Jeffery A. Muller, M.D. • Lisa Rogers- PA-C
2815 S. Main Street, Suite 210, Corona, CA 92882
Phone 951-735-9211

FOLLOW US ON facebook
https://www.facebook.com/CoronaFamilyCare/

Are you on Facebook?○ YES ○ NO

Today's Date: _____

How did you hear about our office?

○ Friend/Family Member ○ Insurance ○ Other: _____
○ Website _____ ○ Advertisement

Patient Information:

Name _____
Address: _____
City: _____ State: _____ Zip: _____
SSN: _____ Driver's License #: _____
Marital Status: Single Married Widowed Divorced

Date of Birth: _____
Home Ph #: _____
Work Ph #: _____
Cell Ph #: _____
E-mail: _____
Gender: Female Male

Employer Information:

Employer Name: _____
Phone #: _____
Address: _____
City: _____ State: _____ Zip: _____

Emergency Contact Information:

Name: _____
Relationship to Patient: _____
Home Ph #: _____
Cell Ph #: _____

Primary Insurance Information:

(Subscriber is the person who holds the policy)
Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Subscriber Name: _____
Subscriber's SSN: _____
Effective Date: _____ DOB: _____
Subscriber/ID Number: _____
Subscriber Ph #: _____
Group #: _____

Secondary Medical insurance Information:

(Subscriber is the person who holds the policy)
Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Subscriber Name: _____
Subscriber's SSN: _____
Effective Date: _____ DOB: _____
Subscriber/ID Number: _____
Subscriber Ph #: _____
Group #: _____

Patient Demographic Information (required for the Centers of Medicare and Medicaid Services):

Ethnicity:

○ Hispanic Not Hispanic/Latino Unknown

Preferred Language:

○ Arabic	○ German	○ Japanese	○ Spanish, Castillian
○ Bulgarian	○ Haitian	○ Korean	○ Thai
○ Chinese	○ Hebrew	○ Polish	○ Urdu
○ English	○ Hindi	○ Portuguese	○ Vietnamese
○ French	○ Italian	○ Russian	○ Other: _____

Race:

○ American Indian/Alaska Native	○ Black/African American	○ White
○ Asian	○ Native Hawaiian/Other Pacific	○ Other Race

Advanced Healthcare Directive:

As your physician, we are required to ask any patient over the age of 18 if they have an existing Advanced Health Directive. This will be placed in your file.

Do you have an Advanced Health Directive? ○ NO ○ YES
If yes, please indicate what type of directive
○ Durable Power of Attorney ○ California Natural Death Act ○ Other: _____

Will you bring a copy of your directive to the office to be placed in your chart? ○ NO ○ YES

Patient Signature: _____ Date: _____

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Patient Name: _____ **Today's Date:** _____
DOB: _____ **Height:** _____ **Weight:** _____

What is your medical problem and how long have you had it? _____
_____

Check any of the following for illness or conditions you have had:

○ Asthma	○ Depression/Anxiety	○ Jaundice	○Seizure/Stroke
○ Bladder Disease	○ Diabetes	○ Kidney Disorder	○ Skin Disorder
○ Bleeding Tendencies	○ Gastrointestinal Disorders	○ Musculoskeletal Disorder	○ STD _____
○ Breast/GYN Disorder	○ Glaucoma	○ Pneumonia	○ Tuberculosis
○ Cancer_____	○ High Blood Pressure	○ Prostate Problem	○ Vein Trouble
○ COPD ○ Heart Trouble	○ High Cholesterol	○ Rheumatic Fever	○ Weight Gain/Loss

Previous Operations (please include dates):

○ Abdominal	○ Eye	○ Hernia	○ Transplant _____
○ Appendectomy	○ Gallbladder	○ Orthopedic	○ Urologic
○ Breast	○ GYN _____	○ Prostate	○ Other: _____
○ Cesarean	○ Heart	○ Tonsillectomy	_____

Women Only:
Are you currently pregnant? ○ **NO** ○ **YES**
# of pregnancies _____ **# of miscarriages:** _____
Any complications? ○ **NO** ○ **YES** _____
Onset Date of Last Menstrual Period: _____
Periods are: ○ **Regular** ○ **Irregular**
Have you gone through Menopause? ○ **NO** ○ **YES**
Last Mammogram Date: _____ ○ **Normal** ○ **Abnormal**
Last PAP Smear Date: _____ ○ **Normal** ○ **Abnormal**

Please list any other illnesses NOT requiring operation for which you were hospitalized: _____
_____
_____
Have you ever had a blood transfusion? ○ **NO** ○ **YES**
If so, when? _____

Men Only:
When was your last PSA (prostate blood test)?

MEDICATIONS: Please list all medications you are currently taking and why:

Medication Name:	Dosage:	Reason for Medication:	Prescribing Physician:

Pharmacy Information:
Pharmacy Name: _____ **Phone #:** _____
Address: _____

Do you take any of the following?
Aspirin/blood thinner: ○ **NO** ○ **YES** _____
Vitamins: ○ **NO** ○ **YES** _____
Laxatives: ○ **NO** ○ **YES** _____
Steroids: ○ **NO** ○ **YES** _____

When was your last TB skin test or Chest X-Ray?
_____

ALLERGIES:
Are you allergic to latex material? ○ **NO** ○ **YES**
Are you allergic to iodine? ○ **NO** ○ **YES**
Are you allergic to any medications? ○ **NO** ○ **YES**
If yes, please list medications and reaction/symptom:
_____
_____

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Family History:

Has anyone of your blood relatives had the following problems? Please indicate the family member and provide other relevant information below:

Cancer:

Family Member Relation to Patient: Cancer Type: Age Cancer Found: Still Living: Did they die of this?

_____
_____
_____

Heart Attack or Stroke:

Family Member Relation to Patient: Heart Attack/Stroke: At What Age: Still Living: Did they die of this?

_____
_____
_____

Any other Health Problems or Disease among your blood relatives?

Alcoholism	Depression	Kidney Disease	Tuberculosis
Allergies	Diabetes	Migraine Headaches	Ulcer Disease
Anemia	Glaucoma	Obesity	Other (specify): _____
Arthritis	High Cholesterol	Osteoporosis	_____
Asthma	Hypertension	Thyroid Disease	_____

Immunization History:

Please indicate which of the following immunizations you have had:

Tetanus shots	Year of Last Shot _____
Measles Mumps	Year of Last Shot _____
Pneumovax	Year of Last Shot _____
Shingles Vaccine	Year of Last Shot _____

Polio shots within last 2 years: ○ NO ○ YES

Influenza Year of Last Shot _____

Childhood History:

Please circle any of the following that you have had:

Chicken Pox	Polio
Diptheria	Rheumatic Fever
German Measles	Scarlet Fever
Measles	Whooping Cough
Mumps	None

Social History:

Occupation: _____

Have you traveled outside of the US? ○ NO ○ YES
If so, where and when? _____

_____
_____
_____
_____
_____

Do you smoke? ○ NO ○ YES
If yes, how many packs per day? _____
If yes, how long have you smoked? _____
When did you quit smoking? _____

Do you drink alcoholic beverages? ○ NO ○ YES
If yes, how often? _____

Have you ever used or do you currently use illicit drugs? ○ NO ○ YES Please explain:

_____
_____
_____
_____
_____

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REVIEW OF SYSTEMS:

Within the last year, have you had any of the following?

	YES	NO
SKIN:		
Change in hair texture		
Change in skin texture		
Any skin rash		
Any new or change in moles		
HEENT:	YES	NO
Blurred vision		
Double vision		
Spots before eyes		
Infected eyes		
Pain behind eyes		
Any change in vision		
Do you wear glasses?		
When did you last have your vision checked? _____		
	YES	NO
Ear aches		
Discharge from ears		
Ringing in ears		
Decrease in hearing		
Recurrent nose bleeds		
Recurrent head colds		
Sinus trouble		
Hay fever		
Strange persistent odors		
Strange taste or loss in taste		
Persistent hoarseness		
Difficulty swallowing		
Enlarged glands		
Recurrent sore throats		
Recurrent sores in mouth		
Soreness or bleeding of gums on brushing		
RESPIRATORY	YES	NO
Shortness of breath		
Night sweats		
Chronic or frequent cough		
Chronic or frequent cough or laying down		
Wheezing		
Coughed up blood		

	YES	NO
CARDIOVASCULAR:		
Chest pain		
Pain in arms		
Wake up at night short of breath		
How many bed pillows do you use?		
Shortness of breath:		
One flight of stairs		
On laying down		
Purple lips or fingers		
Palpitations or fluttering of heart		
Swelling of hands, feet or ankles:		
At what time of day _____		
Leg cramps on walking or at night		
Enlarged veins in legs		
	YES	NO
GASTROINTESTINAL		
Recurrent stomach pain		
Belching or heartburn		
Relieved by food or medication		
Appetite: Good Fair Poor	YES	NO
Nausea or vomiting		
Vomited blood		
Avoid some foods		
What kinds? _____	YES	NO
Avoid spices		
Black bowel movement		
Any blood in bowel movement		
Rectal pain with bowel movement		
Bowel movements average _____		
Frequency per day _____	YES	NO
Change in size, shape or texture of BM		
ENDOCRINE	YES	NO
Goiter		
Hot flashes		
Tiredness without apparent reason		
Brittleness of nails		
Dryness of skin		
Inability to stand heat		
Inability to stand cold		

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REVIEW OF SYSTEMS CONTINUED…

	YES	NO
MUSCULO-SKELETAL		
Recurrent back pains		
Backaches		
Joint pains		
Swelling of any joints		
Redness or heat of any joint		
NEUROLOGICAL		
Frequent or severe headaches		
Fainting spells		
Dizziness on change of position		
Unconscious spells		
Tingling or weakness of hands or feet		
Muscle spasms		
Loss or change of sensation in hands/feet		
Trembling of any extremity		
SIGMOIDOSCOPY OR COLONOSCOPY		
Sigmoidoscopy When? _____		
Colonoscopy When? _____		
Do you know the findings?		
EKG		
Ever had an electrocardiogram?		
Were the results abnormal?		
ECHO		
Ever had an echocardiogram?		
Were the results abnormal?		
STRESS TEST		
Ever had a treadmill stress test?		
Were the results abnormal?		

	YES	NO
GENITOURINARY:		
Lose urine on coughing or sneezing		
Discharge from penis		
Pain in urinating		
Difficulty in starting urination		
Do you get up at night to urinate?		
If yes, how many times? _____		
Any blood in urine?		
Full feeling of bladder, but only small amount of urination?		
HEMATOLOGIC:		
Easy bruising		
Bleeding problems		
GYNECOLOGICAL:		
Birth control _____		
Endometriosis		
Fibroids of uterus		
Ovarian cysts/masses (not cancer)		
Pelvic pain		
Planning on getting pregnant in the next year		
Recurrent vaginal infections		
Vaginal discharge		

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PATIENT COMMUNICATION CONSENT AGREEMENT
PER FEDERAL LAW HIPAA

I, _____, HEREBY GIVE MY CONSENT TO Corona Family Care, Inc., Dr. Jeffery Muller, and Jeremy Johnson, PA-C and their staff to contact me regarding any my treatment with their office including lab results, x-rays, referrals and appointments via:

Please check all that apply:

____ We at Corona Family Care, Inc., will do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children or anyone else) without written consent. If you want anyone other than your referring physician to have access to your medical information, please list his or her name, relationship to you, and phone number below. (Note: uses and disclosures may be permitted without prior consent in an emergency.

Please list names and relationships below:

ADDITIONAL PERSON(S) AUTHORIZED TO MAKE USE OR DISCLOSURE OF MY PMH:

Name:	Relationship to Patient:	Phone Number:

____ Mail
____ Answering machines or voicemails
____ Cell Phone # _____
____ DO NOT CONTACT ANYONE OTHER THAN ME PERSONALLY

PATIENT NAME (please print): _____ DATE: _____
PATIENT SIGNATURE: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/RECORDS

Authorization for use and/or disclosure of Protected Health Information

I hereby authorize: CORONA FAMILY CARE, INC./JEFFERY MULLER MD/JEREMY JOHNSON, PA-C
2815 S. MAIN STREET, SUITE 210, CORONA, CA 92882
PHONE: 951-735-9211 FAX: 877-714-5449

Patient Printed Name: _____ DOB: _____

Disclose Health Information to:
Name of Recipient: _____
Address: _____ City:_____ State: _____ Zip: _____
Phone: _____ Fax: _____

Check the box and initial to specify which type of information is to be disclosed:

- o All medical information/records _____ Dates: _____
- o Imaging/Radiology (X-Ray, Ultrasound, MRI, CT Scan, etc) _____ Dates: _____
- o Consultation/Progress Notes _____ Dates: _____
- o Lab Results/Pathology _____ Dates: _____
- o Other _____ Dates: _____

Duration: This authorization shall become effective and shall remain in effect: (please check selection)

_____ From the date of this authorization until __/____/____
_____ Until the provider fulfills this authorization request
_____ Until the following event occurs: _____

Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorized Representative of Patient:
Signature:_____ Date:_____
Printed Name: _____
Relationship to Patient:_____

Witness:
Signature:_____
Printed Name: _____
Date:_____

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*****PLEASE FAX RECORDS TO: 877-714-5449*****

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

DOB: _____/_____/_____ Phone Number: _____

I authorize the release of my medical records to Corona Family Care, Inc., for review and continuation of my medical care. I authorize the following physician offices, clinics, legal offices, diagnostic centers, and medical providers to provide copies of my health records to Corona Family Care, Inc.

PERSONS/ORGANIZATIONS FROM WHICH RECORDS MAY BE REQUESTED FROM:

(List all facilities, clinics and offices from which information may be requested)

Provider/Attorney/Diagnostic:	Address:	Phone Number:

Restrictions: Check the box and initial to specify which type of information is to be released:

- o All medical information/records _____ Dates: _____
- o Imaging/Radiology (X-Ray, Ultrasound, MRI, CT Scan, etc.) _____ Dates: _____
- o Consultation/Progress Notes _____ Dates: _____
- o Lab Results/Pathology _____ Dates: _____
- o Other _____ Dates: _____

Duration: This authorization shall become effective and shall remain in effect: (please check selection)

_____ From the date of this authorization until __/____/____
_____ Until the provider fulfills this authorization request
_____ Until the following event occurs: _____

PATIENT/AUTHORIZED REPRESENTATIVE
SIGNATURE:_____ DATE: _____

PATIENT/AUTHORIZED REPRESENTATIVE PRINTED NAME: _____

RELATION OF AUTHORIZED REPRESENTATIVE TO PATIENT: _____

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CONSENT AND FINANCIAL RESPONSIBILITY

_____ I hereby consent to medical treatment by Jeffery A. Muller, MD, and Jeremy Johnson, PA-C.
(Initials)

_____ I understand that all fees are due at the time of service unless Jeffery A. Muller, MD and/or
(Initials) Jeremy Johnson, PA-C, are a contract provider for my insurance plan in which case all co-pays, deductibles, and/or patient percentage required by my insurance are due at the time of service. I understand that my medical insurance may not pay fully for my medical bill and I accept full financial responsibility for all charges that I incur under the treatment of Corona Family Care, Jeffrey A. Muller, MD, and Jeremy Johnson, PA-C. I understand that any banking or return check fees will be my responsibility. Return check fees are $35.00 per return.

_____ I understand that I will receive a monthly billing statement for any balance for which I am
(Initials) responsible and that if I fail to pay the "Due From Patient" portion in full by the due date, I will be charged a 1.5% interest per month on the unpaid balance.

DATE: _____ SIGNATURE: _____

If you wish to have our office bill your insurance company for your incurred charges, you must sign the Assignment of Benefits and Release below. This assignment is assumed to apply to all future claims unless you notify us in writing to the contrary.

I hereby authorize my insurance benefits to be paid directly to Jeffery A. Muller, MD and Jeremy Johnson, PA-C, and I accept financial responsibility for any non-covered services. I authorize to release Jeffery A. Muller, MD and Jeremy Johnson, PA-C, any information to process insurance claims made on my behalf.

DATE: _____ SIGNATURE: _____

If you are signing this agreement as the responsible part for a minor child, please fill out the statement below as indicated.

I, _____, _____, accept full financial responsibility as
(Name of Responsible Party) *(Relationship to Patient)*
Described above and consent to medical treatment by Jeffery A. Muller, MD and Jeremy Johnson, PA-C for _____, a minor.
(minor's name)

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No Show Policy

Patient Name: _____

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "No-Show" Appointment

Corona Family Care defines a "No-Show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours' notice
- Arrives more than 10 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a "No Show"

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation
   Corona Family Care will attempt to contact you one business day before your scheduled appointment to confirm your visit. If we are unable to speak with you and have the leave a message, you will need to contact Corona Family Care by 2:30 p.m. the business day before the appointment—otherwise the appointment will be cancelled and marked as a "no-show".
2. Always Arrive 5-10 Minutes Early
   When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for your and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.
3. Give 24 Hours' Notice if You Need to Cancel
   When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-Show" Appointments

If you miss 3 or more appointments within a year, you may be dismissed from the clinic.

1. Patient dismissal is at the discretion of your medical provider.
2. **If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled.**
3. Only emergency medical treatment will be offered within the first 30 days of dismissal.
4. Reapplication to the clinic after a six-month period after initial dismissal letter will be considered by your medical provider.

I have read and understood the Corona Family Care "No Show" Policy as described above.

DATE:_____ PATIENT SIGNATURE:_____

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Self Pay Patients

Please be advised that your appointment today is for a CONSULTATION with the doctor. A consultation is to diagnose your condition and to determine the most appropriate and effective treatment plan for your condition.
There is no guarantee that the doctor will prescribe medications or refill the medications previously given to you by another doctor.
Your payment for today's visit is for a consultation.
We only take cash, credit card, or debit card with a Visa or MasterCard logo.
NO REFUNDS will be issued

I agree to the above-mentioned terms:

_____ _____
PATIENT SIGNATURE DATE

_____
PATIENT'S PRINTED NAME

Pacientes que Pagan de su Bolsillo

Por favor tenga en cuenta que la cita de hoy es para una consulta con el medico. Una consulta es para diagnosticar su condicion y para determiner el plan de tratamiento mas adecuado y eficaz para su condicion.
No hay ninguna garantia de que el medico le recete medicamentos o le de refills de medicamentos previamente recetados por otro medico.
Su pago por la visita de hoy es la de una consulta.
Solamente tomamos dinero en efectivo, tarjeta de credito o tarjeta de debito con el logo de Visa o MasterCard.
NO Habra DEVOLUCION de su dinero.

Estoy deacuerdo a los terminus mencionados arriba:

_____ _____
FIRMA DEL PACIENTE FECHA

_____
NOMBRE DEL PACIENTE