Jeffery A. Muller, M.D. & Associates
2815 S. Main Street, Suite 210, Corona, CA 92882
Phone 951-735-9211

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: ____________________________**

○ Internet **○ Advertisement**

Patient Information:

Name ____

Address: __________________________________

City: ________________ State: _____ Zip: _________

SSN: _____________ Driver's License #: _____________

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

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

○ Durable Power of Attorney **○ California Natural Death Act** **○ Other: ______________________________________**

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

Previous Operations (please include dates):

- ○ Abdominal
- ○ Appendectomy
- ○ Breast
- ○ Cesarean
- ○ Eye
- ○ Gallbladder
- ○ GYN ________
- ○ Heart
- ○ Hernia
- ○ Orthopedic
- ○ Prostate
- ○ Tonsillectomy
- ○ Transplant ______________________________
- ○ Urologic
- ○ Other: ________________________________
____

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: ____________________________________
Marital Status: Single Married Widowed Divorced
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?

SKIN:	YES	NO
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		

CARDIOVASCULAR:	YES	NO
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		

GASTROINTESTINAL	YES	NO
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…

MUSCULO-SKELETAL	YES	NO
Recurrent back pains		
Backaches		
Joint pains		
Swelling of any joints		
Redness or heat of any joint		

NEUROLOGICAL	YES	NO
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	YES	NO
Sigmoidoscopy When? ___________		
Colonoscopy When? ___________		
Do you know the findings?		

EKG	YES	NO
Ever had an electrocardiogram?		
Were the results abnormal?		

ECHO	YES	NO
Ever had an echocardiogram?		
Were the results abnormal?		

STRESS TEST	YES	NO
Ever had a treadmill stress test?		
Were the results abnormal?		

GENITOURINARY:	YES	NO
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? ______

	YES	NO
Any blood in urine?		
Full feeling of bladder, but only small amount of urination?		

HEMATOLOGIC:	YES	NO
Easy bruising		
Bleeding problems		

GYNECOLOGICAL:	YES	NO
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 & Associates 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 & ASSOCIATES
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:

- ○ All medical information/records _____________________________________ Dates: _______________________
- ○ Imaging/Radiology (X-Ray, Ultrasound, MRI, CT Scan, etc) __________________ Dates: _____________________
- ○ Consultation/Progress Notes ____ Dates: ______________________
- ○ Lab Results/Pathology ____ Dates: ______________________
- ○ 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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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:

- ○ All medical information/records ____ Dates: ______________________
- ○ Imaging/Radiology (X-Ray, Ultrasound, MRI, CT Scan, etc.) ___________________ Dates: ______________________
- ○ Consultation/Progress Notes ____ Dates: ______________________
- ○ Lab Results/Pathology ____ Dates: ______________________
- ○ 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

_______ *(Initials)* I hereby consent to medical treatment by Jeffery A. Muller, MD & Associates.

_______ *(Initials)* I understand that all fees are due at the time of service unless Jeffery A. Muller, MD & Associates. 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, Inc., Jeffery A. Muller, MD & Associates. I understand that any banking or return check fees will be my responsibility. Return check fees are $35.00 per return.

_______ *(Initials)* I understand that I will receive a monthly billing statement for any balance for which I am 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 & Associates. and I accept financial responsibility for any non-covered services. I authorize to release Jeffery A. Muller, MD & Associates 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 & Associates for _____________________, a minor.

(minor's name)

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No Show Fees

Dear Valued Patient:

I would like to begin by thanking you for trusting my team and myself with your care. We are here to help you with your medical needs and understand that you have choices when it comes to your healthcare.

Lately, I have noticed an increase in patients who do not show up for their appointments at the office. This is resulting in an inconvenience for myself, the staff and other patients that were not able to schedule that appointment because my schedule was booed.

I understand that events occur and patients may need to reschedule their appointments. However, I am asking that if you are unable to keep your scheduled appointment, that you will call the office no less than 48 hours prior to your scheduled appointment time to notify us that you will need to reschedule. This will allow another patient to receive the treatment that they need.

Unfortunately, if you do not call to reschedule and do not show up to your scheduled appointment, we will now begin charging a “no-show, no-call” fee of $25.00. This fee will be charged to your clinical account and will need to be paid prior to your next visit.

Avoiding the fee is easy. If you need to reschedule or make any changes to your appointment, simply call the office and let the staff know you will not be able to keep your appointment.

My staff and I greatly appreciate your understanding.

Please sign below to acknowledge understanding.

DATE:____________________ PATIENT SIGNATURE:____________________________________
PATIENT PRINTED NAME: ____

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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