SmartCare
COMMUNITY CLINIC INC

8055 Natick Ave
Panorama City CA 91402

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Pharmacy Information

Pharmacy Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

ALL PRESCRIPTIONS NEED TO BE ELECTRONICALLY SEND AFTER JANUARY 1 2023. PLEASE PROVIDE US WITH YOUR PHARMACY'S INFORMATION THANK YOU.

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Adult Health History

Patient Name _____ Age_____ D.O.B _____ Date _____

History of Past Illness

Have you ever had ?

Measles	☐ YES ☐ NO	Chickenpox	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Mumps	☐ YES ☐ NO	Stroke(s)	☐ YES ☐ NO	Heart Disease	☐ YES ☐ NO
Tuberculosis	☐ YES ☐ NO	Veneral Diseases/STDs	☐ YES ☐ NO	Serious Disease	☐ YES ☐ NO

Ever been Hospitalized ? ☐ YES ☐ NO if yes, explain _____
Ever had surgery ? ☐ YES ☐ NO if yes, explain _____
Have had broken bones ? ☐ YES ☐ NO if yes, explain _____
Head Concussions or injuries ? ☐ YES ☐ NO if yes, explain _____
Date of last tetanus shot: _____ Pap Smear (females) _____ Mammogram (females) _____

Family History

Has anyone in your family had?

Cancer ☐ YES ☐ NO if yes, explain _____
Diabetes ☐ YES ☐ NO if yes, explain _____
Heart trouble/disease ☐ YES ☐ NO if yes, explain _____
High blood pressure ☐ YES ☐ NO if yes, explain _____
Stroke ☐ YES ☐ NO if yes, explain _____
Convulsions ☐ YES ☐ NO if yes, explain _____
Suicidal attemts ☐ YES ☐ NO if yes, explain _____

Social History

Marital Status ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED
Do you drink Alcohol? ☐ YES ☐ NO if yes, how much _____
Do you Smoke? ☐ YES ☐ NO if yes, how much _____
Are you sexualy active?
Highest Education Level _____ What is your job ? _____
Etnicity ☐ AMERICAN/INDIAN ☐ ASIAN/PACIFIC ISLANDER ☐ BLACK ☐ HISPANIC/LATINO ☐ WHITE

General Systemic Review

Have you had any recent weight changes ? ☐ YES ☐ NO
Have you been in good health most of your life ? ☐ YES ☐ NO

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Have you ever had problem with ?

Skin	☐ YES ☐ NO	if yes, explain _____
Head	☐ YES ☐ NO	if yes, explain _____
Eyes	☐ YES ☐ NO	if yes, explain _____
Ears	☐ YES ☐ NO	if yes, explain _____
Nose	☐ YES ☐ NO	if yes, explain _____
Throat	☐ YES ☐ NO	if yes, explain _____
Neck	☐ YES ☐ NO	if yes, explain _____
Lungs	☐ YES ☐ NO	if yes, explain _____
Heart	☐ YES ☐ NO	if yes, explain _____
Circulatory System	☐ YES ☐ NO	if yes, explain _____
Emotions	☐ YES ☐ NO	if yes, explain _____
Nerves	☐ YES ☐ NO	if yes, explain _____
Muscles	☐ YES ☐ NO	if yes, explain _____
Bones	☐ YES ☐ NO	if yes, explain _____
Stomach	☐ YES ☐ NO	if yes, explain _____
Bowles	☐ YES ☐ NO	if yes, explain _____
Sexual Organs	☐ YES ☐ NO	if yes, explain _____
Urinary Tract	☐ YES ☐ NO	if yes, explain _____
Any Other Problem	☐ YES ☐ NO	if yes, explain _____

Allergies or reactions to food and or medications _____

_____

Patient's signature _____ Date _____

Doctor's signature _____ Date _____

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Registration Record

Patient Information

Patient Name _____
First Name Last Name Middle Initial

Address _____
Street City State Zip

Phone _____ Social Security # _____

D.O.B. _____ Gender ☐ MALE ☐ FEMALE

Responsible Party information

Responsible Party Name _____
First Name Last Name Middle Initial

Relationship to Patient ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN ☐ SELF

Address _____
Street City State Zip

Phone _____

Employer Information

Employer Name _____

Address _____
Street City State Zip

Phone _____ Occupation _____

Linguistic Service Needs

Primary Language _____ Secondary Language _____

Interpreter Services Offered ☐ MALE ☐ FEMALE

Interpreter Services Accepted ☐ MALE ☐ FEMALE
(if No - indicate who will interpret for patient)

Interpreter Services by ☐ PCP ☐ OTHER

Is Patient Hearing Impaired ☐ YES ☐ NO
(if Yes - indicate services offered)

Emergency Contact Information

Name _____ Relationship _____

Phone _____ Message Phone _____

Authorization

I hereby authorize the doctor's of SmartCare Medical Clinic to be attending physicians and to administer to me any examination, treatment, and medications he/she deems therapeutic to my presenting complaint. I hereby authorize Smart Care Medical Clinic to furnish information to my insurance carriers concerning this illness and I hereby irrevocably assign to the doctors all payments for medical services.

Patient's signature _____ Date _____

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Adult TB (Tuberculosis) Risk Assessment

*YOU MAY BE AT INCREASED RISK FOR TB IF YOU ANSWER YES TO ANY OF THE FOLLOWING	DATE	DATE	DATE	DATE
Do vou have a family member, or close contact with history of confirmed or suspected TB ?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Are you from Asia, Africa, Central America, or South America? (These areas have higher prevalence of TB.)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Do You live in an"out of home" placement facility?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Do you have any history of confirmed or suspected HIV infection?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Do you live with a n individual who is HIV positive?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Have you been or do you live with any individual who has been incarcerate in the last5 years?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Do you live among, or are you frequently exposed to individuals who are homeless, migrant farm workers, used of street drugs, or residents in a nursing home?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

A PERSON WHO IS AT INCREASED RISK FOR TB SHOULD HAVE A YEARLY TB TEST.

Name _____ Date _____

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FINANCIAL AGREEMENT AUTHORIZATION AND RELEASE OF RECORDS

Authorization for Treatment: I voluntarily consent to the administration and cost of medical, surgical procedures, x-ray, Injectable medicines/antibiotics-orthopedic supplies, laboratory test, and medication for myself and my dependents.

Assignments of Insurance Benefits: I authorize payment directly to this urgent care center forall benefits otherwise payable to me.

Guarantee of Payment: I understand that Iam financially responsible and agree to pay AND INC all of the charges that are not paid or billed to insurance or any other third party payer. Iunderstand that I must pay in full today for all services rendered uness my insuranceis accepted. I also understand that if my Insurance is accepted, I must pay all applicable insurance copays, coinsurance, and deductibles today. If you are unable to verify myinsurance at time of service, I wil pay in full for all services.

Releaseo Records: I authorize this urgent care center to releasein writing confidential medical information to anyperson or entity includingm yinsurance carrier, employeriftreatment is relatedto employment purposes, or other health careoperations which may be liable to me or my practitioner(s) forcharges for thistreatment and forquality management, utilizationreview, transfer, and follow-up purposes.

Receipt of Privacy Practices: Iacknowledge that Ihave received and read the Notice of Privacy Pradices ofthis urgent care center I understand that a copy of this agreement may be used with the same aflectiveness as the original.

Name _____ Date _____