Julia S. Hohman, MD, Inc.

PATIENT REGISTRATION FORM

PLEASE PRINT

Name_____ **Date of Birth**_____
LAST FIRST MI

Address_____ Home ☎_____

City_____ Zip_____ Cell ☎_____

Email _____ Work ☎ _____

Gender: Male Female Trans **SSN** _____ Primary Language_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name_____

Occupation_____ Employer_____

In case of emergency, notify_____ Relationship:_____

Address_____

Home ☎_____ Work ☎_____ Cell ☎_____

Responsible Party:_____ Relationship:_____

Primary Insurance _____ ☎_____

Subscriber's Name_____ **Subscriber's SSN:**_____

Subscriber's DOB:_____ Member ID#:_____ Group#:_____

Billing Address_____

Secondary Insurance _____ ☎_____

Subscriber's Name_____ **Subscriber's SSN:**_____

Subscriber's DOB:_____ Member ID#:_____ Group#:_____

Billing Address_____

Preferred Pharmacy _____ ☎_____

Preferred Laboratory: LabCorp Quest Diagnostics Other Lab:_____

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to **Julia S. Hohman, MD, Inc.** For Medicare, the provider agrees to accept assignment, and I am only responsible for deductibles, co-insurance, and any non-covered services. **I understand that in all other cases, I am financially responsible for the payment of any and all charges incurred with Julia S. Hohman, MD, Inc.**

_____

Signature (Patient or Guardian) Date

Revised 12/2019

Julia S. Hohman, M.D., Inc.
Wise Medical Inc.

1181 Boulevard Way, Suite B
Walnut Creek, CA 94595

Acknowledgment of Receipt of Notice of Privacy Practices

Julia S. Hohman, M.D., Inc. and Wise Medical Inc. reserve the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **Julia S. Hohman, M.D., Inc. and Wise Medical Inc.**

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient

Acknowledgment of Receipt of Notice of Financial Policies

Julia S. Hohman, M.D., Inc. and Wise Medical Inc. reserve the right to modify the financial policies outlined in the notice.

Signature

I have read and received a copy of the Notice of Financial Policies for **Julia S. Hohman, M.D., Inc. and Wise Medical Inc.**

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient

MEDICAL RECORD HISTORY

Name _____ **Date of Birth:** ___/___/_____

MEDICINES YOU ARE TAKING List prescription medicines, birth control pills, over-the-counter medicines, injections, herbal medicines, and vitamins that you are taking.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES List any drugs, medications, or allergens to which you are allergic.

1. _____ Please list allergic reaction here: _____
2. _____ Please list allergic reaction here: _____
3. _____ Please list allergic reaction here: _____
4. _____ Please list allergic reaction here: _____

HOSPITALIZATIONS List serious illnesses and injuries requiring hospitalization.

Year	Serious illness or injury	Name of Hospital	City and State

SURGERIES List any past surgeries, including gynecological procedures and C-sections.

Year	Name of Surgery	Name of Hospital	City and State

OTHER PAST MEDICAL HISTORY

List any medical problems not mentioned above.

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

PREGNANCY HISTORY

Enter the number of:

Times pregnant ____

Live births_____ Living children_____

Abortions_____ Miscarriages_____

Complications? ☐Yes ☐No

History of chickenpox infection: Yes No

HEALTH CARE PROVIDERS Who else have you seen for your health care in the past 7 years?

Year	Name of doctor or other provider	Location (City, State)	Primary Problems Cared For

Patient Name _____

WORK HISTORY Are you working now? ☐YES ☐No, I'm out of work ☐No, I'm retired ☐No, I've never had a job
Starting with your most recent job, what type of work have you done?

	Type of Work or Job Title	Dates From	To
1.			
2.			
3.			

SMOKING HISTORY

Do you smoke or use tobacco now? ☐**YES** ☐**NO** If yes, how much? _____ packs per day for _____ years
If you quit smoking/using tobacco, when was it? _____ (date that you quit)
How much did you smoke/use before you quit? _____ packs per day for _____ years

ALCOHOL AND DRUG HISTORY

How much alcohol do you drink, if any? _____ drinks per week
If you no longer drink alcohol, when did you quit? _____
Have you ever used other "recreational" drugs? ☐**YES** ☐**NO**
If yes, which drugs and when? _____
If you no longer use "recreational" drugs, when did you quit? _____

EXERCISE HISTORY

Do you exercise? ☐**YES** ☐**NO** If yes, how much do you exercise per week? _____
What activities do you include in your exercise regimen? _____

YOUR FAMILY'S HEALTH

	First Name	Health is: Good	Poor	Died at	Age	Medical Problems and/or Cause of Death
Father		☐	☐	☐		
Mother		☐	☐	☐		
Paternal Grandfather		☐	☐	☐		
Paternal Grandmother		☐	☐	☐		
Maternal Grandfather		☐	☐	☐		
Maternal Grandmother		☐	☐	☐		
Brothers and sisters		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
Spouse		☐	☐	☐		
Children		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
Others living in household		☐	☐	☐		

Check any illnesses where members of your family have had the following illnesses or problems:

☐ Alcoholism	☐ Diabetes	☐ Heart disease	☐ Liver disease	☐ Cancer, tumor
☐ Anemia	☐ Drug abuse	☐ Heart attack	☐ Mental illness	☐ Breast cancer
☐ Asthma	☐ Epilepsy	☐ High blood pressure	☐ Stroke	☐ Lung cancer
☐ Deep vein thrombosis	☐ Eye problems	☐ Lung disease	☐ Suicide attempt	☐ Colon cancer
☐ Depression	☐ Glaucoma	☐ Kidney disease	☐ Thyroid disease	☐ Other _____

Member Acknowledgement of Financial Responsibility

Provider This form may be used for members who wish to receive healthcare services from you that may not be covered by their Benefit Plan.

Member Your signature on this form acknowledges that you agree to bear full financial responsibility for all service provided as listed below if:

- The services are not covered under Benefit Plan, or,
- The services have not been otherwise approved for payment by your plan.
- Claims are denied due to eligibility status, invalid medical group, or invalid primary care provider (PCP).

Services Any service not described as a covered benefit in the member's Evidence of Coverage.

_____

_____

_____

Member or Member's Legal Representative (Please Print)

_____

Member or Member's Legal Representative Signature Date

Provider **Julia S. Hohman, M.D., Inc.**
1181 Boulevard Way, Suite B
Walnut Creek, CA 94595

_____

Provider or Provider's Representative (Please Print)

_____

Provider or Provider's Representative Signature

Julia S. Hohman, M.D., Inc.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Julia S. Hohman, MD, to use and/or disclose certain protected health information (PHI) about me to other health care providers involved in my care, staff involved in my care or billing, and third party payers. I also give permission to Dr. Hohman to share my information with:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

This authorization permits Julia S. Hohman, MD, to use and/or disclose the following individually identifiable health information about me: medical history, symptoms, examination, test results, diagnoses, treatment, and future plans for treatment.

The information will be used or disclosed for the following purposes:

- To communicate to other health professionals about my care.
- A source of information to apply a diagnoses to my bill.
- A way for third party payers to verify that services billed were actually provided.
- A tool for quality assurance of systems and providers.

The purposes are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Julia S. Hohman, MD. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Julia S. Hohman, MD
1181 Boulevard Way, Suite B
Walnut Creek, CA 94595

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Name of Legal Guardian, if applicable