Account Number ________________________________

NAME: LAST ___________________________________

FIRST: _______________________________ MI ______

ADDRESS 1: ____________________________________

ADRESS 2: _____________________________________

CITY: ____

STATE: __________________ ZIP CODE: ____________

HOME PHONE: _________________________________

OK TO LEAVE MESSAGE ON HOME PHONE: YES: ___ NO: ____

CELL PHONE: ___________________________________

WORK PHONE: ____________________EXT: ________

OK TO LEAVE MESSAGE ON WORK PHONE: YES: ___ NO: ____

RESPONSIBLE PARTY: SELF: ______ GRANTOR: _______

RELATIONSHIP TO RESPONSIBLE PARTY: _____________

INSURANCES:

PRIMARY: ______________________________________

GRANTOR: _____________________ DOB: _________

SECONDARY: ___________________________________

GRANTOR: ______________________ DOB: _________

TERCIARY:

____

GRANTOR: ______________________ DOB: _________

PHARMACY: ____________________________________

EMAIL ADDRESS: _______________________________

LANGUAGE SPOKEN: ____________________________

PRIMARY CARE DR: _______________________________

REFERRING PROVIDER: ___________________________

RENDERING PROVIDER:

MARTIN BERRY M.D. _______

JEFFREY BACON D.O. _______

DATE OF BIRTH: __________________________________

SEX: M ________ F _________

MARITAL STATUS: M ___ S ___ D ___ W ___ Sep ___

SOCIAL SECURITY NUMBER: _______________________

EMPLOYER: ______________________________________

EMPLOYER ADDRESS: _____________________________

____

EMPLOYMENT STATUS: FT ___ PT ___ RETIRED ___

LAID OFF ___ DISABLED ___ OTHER ___

EMERGENCY CONTACT:

NAME: _______________________________________

PHONE: Home: ______________ Cell: ______________

RELATIONSHIP: _________________________________

ADDRESS:

____

____

SIGNATURE: ____________________________________

DATE: _______________________________________

NAME: ____ DATE: ________________ AGE: _____

Present Medications:

Drug:	Mgs (strength)	Times per day taken

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____

Others: ____

Medication Allergies: ____

____

Please list past surgeries:____

____

____

For MA to fill out:

Temp: ________ Pulse: ________ BP: ___________ Resp: _____ Weight: ___________

Rheumatology Services Medical Group
8329 Brimhall Road #801
Bakersfield, CA 93312
P (661) 327-5037
F (661) 327-7633

Authorization to Disclose Protected Health Information

By signing this Authorization, I authorize Rheumatology Services Medical Group to disclose my protected health information.

Patient's Full Name_________________________________ Date of Birth____/____/____

RELEASE INFORMATION TO:

Name_____________________________Relationship ______________ Phone#____________

1. Information authorized for disclosure, *if included in my records*:
   ☐ Complete Health Record
   ☐ Complete Billing Record
   ☐ Insurance Information
   ☐ Sensitive Protected Health Information i.e. HIV, STD, Hepatitis B or C, etc.
   ☐ Any Exclusions (please list) ____

2. **I understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Rheumatology Services Medical Group.
   I understand that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will not expire and can be documented as unlimited. It is the responsibility of the patient to notify our practice of change.

3. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPPA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact our office.

4. Rheumatology Services Medical Group, its employees and physicians, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____ ____/___/____
Signature of Patient (or Legal Representative, Parent, or Legal Guardian) Date

Rheumatology Services Medical Group

We now have Eclinical Messenger, which allows us to be able to remind you of your appointments by way of your choice of phones or text message. It will also allow us to contact you at a time which is most convenient for you.

FOR PATIENT REMINDERS: We need the following information

Preferred phone number to call you (please choose ONE and put contact number)

_______ Home ______________________________

_______ Cell ______________________________

_______ Work ______________________________

_______ Text Message ______________________________

Is it OK to leave a message on this phone? YES ________ NO _________

Preferred time to receive a call (Please choose ONE)

_______ Morning 9AM TO 12PM

_______ Afternoon 1PM TO 4PM

_______ Evening 5PM TO 7PM

Email Address: ______________________________

The government is now also requiring us to collect the following information. Please complete.

ETHNICITY:

_______ Hispanic or Latin

_______ Not Hispanic or Latin

LANGUAGE:

_______ English

_______ Spanish

_______ Other

RACE:

___ American Indian or Alaska Native

___ Asian

___ Native Hawaiian or Other South Pacific Islander

___ Black or African American

___ White

___ Hispanic

___ Other Race

Print Name: ______________________________ Signature: ______________________________

Date: _________________________