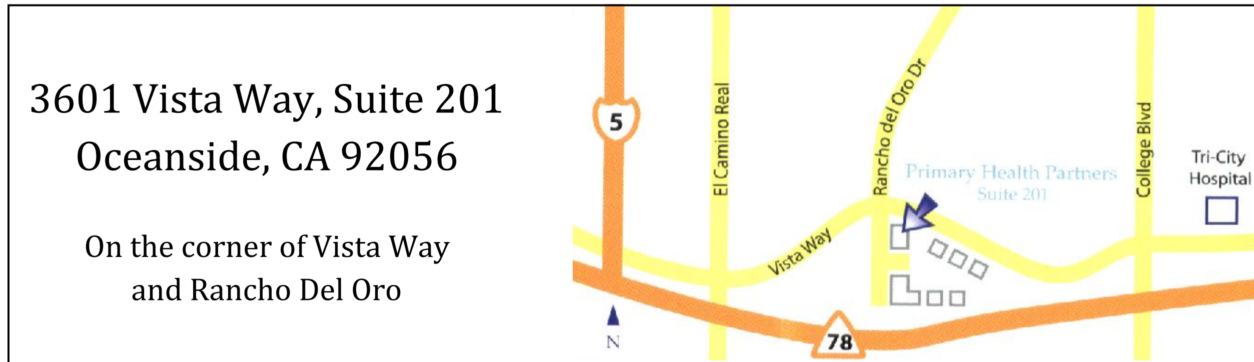
Primary Health Partners

Michelle Gonzales, M.D. (760) 639-1204



Welcome to our practice!

Your appointment is scheduled for ______________@________ am / pm.
Please arrive 15 minutes early to your appointment to allow time for registration to be completed.

Please bring with you to your appointment:

1. Completed new patient packet
2. List of all medications and any over the counter medicines
3. Insurance cards
4. Immunization records (if applicable)
5. Previous doctor contact information to request records

If you need to reschedule or cancel, please give at least 24 hours notice so that we may offer your time to another patient in need. Thank You!

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Gonzales will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Michelle Gonzales MD

Pursuant to recent regulations under the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct (**HIPAA**), we are now required to have a written signature from you authorizing us to leave messages at your home or with a family member.

Patient Information

Name: ______ Age: ______ DOB: ______

Address: ______ City: ______ State: ______ Zip: ______

Phone Number	Type	OK to leave message?		
1.		YES	NO	SSN #
2.		YES	NO	Email:
3.		YES	NO	Marital Status: S M D W
				Spouse Name:

Insurance Information

Primary Insurance: ______ Co-Pay: ______

Member ID # ______ Group # ______

Secondary Insurance: ______ Co-Pay: ______

Member ID # ______ Group # ______

Responsible Party: ______ DOB: ______

SSN# Relationship to Patient:

Emergency Contact

NAME	RELATIONSHIP	NUMBER

Individuals Involved In My Healthcare

With your written permission, we may disclose health information or payment information about you to the following family members, caregivers, or friends who may be involved in your healthcare.

NAME	RELATIONSHIP	NUMBER

Payment of Services

The undersigned authorizes care and treatment by Michelle Gonzales, M.D. Payments and co-payments are due at time of service. Patients (or responsible parties) must keep their account current while waiting for payment from insurance companies. If collection becomes necessary, the undersigned agrees to pay all associated costs. The undersigned understands that a $50.00 charge may be billed to their account for failure to cancel or reschedule an appointment at least 24 hours in advance (except in the event of an emergency). The undersigned will be responsible for fees when copies of medical records are requested and authorized with their signature and when forms are completed at their request by the physician

Insurance Authorization and Assignment of Benefits

I hereby authorize Michelle Gonzales, M.D. to furnish information to my insurance carrier(s) concerning illness and treatments and assign all payments to Michelle Gonzales, M.D. for medical services rendered to me or my dependants. I, the undersigned, affirm that I am an eligible member of the above insurance company. My signature below is proof of my acceptance of full financial responsibility of services rendered if patient is determined not to be eligible under insurance plan listed above.

Acknowledgement of Notice of Privacy Practices

My signature acknowledges that I have been advised of Dr. Michelle Gonzales's Notice of Privacy Practices, which detail how my information may be used and disclosed as permitted under federal and state law. I understand that a copy of the Notice of Privacy Practices is posted in the reception area and that I have obtained a copy for my personal use.

The undersigned hereby consents to the above agreements

Signature: Date:

Michelle Gonzales MD

Date: ______	Name: ______		DOB: ______
Occupation or Previous Occupation if retired: ______			
Ethnicity: ______	Circle One: Hispanic	Non-Hispanic	Decline
Language:	Last Blood Work:	Last Physical Exam:	

Current Symptoms or Problems

Medication Allergies	Reaction

Current Medications		
Name	Dose	Frequency

continue list on back if needed

Illnesses		
Measles	Y	N
Pneumonia	Y	N
Asthma or Wheezing	Y	N
Allergies	Y	N
Heart Disease	Y	N
Type:		
High Blood Pressure	Y	N
High Cholesterol	Y	N
Stroke or TIA	Y	N
Migraine Headaches	Y	N
Seizures	Y	N
Depression	Y	N
Psychiatric Illness	Y	N
Kidney Disease	Y	N
Kidney Stones	Y	N
Bladder Infection	Y	N
Thyroid Disease	Y	N
Diabetes	Y	N
Cancer	Y	N
Arthritis	Y	N
Osteoporosis	Y	N
Diverticulitis	Y	N
HIV or AIDS	Y	N

Surgeries		
1. Type:		
Year:		
2. Type:		
Year:		
3. Type:		
Year:		
continue list on back if needed		
Blood Transfusion	Y	N

Social History		
Ever Smoked	Y	N
When:		
Packs Per Day:		
Quit	Y	N
When:		
Drink Alcohol	Y	N
Type:		
Amount:		
Frequency:		
Recreational Drugs	Y	N
Type:		
Amount:		
Frequency:		

Weight	
Now	
1 year ago	
Exercise Type	
Frequency	

Immunizations	Year
Tetanus	
PPD (TB Test)	
History of Tuberculosis	Y N
Flu Shot	
Pneumovax	
Zostavax (Shingles)	
Hep A or B	

Procedures	Year
Chest Xray	
Bone Density	
Heart Angiogram	
Echocardiogram	
Holter Monitor	
EKG	
Treadmill Test	
Sigmoidoscopy	
Colonoscopy	
Cystoscopy	

any additional information can be listed on back

Michelle Gonzales MD

Family History		If Living
	Age	Health
Father		
Mother		
Siblings		
Children		

If Deceased	
Age	Health

Has any blood relative ever had...			
			Who?
Cancer	Y	N	
Type	Y	N	
Heart Trouble	Y	N	
High Blood Pressure	Y	N	
Stroke	Y	N	
Diabetes	Y	N	
Depression	Y	N	
Tuberculosis	Y	N	

Do you now have or have you had in the past year…

Frequent or Severe headaches	Y	N
Fainting spells	Y	N
Dizziness on change of position	Y	N
Tingling, Weakness, Numbness in hands or feet	Y	N
Trembling of any extremity	Y	N

Glaucoma	Y	N
Cataracts	Y	N
Other visual problems	Y	N
Date of last eye exam:		
Any problems with hearing	Y	N
Frequent sinus infections	Y	N
Hay fever or Allergies	Y	N
Difficulty swallowing	Y	N
Recurrent sores in mouth	Y	N

Chest pain	Y	N
Pain in arms	Y	N
Palpitations or Fluttering of heart	Y	N
Chronic or frequent cough	Y	N
Wake up at night short of breath	Y	N
Shortness of breath	Y	N
When walking how far:		
On a flight of stairs	Y	N
Laying Down	Y	N

Recurrent stomach pain or cramping	Y	N
Belching, Heartburn or Indigestion	Y	N
Relieved by medication or food	Y	N
Change in appetite or Weight loss	Y	N
Vomited blood	Y	N

Blood in BM or Black stool	Y	N
Rectal pain	Y	N
Pain in urination	Y	N
Difficulty urinating	Y	N
Lose urine when coughing or sneezing	Y	N
How many times do you urinate after bedtime		
Blood in urine	Y	N
Genital herpes	Y	N
Are you presently sexually active	Y	N

Women Only:

Date of last mammogram: ______________

Menstrual History

Age at onset: ____________ Days of flow: ____________

Days from one cycle to the next: ____________

Regular? Y N Varies Pain or Cramps? Y N

Date of last period: ____________

Form of birth control: ____________

Date of last pap or pelvic exam:

Abnormal pap	Y	N
Pain with intercourse	Y	N
Vaginal discharge or itching	Y	N

Pregnancies

How many: __________ C-Section: How many: __________

How many children: ____________ Still births: __________

How many miscarriages: Abortions:

Men Only:

Discharge from penis	Y	N
Problems with impotence or erections	Y	N
Date of last PSA test:		

Michelle Gonzales MD

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)

CITY STATE
8. RESERVED FOR NUCC USE
CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )
ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED

MM DD YY QUAL. QUAL. MM DD YY
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Michelle Gonzales MD

Medical Records Release

3601 Vista Way Suite 201
Oceanside, CA 92056

I Hereby Authorize:	**To Furnish To:**
☐**Other**: ______________	☐ **Michelle Gonzales, MD**
Phone: ______________	**P** 760.639.1204
Fax: ______________	**F** 760.630.1252

Please Send: ____

____

I understand that general records may contain Doctor's Office Notes, Emergency Room Reports, X-ray/Lab Reports, Medical and/or Mental Conditions, Alcohol and Drug Conditions, HIV Testing and other sensitive information.

I understand that I may formally request exclusion of any sensitive information.

Exclude: ____

You have a right to have a copy of this authorization. This consent shall remain valid for 6 months from the date of signature. This authorization may be revoked in writing to the above address.

Name: ______________________ DOB: __________

Address: ____

City: ______________ State: __________ Zip: __________

Signature: ______________________ Date: __________

Relationship to Patient (circle): Self / Parent / Guardian / Legal Representative