to the following family members (if no family members are listed, they will NOT be given any information about your care, this includes the event of any hospitalization):

Name	***Relationship***	***Phone***

Patient Signature_____Date_____

Patient Name_____Date_____

PERSONAL HISTORY

Birthplace _____Date of Birth_____Age_____
Nationality_____Religion_____
Marital Status_____Health of Spouse_____
Occupation_____

Residence past 5 years
Education through_____grade
Sleep (usual hours)_____Sleep aid required_____
Recreation_____
Exercise_____
Average per day:
Alcohol (type)_____
Tea, coffee, caffeine_____
Tobacco (type)_____

Any history of:

Smoking	YES	NO
Drug Use	YES	NO
HIV	YES	NO
STD's	YES	NO

Risk of Exposure to:

HIV	YES	NO
Hepatitis	YES	NO
STD's	YES	NO

PERSONAL PAST HISTORY:

ALCOHOLISM	YES	NO
ANEMIA	YES	NO
ARTHRITIS	YES	NO
ASTHMA	YES	NO
BACK TROUBLE	YES	NO
BLADDER INFECTIONS	YES	NO
BLEEDING TENDENCY	YES	NO
BLOOD TRANSFUSION	YES	NO
BRONCHITIS	YES	NO
CANCER-type_____	YES	NO
DIABETES	YES	NO
DIPHTHERIA	YES	NO
DIVERTICULOSIS	YES	NO
EMPHYSEMA	YES	NO
EXPOSURE TO TB	YES	NO
GALL STONE	YES	NO
GLUCOMA	YES	NO
HAY FEVER/SINUSITIS	YES	NO
HEART DISEASE	YES	NO
HEMORRHOIDS	YES	NO
HEPATITIS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
HIVES	YES	NO
INFECTIOUS MONO	YES	NO
KIDNEY DISEASE	YES	NO
KIDNEY STONE	YES	NO
MALARIA	YES	NO
MEASLES	YES	NO
MENINGITIS	YES	NO
MIGRAINE HEADACHES	YES	NO
MUMPS	YES	NO
NOSE BLEEDS	YES	NO
PANCREATITIS	YES	NO
PELVIC DISEASE	YES	NO
PLEURISY	YES	NO
PNEUMONIA	YES	NO
POLIO	YES	NO
RHEUMATIC FEVER	YES	NO
SCARLET FEVER	YES	NO
SEIZURES	YES	NO
STROKE	YES	NO
THYROID DISEASE	YES	NO
TUBERCULOSIS	YES	NO
ULCER	YES	NO
VALLEY FEVER	YES	NO
VENEREAL DISEASE	YES	NO
WHOOPING COUGH	YES	NO

MEDICATIONS TAKEN REGULARLY

Name/Dose	Frequency

MEDICATION ALLERGIES

Medication name	Reaction

MY DESIRES CONCERNING LIFE SUPPORT ARE AS FOLLOWS:

___I would never want resuscitation or life support_____
___I would want resuscitation or life support only if something happened that was easily correctable._____
___I want everything possible done to prolong my life, even if I were in a permanent coma._____

ADVANCED DIRECTIVE:

___I have executed an Advanced Healthcare Directive, Durable Power of Attorney for Healthcare, Living will or Health Care Proxy_____
___Copy placed in chart (Indicate which one_____)
___I would like to fill out an Advanced Healthcare Directive Packet provided to patient by _____
___Patient does not desire information at this time.

SURGICAL HISTORY			Date/Yr
APPENDIX	YES	NO	
TONSILS	YES	NO	
GALL BLADDER	YES	NO	
STOMACH	YES	NO	
BREAST	YES	NO	
HYSTERECTOMY	YES	NO	
PROSTATE	YES	NO	
HERNIA	YES	NO	
THYROID	YES	NO	
VARICOSE VEINS	YES	NO	
HEMORRHOIDS	YES	NO	
HEART	YES	NO	
OTHER:	YES	NO	
Type_____			

SERIOUS INJURIES			
HEAD	YES	NO	
CHEST	YES	NO	
ABDOMEN	YES	NO	
BROKEN BONES:	YES	NO	
Type_____			
NECK	YES	NO	
OTHER	YES	NO	
BACK	YES	NO	

FAMILY HISTORY

	PRESENT AGE	AGE AT DEATH	OVERALL HEALTH (good, fair, poor)
Father			
Mother			
Brothers/Sisters			
1			
2			
3			
4			
5			
Children			
1			
2			
3			
4			
5			
6			
7			
Others who live at home			
Relationship			Health
1			
2			
3			
4			

OVER

Name_____

Circle "YES" or "NO", if unsure, leave blank

GENERAL

TIRE EASILY, WEAK	YES	NO
WEIGHT CHANGE	YES	NO
NIGHT SWEATS	YES	NO
PERSISTENT FEVER	YES	NO
SENSITIVE TO HEAT	YES	NO
SENSITIVE TO COLD	YES	NO

SKIN

ERUPTIONS (RASH)	YES	NO
CHANGE IN COLOR	YES	NO
CHANGE IN HAIR	YES	NO
CHANGE IN NAILS	YES	NO

EYES

TROUBLE SEEING	YES	NO
EYE PAIN	YES	NO
INFLAMED EYES	YES	NO
DOUBLE VISION	YES	NO
WEAR GLASSES	YES	NO

NOSE

LOSS OF SMELL	YES	NO
FREQUESNT COLDS	YES	NO
OBSTRUCTION	YES	NO
EXCESS DISCHARGE	YES	NO
NOSEBLEEDS	YES	NO

EARS

LOSS OF HEARING	YES	NO
RINGING IN EARS	YES	NO
DISCHARGE	YES	NO

MOUTH

SORE GUMS	YES	NO
SORE TONGUE	YES	NO
DENTAL PROBLEMS	YES	NO

THROAT

POSTNASAL DRIP	YES	NO
SORENESS	YES	NO
HOARSENESS	YES	NO

BREASTS

LUMPS	YES	NO
DISCHARGE	YES	NO

CARDIO RESPIRATORY

COUGH, PERSISTENT	YES	NO
SPUTUM (PHLEGM)	YES	NO
BLOODY SPUTUM	YES	NO
WHEEZING	YES	NO
CHEST PAIN/DISCOMFORT	YES	NO
PAINFUL BREATHING	YES	NO
SHORTNESS OF BREATH	YES	NO
DIFFICULTY BREATHING	YES	NO
SWOLLEN ANDKLES	YES	NO
BLUE FINGERS OR LIPS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
PALPITATIONS	YES	NO
VEIN TROUBLE	YES	NO

ENDOCRINE

THYROID TROUBLE	YES	NO
ADRENAL TROUBLE	YES	NO
CORTISONE TREATMENT	YES	NO
DIABETES	YES	NO

GASTRO-INTESTINAL

CHANGE IN APPETITE	YES	NO
DIFFICULTY SWALLOWING	YES	NO
HEARTBURN	YES	NO
ABDOMINAL DISTRESS	YES	NO
BELCHING/EXCESSIVE GAS	YES	NO
ABDOMINAL ENLARGEMENT	YES	NO
NAUSEA	YES	NO
VOMITTING	YES	NO
RECTAL BLEEDING	YES	NO
TARRY STOOLS	YES	NO
DARK URINE	YES	NO
JAUNDICE	YES	NO
CONSTIPATION	YES	NO
DIARRHEA	YES	NO
HEMRRHOIDS	YES	NO
USE OF LAXATIVES	YES	NO

GENITOURINARY SYSTEM

FREQUENT URINATION	YES	NO
DISCOMFORT URINATING	YES	NO
NIGHT TIME URINATION	YES	NO
UNABLE TO HOLD URINE	YES	NO
BLOOD IN URINE	YES	NO
PROTEIN IN URINE	YES	NO
PELVIC PAIN	YES	NO
VAGINAL DISCHARGE	YES	NO
VAGINAL ITCH	YES	NO
IMPOTENCE	YES	NO
LACK OF SEX DRIVE	YES	NO
PAINFUL INTERCOURSE	YES	NO

LOCOMOTOR

MUSCLE CRAMPS	YES	NO
MUSCLE WEAKNESS	YES	NO
PAIN IN JOINTS	YES	NO
SWOLLEN JOINTS	YES	NO
STIFFNESS	YES	NO
DEFORMITY OF JOINTS	YES	NO
NECK PAIN	YES	NO
BACK PAIN	YES	NO

NERVOUS SYSTEM

HEADACHES	YES	NO
DIZZINESS	YES	NO
FAINTING	YES	NO
CONVULSIONS/FITS	YES	NO
NERVOUSNESS	YES	NO
SLEEPLESSNESS	YES	NO
DEPRESSION	YES	NO
CHANGE IN SENSATION	YES	NO
MEMORY LOSS	YES	NO
POOR COORDINATION	YES	NO
WEAKNESS OR PARALYSIS	YES	NO

FAMILY HISTORY

HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING:

			Whom
Anemia	YES	NO	_____
Asthma	YES	NO	_____
Bleeding	YES	NO	_____
Cancer**	YES	NO	_____
*****PLEASE LIST WHO & TYPE BELOW***			
Convulsions	YES	NO	_____
Diarrhea	YES	NO	_____
Diabetes	YES	NO	_____
Gout	YES	NO	_____
Heart disease	YES	NO	_____
High Blood Pressure	YES	NO	_____
Kidney disease	YES	NO	_____
Leukemia	YES	NO	_____
Mental illness	YES	NO	_____
Migraine headache	YES	NO	_____
Obesity	YES	NO	_____
Repeated infections	YES	NO	_____
Severe allergies	YES	NO	_____
Thyroid problems	YES	NO	_____
Tuberculosis	YES	NO	_____
Ulcers	YES	NO	_____

If yes, please list problem & relationship:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

OB/GYN

Started menstruating at _____ Date of last pap_____

Interval between periods_____ Duration_____

# of pregnancies_____ # of births _____

Contraception_____ Last mammogram_____

SCREENINGS **Date**

COLONOSCOPY_____

MAMMOGRAM_____

PSA/PROSTATE EXAM_____

PAP SMEAR_____

IMMUNIZATIONS **Date**

Tetanus/dT_____

Pneumovax_____

Influenza/flu_____

OVER

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Authorization to Obtain Medication History

Patient Name: _____

DOB: _____

Address: _____

_____

I, _____ hereby authorize RH Villarosa, M.D., Inc. to obtain/download my medication history from SureScripts and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug to drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

_____
Date of Authorization

_____
Print Name (Patient/Legal Representative or Parent/Legal Guardian)

_____
Signature (Patient/Legal Representative or Parent/Legal Guardian)

Rafael Villarosa, M.D.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
PURSUANT TO CHAPTER 782 (SB889), PART 2, 6, SECTION 56 OF CIVIL CODE

Please **REQUEST** medical information **FROM**

Name of Doctor, Medical Group, Hospital or Health Care Facility

Street Address

City State Zip

Please **SEND** Medical information **TO**:

Rafael Villarosa, M.D.
Name of Doctor, Medical Group, Hospital or Health Care Facility
255 Terracina Blvd. #207
Redlands, CA 92373
(909) 793-2226 fax (909) 793-3336

Is requested to furnish the following information concerning me:

☐ General Medical Information (from_____ to _____)
☐ Information regarding specific injury or treatment (from_____ to _____)
☐ X-ray reports/EKG's
☐ Laboratory results
☐ Colonoscopy reports
☐ Mental Health (from_____to _____)
☐ HIV test results (from_____)
☐ Other (specify)_____

The undersigned understands this authorization shall become effective immediately and shall remain in effect for one year from the date of signature if no date is entered. This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in alliance on this authorization before the written revocation was received. I also understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Patient's Name:_____ **Date of birth:**_____
(please print) Last name First name Int.

Address:_____

SS#_____ Phone_____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only: ☐ Moved ☐ Change of insurance ☐ Second opinion

☐ Personal use (a copy fee may apply) ☐ Tranfer of physicians

☐ Other_____

Signed:_____ Date:_____

Relationship if other than patient:_____