Registration

West Point Medical Center

Rancho Cucamonga
8520 Archibald St. Ste. B Bldg. #20

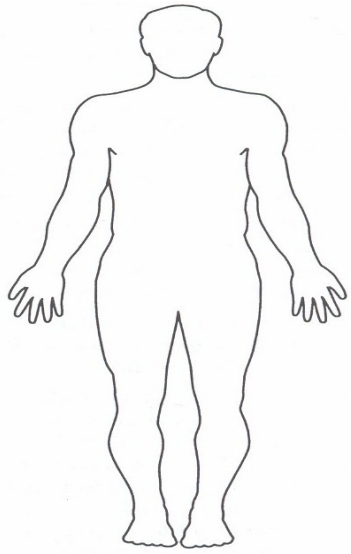
Fontana
7774 Cherry Ave.

San Bernardino
1800 Medical Center Dr. Ste. 99

DATE/FECHA:				**SSN#:** - -	
Last/Apellido	**First/Nombre**	Middle	Title	Marital Status / Estado Civil	
Street Address / Direccion De Casa				**DOB** Fecha de nacimiento	**Gender H/M**
City/Ciudad	**State/Estado**	**ZIP/ Código Postal**		/ /	❑ **M** ❑ **F**
				Home # (Numero de telefono)	
I wish to be contacted in the following manner:				( )	
• Written Communication • Verbal Communication Other:				Cell	
PHARMACY:				( )	
Occupation / Ocupacion	**Employer / Trabajo**			**Employer Ph** (Número De Trabajo)	
				( )	

DESCRIBE THE INJURY / DESCRIBE EL ACCIDENTE/OR SINTOMAS

MARK THE BODY PART INJURED & LEVEL OF PAIN
From 0 to 10. Zero means no pain and 10 means very severe pain.
MARQUE LA PARTE DEL CUERPO QUE SE LASTIMÓ.
Del 0 al 10. 0 ciendo no tanto dolor 10 siendo mucho dolor. uhjknm



Anatomical Position

Where was the accident? /Donde se lastimó

Date & Time of Injury (Fecha y Hora de Accidente)

IN CASE OF EMERGENCY CONTACT (EN CASO DE EMERGENCIA)

Name / Nombre	Relationship / Relacion	Home#(casa)	Work #(Trabajo)
1)		( )	( )
2)		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to WPMC. I understand that West Point Medical Center will bill my insurance company or your employer for the services provided. However if the insurance company denies the payment for any reason, injury is determined not to be work related, or the claim is denied I will be responsible for the full payment. I authorize my medical records to be released to my employer, insurance company, 3rd party administrator, and/or PCP. I give West Point Medical Center consent to treat me.

Según mi conocimiento la información anteriormente mencionada es correcta. Yo autorizo que los beneficios de mi seguro sean pagados directamente a WPMC. Yo comprendo que el Centro Médico Westpoint le enviará el cobro directamente a mi empleador por los servicios rendidos. Sin embargo, si por alguna razón la aseguranza no paga yo seré responsable de pagar la cuenta, si se determina que mi lesión no está relacionada con el trabajo, o si la demanda es rechazada, yo seré responsable de pagar la cuenta. Yo autorizo que mis archivos médicos estén disponibles para mi empleador, mi aseguranza, alguna tercera persona administrativa, y/o Proveedor.

Signature (Firma)	**Date / Fecha**
Parent/Guardian (Padres/Guardian)	**Date/ Fecha**

West Point Medical Center Health History Questionaire

Rancho Cucamonga 8520 Archibald St. Ste. B Bldg. #20 | Fontana 7798 Cherry Ave. | San Bernardino 1800 Medical Center Dr. Ste. 99

Name (*Last, First, M.I.*): _____ • **M** • **F** **DOB:** _____ **Date**_____

1. Reason For Your Visit **How many days?**

_____ _____

_____

2. Describe any medical problems for which you are being currently reated_____

_____

3.Describe any surgeries you may have had

_____

4.List all the medications you are now taking, including those you have bought without a prescription (such as Aspirin, cold medicines, vitamins, herbs, supplement)

_____

5. List any ALLERGIES and SENSITIVITIES to medications, soaps, pollens, bee stings, etc.

Allergic To	Reaction	Allergic To	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

6. Childhood illnesses • Measles • Mumps • Rubella • Chickenpox • Polio • Rheumatic Fever

7. Immunizations • Tetanus Booster _____ yrs ago • Hepatitis • MMR • Polio • HIB • Pneumonia

9. Family History: • Diabetes • High Blood pressure • Heart Dz • Cancer _____ Other _____

10. Do you drink, smoke or abuse any other substance and how much?

_____

Health History

Yes	No	Do you have any?	Yes	No	Do you have any?
		Weakness, weight change, night sweats?			Painful / frequent urination, urgency, blood in urine?
		Headaches, dizziness, visual problems?			Incontinence or change in urine stream?
		Ear pain, discharge, infection, impaired hearing?			Increased menstrual bleeding or pain?
		Runny nose, congestion, sore throat?			History of neck, back pain, hands or other joint pain?
		Swollen lymph nodes or neck pain?			History of any work injuries, accidents or disabilities?
		Shortness of breath, wheezing, asthma, emphysema?			Arthritis or family history of arthritic disorders?
		Cough, blood in sputum, or chest congestion?			Missing or impaired hand, arm, foot, leg, finger, toe?
		Other Lung disease, TB, or exposure to it?			History of seizures, stroke, or spinal injury?
		Chest pain, tightness, or sweating with chest pain?			History of head trauma or concussion?
		Hypertension, murmurs, heart disease?			Seizures, loss of consciousness, or dizziness?
		Heart surgery, angioplasty, pacemaker?			Paralysis, tremor, in-coordination?
		Difficulty swallowing, acid reflux, gastritis, or ulcers?			Difficulty with memory or speech?
		Nausea, vomiting or diarrhea?			Sensory or motor disturbance?
		Abdomen pain, bloated ness, gas, or indigestion?			Depression, anxiety or nervousness?
		Blood in stool, or changes in bowel habits?			History of suicide attempt?
		Liver Disease, diverticulitis, or colitis?			Rash, itching. abnormal moles
		Diabetes, kidney disease or dialysis?			Anemia, easy bleeding or bruising?
		Venereal diseases?			Thyroid or other hormonal disorders?

For any yes answer, indicate onset date, diagnosis, and current treatment_____

_____

_____

WPMC Financial Policy

I understand that West Point Medical Center will bill my Insurance company for services provided. However, if my insurance company denies payment for any reason, including but not limited to; deductible not met, out of network services, denial of pre-authorized, or unauthorized service, I will be responsible for payment. Payment for service is due at the time service is provided in our office or upon notice of insurance claim denial. **No refunds. I give my consent to be treated by WPMC.**

For Patients with Insurance: We bill most insurance carriers for you if proper paperwork is provided to us. Copayments and deductibles are due at the time of service.

Medicare Patients: We will bill Medicare for you. All copayments or deductibles are due and payable at the time of service is provided.

Surgery Fees: All co-pays, deductibles and payment for non-covered surgical procedures are due prior to surgery. Your insurance carrier may require prior authorization.

Non-covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Workers Compensation: If your injury is work related we will need authorization to treat your employer, the case number and carrier name prior to your visit in order to bill the workers compensation insurance company. It is the responsibility of the patient to make and verify their appointments. Should a patient miss an appointment a $25 missed appointment will be billed to the patient.

Yearly Health checks: Periodic preventative health checks may or may not be covered under your health insurance policy. It is your responsibility to verify with your insurance company that these services are covered under your health insurance policy prior to scheduling the exam, as you will be responsible for all non-covered services.

HMO Insurance: We do participate with some, but not all, Health Maintenance Organizations. In most cases, you need a referral from your primary care physician or an authorization number from your HMO, which allows us to treat you. It is your responsibility to verify with your insurance carrier that these services are covered under your plan prior to your being seen, as you will be responsible for all non-covered services.

Late Fees: Interest at 18% and $30.00 late fee will be charged for all bills 30 days past due from the date of the statement. Courtesy discount is only valid if bills are paid within 15 days.

Missed Appointment Fee: A $25 fee will be charged to patients for any missed appointment made. It is the responsibility of the patient to make, verify their appointments. Patients may call to reschedule or cancel an appointment within 24-hours of the appointment. This applies to all patients that make appointments with any department under WPMC. Including patients in Family Practice that will be responsible for Co-pays collected for appointment (will forfeit co-pay for missed appointment) and if no co-pay is collected then the $25 missed appointment fee will be charged.

Signature: _____

"**We require copies of a photo identification and your insurance card(s)"**

Medicare Patients: Signature on File: I request payment of authorized Medicare benefits be made directly to West Point Medical Center for any services furnished either to me or on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay any claims. If "other health insurance: is indicated in Item 9 of the HCFA-1500 form or else were on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible and/or coinsurance and deductibles are based upon the charge determination of the Medicare Intermediary.

Patient's Name: _____Medicare# _____Date_____

Notice of Privacy Practices

WEST POINT MEDICAL CENTER

7774 Cherry Avenue. Fontana, Calif. 92336
Privacy Officer 909-355-1296

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone:_____

Notificación de Prácticas Privadas

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación: