Foster City Medical Center
Primary Care and Urgent Care
PATIENT REGISTRATION FORM

Today's Date:			**Doctor/PCP:**	
Patient's Last Name:	**First:**	**Middle:**	Marital Status: Single / Married / Divorced / Separated / Widowed	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	**Birthdate: (MM/DD/YY)** / /	**Age:**
E-Mail Address:				**Sex:** ☐ M ☐ F
Street Address/P.O. Box:	**City:**	**State:**	**ZIP Code:**	
Occupation:	**Home Phone Number:** ( )	**Cell Phone Number:** ( )		
Primary Language:	**Social Security Number:** - -			

How did you hear about Foster City Medical Center?

☐ Family ☐ Friend ☐ Close to Home/Work ☐ Yelp ☐ Postcard/Letter ☐ Insurance ☐ Other

Other family members seen here:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relation:	Phone Number: ( )

FINANCIAL AND OFFICE POLICIES

Communication: By providing us with your landline or cell phone number(s), you give express authorization to contact you at those numbers. This express authorization also applies to any landline or cell phone you may acquire in the future. Phone calls to you may be made utilizing automated dialer technology. Providing your phone number(s) is not a condition of receiving our services. I hereby authorize Foster City Medical Center to communicate with me via email AND leave voicemail about my medical conditions including sharing medical information and test results.

Release of Medical Records: I authorize the release of any medical/surgical information necessary for determining the extent of third-party coverage and for processing insurance claim on my behalf. I permit a copy of this authorization to be valid as the original. Additionally, I hereby authorize FCMC to release any or all medical records t other medical providers requesting such only when related to the coordination of my care

Sharing Information: If none of the following boxes are checked, you permit us to share your health information with adults who live at your address.

☐ information should not be shared with any other person, even those who live at my address

☐ information may be shared with the following person(s): _____

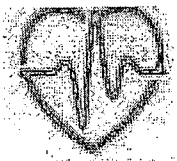
Consent to Treat: I voluntarily consent to medical treatment and procedures that may be performed on me during this visit. This includes, but is not limited to, medical, therapy, or surgical care, x-rays, tests, medications, laboratory tests, or other services, which may be ordered by the physician participating in my care.

-I understand coverage and cost of lab or other diagnostic tests ordered during office visits and annual preventive exam is subject to my insurance plan. For detailed benefit explanation, I could consult my insurance company before the tests are done.
-I understand that any balance unpaid by insurance will be billed to me. If this balance is not paid within two months then there will be a collection fee added, and I, the consumer, acknowledge responsibility for the payment of any collection fees added.
-If a patient makes a payment on a bill online with HSA they need to send our billing department a copy of the payment to Billing@fostercitymedicalcenter.com

☐ I, the undersigned, acknowledge that the information I have provided above is accurate to the best of my knowledge. I have read and understood the above mentioned policies.

_____ _____

Patient/Responsible Party/Guardian Signature ***Date***



Foster City Medical Center
Primary Care and Urgent Care

PATIENT CONSENT FORM (HIPAA)

Under Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain right to privacy, which are outlined in the HIPAA form provided. This information will be used to:

1. Plan, conduct and direct your treatment and follow-up among multiple health care providers involved in your treatment.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessment and physician certification.

You have the right to review a NOTE OF PRIVACY PRACTICES prior to signing this consent. Foster City Medical Center has the right to change its Notice of Privacy Practices from time to time and that you may contact FCMC at anytime to obtain a copy of the Notice of Privacy Practices.
You may revoke this consent in writing at anytime.

PatientName:_____

Signature:_____

Relationship to Patient:_____

Date:_____

PERSONAL MEDICAL HISTORY:

Do you have now or have you had (past) any of the following conditions?

Diseases & Conditions	Now	Past
Alcohol / Drug abuse	☐	☐
Allergy (Hay Fever)	☐	☐
Anemia	☐	☐
Angina (chest pain)	☐	☐
Anxiety	☐	☐
Arthritis (Rheumatoid)	☐	☐
Arthritis (Osteoarthritis)	☐	☐
Asthma	☐	☐
Bladder / Kidney Problems	☐	☐
Blood Clots	☐	☐
Blood Transfusion	☐	☐
Breast Lump (benign)	☐	☐
Cancer		
Breast Cancer	☐	☐
Colon Cancer	☐	☐
Ovarian Cancer	☐	☐
Prostate Cancer	☐	☐
Other Cancer Type Please List:		
Cataracts	☐	☐
Chicken Pox	☐	☐
Colon Polyp	☐	☐
Coronary Artery Disease	☐	☐
Depression	☐	☐
Diabetes Type II (adult onset)	☐	☐
Diabetes Type I (childhood onset)	☐	☐
Diverticulosis	☐	☐
Emphysema (COPD)	☐	☐
Fractures (broken bones)	☐	☐
Location:		
Gallbladder Disease	☐	☐
Gastroesophageal Reflux (Heartburn/GERD)	☐	☐
Glaucoma	☐	☐
Gout	☐	☐
Hemorrhoids	☐	☐
Check box if you have no history of significant medical illnesses	☐	

Diseases & Conditions	Now	Past
Gynecological / Female Conditions		
Endometriosis	☐	☐
Fibroids	☐	☐
Other Gynecological Conditions:		
Heart Attack (Myocardial Infarction)	☐	☐
Congestive heart failure (CHF)	☐	☐
Irregular Heartbeat / Arrhythmia	☐	☐
Heart valve problem	☐	☐
Other Heart Disease:		
Hepatitis (Type A - C)	☐	☐
High Blood Pressure / Hypertension	☐	☐
High Cholesterol	☐	☐
Irritable Bowel Syndrome	☐	☐
Kidney Disease / Failure	☐	☐
Kidney Stones	☐	☐
Liver Disease	☐	☐
Migraine Headaches	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Prostate (enlargement)	☐	☐
Prostate (nodules)	☐	☐
Seizure / Epilepsy	☐	☐
Skin Conditions		
Eczema	☐	☐
Psoriasis	☐	☐
Abnormal Moles	☐	☐
Acne	☐	☐
Other Skin Condition:		
Sinusitis / Sinus Problems	☐	☐
Sleep Apnea	☐	☐
Sexually transmitted disease (STD) Abnormal	☐	☐
Stomach Ulcer	☐	☐
Stroke	☐	☐
Thyroid (Nodule)	☐	☐
Thyroid High (Overactive) / Hyperthyroidism	☐	☐
Thyroid Low (Underactive) / Hypothyroidism	☐	☐

Please list any other chronic medical conditions or congenital disorders not listed above:

IMMUNIZATIONS AND HEALTH MAINTENANCE HISTORY:

Date of PneumoniaVaccine?	
Most recent Colonoscopy by Dr?	
Date of due for next Colonoscopy?	
Date of last Tetanus shot?	

Female Related:

Date of Last Pap? _____/_____/_____

History of Abnormal Pap? _____

Most recent mammogram? _____

SOCIAL HISTORY:

Do you drink Alcohol? Yes ☐ No ☐ If Yes, number of drinks per week: _____

Do you use Tobacco? Yes ☐ No ☐ Former Smoker ☐ Quit Date: _____

Do you use Cannabis? Yes ☐ No ☐

Do you have Children? Yes ☐ No ☐ If Yes, how many? _____

FAMILY HISTORY:

Please list if one of your relatives has had one of the following conditions:

Example #1: *Depression: Paternal Grandmother and Maternal Uncle*

Example #2: *Breast CA: Mother, Paternal Aunt and Sister*

General	
Arthritis	
Asthma	
Bleeding Disorder	
COPD	
Depression	
Diabetes	
Heart Attack	
Heart Disease	
High Cholesterol	
Hypertension	
Mental Illness	
Osteoporosis	
Stroke	

Cancer	
Breast CA	
Colon CA	
Ovarian CA	
Uterine CA	
Prostate CA	
Other CA	

Please list below any other important conditions that have affected family members:

PAST SURGERIES AND HOSPITALIZATIONS:

Reason for Surgery / Hospitalization and year:

PREFERRED PHARMACY: (Name, City/Cross Street)

CURRENT MEDICATIONS:

Medication / Supplement	Dose (e.g. mg/pill)	How many times per day at what time?

DRUG ALLERGIES:

Name of Medicine:	Your Reaction to Medicine (rash, short of breath, etc...):

☐ **Check box if you have no known allergies**

Patient / Guardian Signature: _____ **Date:** _____

Patient Symptom Survey

Patient Name_____ **DOB**____/___/_____

Please indicate symptoms you or the patient have experienced **over the past 12 months.** 1= Mild 5= Severe

	1	2	3	4	5		1	2	3	4	5
Acid Indigestion	☐	☐	☐	☐	☐	Skin Rash	☐	☐	☐	☐	☐
Abdominal Pain	☐	☐	☐	☐	☐	Hives	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐	Eczema	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	Diaper Rash	☐	☐	☐	☐	☐
Bloating	☐	☐	☐	☐	☐	Mental Confusion	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐	Brain Fog	☐	☐	☐	☐	☐
Congestion	☐	☐	☐	☐	☐	Fatigue	☐	☐	☐	☐	☐
Stuffy Nose	☐	☐	☐	☐	☐	Arthritis/Muscle Pain	☐	☐	☐	☐	☐
Runny Nose	☐	☐	☐	☐	☐	Teary or Watery Eyes	☐	☐	☐	☐	☐
Headaches or Migraines	☐	☐	☐	☐	☐	Red or Bloodshot Eyes	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	Dry Scratchy Eyes	☐	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐	☐	Burning Eyes	☐	☐	☐	☐	☐
Strep Throat	☐	☐	☐	☐	☐	Dark Circles Under Eyes	☐	☐	☐	☐	☐
Tongue or Lip Swelling	☐	☐	☐	☐	☐	Asthma Wheezing or Breathlessness	☐	☐	☐	☐	☐
Frequent Sinus or Ear Infection	☐	☐	☐	☐	☐	Swelling or Inflammation	☐	☐	☐	☐	☐
Frequent Colds or Sore Throat	☐	☐	☐	☐	☐	Trouble Sleeping	☐	☐	☐	☐	☐
Itchy Mouth, Throat or Ears	☐	☐	☐	☐	☐	Other (write in below)	☐	☐	☐	☐	☐

HISTORY:

Do you have a history of allergies? Yes ☐ No ☐ If yes, how long? _____

Have you been allergy tested before? Yes ☐ No ☐ If yes, when? _____

Are your allergies year-round or seasonal? All year ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐

What medications have you taken or are currently taking for your allergies? _____

Do they work? Never ☐ Occasionally ☐ Usually ☐ Always ☐

Which if any foods which cause you problems? _____

Symptoms: _____

Have your allergies ever kept you home from school or work? Yes ☐ No ☐

Do you have any pets or are regularly exposed? Yes ☐ No ☐ Type _____

Do you smoke? Yes ☐ No ☐ How Much? _____ Are you exposed to 2nd hand smoke? Yes ☐ No ☐

Do you have Air Conditioning (AC)? Yes ☐ No ☐ If yes, central HVAC ☐ or Window Units ☐

Are you aware of any mold in your home, basement, walls, ceilings, or ductwork? Yes ☐ No ☐

Are you aware of any standing water in basement or under house? Yes ☐ No ☐

Was your home built before 1970? Yes ☐ No ☐ Is your home a single ☐ or multiple unit ☐ dwelling?

Are you aware of any cockroaches or mice in your home? Yes ☐ No ☐

Have you ever been diagnosed with Asthma? Yes ☐ No ☐ If yes, when? _____

Severity: Mild ☐ Moderate ☐ Severe ☐ Controlled with medication? Yes ☐ No ☐

How often do you use your inhaler? _____ Last date used? ____/___/_____

Do you use any sleep aids? Yes ☐ No ☐ If yes, what type including OTC _____

Patient Symptom Survey

CONTRAINDICATIONS

1. Do you suffer from uncontrolled asthma or reduced lung function? Yes ☐ No ☐
2. Have you had a severe allergic reaction? Yes ☐ No ☐ If yes, what was the cause of the reaction?

   _____
3. Are you currently taking a beta blocker to treat heart disease? Yes ☐ No ☐

   If yes, what medication(s)? _____
4. Have you taken any medication in the last 72 hours? Yes No

   If yes, what medication(s)? _____
5. Are you pregnant? Yes ☐ No ☐

CLINICAL USE ONLY

Is allergy testing indicated for this patient? Yes ☐ No ☐

Date of test ____/___/_____ Skin ☐ Blood ☐

Refer Patient to a Specialist? Yes ☐ No ☐

Provider _____ Date ____/___/_____

Patient Signature: _____ Date ____/___/_____

Reviewed By: _____ Date ____/___/_____

Foster City Medical Center

Primary Care and Urgent Care

Welcome to Foster City Medical Center! For our patients, who come from a wide range of places and backgrounds, here is what to expect for your first visit:

If you already have your own Primary Care Provider (PCP, a family doctor or equivalent), and are here for Urgent Care because your own PCP is temporarily not available, welcome! We will see what we can do for you until you follow-up with your PCP again. If you are establishing care long-term at our clinic, welcome also! We will get to know you and your medical situation, and figure out what we need to diagnose and/or treat you. If you don't have any particular ongoing issues, and are here for an annual physical (or "general checkup"), we will check you as appropriate for your health background. Note that it is not enough just to order blood tests, as many of these checks are not blood tests.

If your issue is a new recent issue, we will handle it the usual way. If your condition is part of a longer-term problem for which your PCP has already been seeing you, please bring any medications, test results and other medical records, so we don't have to repeat the medical work-up that has already been done. If you don't have that with you, we may need to contact your PCP or get records from elsewhere.

If you need refills today, it means another doctor already saw you and prescribed medicine for you, so please bring records, or at least be prepared to explain what your medical situation is. We will make a medical decision whether it is appropriate to refill, adjust the dose, or use another medication altogether. Usually we start with refilling a small amount; a larger amount can come at a later visit when we know enough about your situation to take responsibility for refilling more. If the medicine you need is a Controlled Substance (government classified as high abuse potential), we might not be able to fill your medicine if we don't have enough information.

If you are asking for a referral, we need to have a basis for the referral. Sometimes we can base it on information from past records or from you; other times we will need to go through the diagnostic process to establish the need for a referral.

If you have multiple medical conditions, we may not be able to get through all of your issues in one visit, especially since this is our first time meeting you. Please let us know which issue we should start with, so we deal with the urgent problem first. We will keep seeing you for as many visits as it takes to work through your issues.

Welcome!