Samer Kanaan, M.D., A Prof Corp.
Phone: 949-444-5864
Fax: 949-258-5863
27451 Los Altos Suite 290
Mission Viejo, CA. 92691

Patient Registration Form

(Please Print)

General information

Name

LAST _____ **FIRST** _____ **MIDDLE** _____

DATE OF BIRTH _____ **SOCIAL SECURITY NUMBER** _____

SEX ❑ **M** ❑ **F** **DRIVERS LICENSE #** _____ **STATE** _____

MARITAL STATUS: ❑ **Married** ❑ **Single** ❑ **Divorced** ❑ **Widowed**

PARENT/GUARDIAN NAME _____ **RELATIONSHIP** _____

Addresses

Home Address

STREET ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP** _____

HOME PHONE _____ **CELL PHONE** _____

EMAIL ADDRESS _____

EMPLOYER _____

OCCUPATION _____

WORK ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

WORK PHONE _____ **EMAIL ADDRESS** _____

IN CASE OF EMERGENCY CONTACT _____ **PHONE** _____

Primary Insurance

NAME OF PRIMARY INS CO _____ **PHONE** _____

ID/POLICY NUMBER _____ **GROUP NUMBER** _____

SUBSCRIBER/INSURED _____ **RELATIONSHIP** _____ **SEX** _____

DATE OF BIRTH _____ **SOCIAL SECURITY NUMBER** _____

EMPLOYER NAME _____ **EMPLOYER PHONE** _____

Secondary Insurance

NAME OF SECONDARY INS CO _____ **PHONE** _____

ID/POLICY NUMBER _____ **GROUP NUMBER** _____

SUBSCRIBER/INSURED _____ **RELATIONSHIP** _____ **SEX** _____

DATE OF BIRTH _____ **SOCIAL SECURITY NUMBER** _____

EMPLOYER NAME _____ **EMPLOYER PHONE** _____

I, the undersigned, assign directly to Samer Kanaan, M.D., A Prof Corp., all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not by insurance. I hereby authorize the medical center to release all information necessary to secure payment of benefits.

Signature _____ Date _____

(If the patient is a minor, signature of parent or guardian authorizing treatment)

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Health History Checklist

Patient Name _____ **Date** _____

History of Past Illness: Please mark on "yes" or "no" to indicate of you have had any of the following:

Childhood

Measles	❑Yes ❑No	Tuberculosis	❑Yes ❑No	Other serious diseases	❑Yes ❑ No
Mumps	❑Yes ❑No	Venereal Disease	❑Yes ❑No		
Chickenpox	❑Yes ❑No	Rheumatic fever or			
Strokes	❑Yes ❑No	heart disease	❑Yes ❑No		
Cancer	❑Yes ❑No	Congenital Abnormalities	❑Yes ❑No		

Adult

Have you ever had any serious illness?	❑Yes ❑No	Have you ever been hospitalized?	❑Yes ❑No	If yes, for what reason?

Operations

Have you ever had any surgery? ❑Yes ❑No

Please list _____

Injuries

Have you ever had any broken bones? ❑Yes ❑No	Have you ever had any head concussions or injuries? ❑Yes ❑No	Have you ever been knocked unconscious? ❑Yes ❑No

Family History

Relative		*Their General Health Condition*
Father living?	❑Yes ❑No	
Mother living?	❑Yes ❑No	
Brother/Sister living?	❑Yes ❑No	
Husband/Wife living?	❑Yes ❑No	
Son/Daughter living?	❑Yes ❑No	

Has any blood relative ever had

Cancer	❑Yes ❑No	High Blood Pressure	❑Yes ❑No	Bleeding tendency	❑Yes ❑No
Tuberculosis	❑Yes ❑No	Stroke	❑Yes ❑No	Mental Illness	❑Yes ❑No
Diabetes	❑Yes ❑No	Convulsions	❑Yes ❑No	Suicide	❑Yes ❑No
Heart Trouble	❑Yes ❑No	Gout or Arthritis	❑Yes ❑No		

Social History

Please check as appropriate ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Are you living with your husband, wife, or significant other? ❑ Yes ❑ No

Do you have dependents at home? ❑ Yes ❑ No

Do you drink alcoholic beverages? ❑ Never ❑ Rarely ❑ Moderately ❑ Daily

Systemic Review

General		**Skin**			
Good health most of your life?	❑Yes ❑No	Skin disease	❑Yes ❑No	Frequent infections or boils	❑Yes ❑No
		Jaundice	❑Yes ❑No		
Recent weight change?	❑Yes ❑No	Hives, eczema or rash	❑Yes ❑No	Abnormal pigmentation	❑Yes ❑No

Head, eyes, ears, nose & throat					
Eye disease or injury	❑Yes ❑No	Glaucoma	❑Yes ❑No	Dizziness or unconciousness	❑Yes ❑No
Do you wear glasses?	❑Yes ❑No	Itching eyes or nose	❑Yes ❑No	Impaired hearing	❑Yes ❑No
Double vision	❑Yes ❑No	Sneezing or runny nose	❑Yes ❑No	Ear disease	❑Yes ❑No
Headaches	❑Yes ❑No	Nosebleeds	❑Yes ❑No		
		Chronic sinus trouble	❑Yes ❑No		

Continued>>

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Neck

Stiffness	❑Yes ❑No
Thyroid trouble	❑Yes ❑No
Enlarged glands	❑Yes ❑No

Respiratory

Respiratory infection	❑Yes ❑No
Spitting up blood	❑Yes ❑No
Constant or frequent cough	❑Yes ❑No
Asthma or wheezing	❑Yes ❑No
Difficulty breathing	❑Yes ❑No

Cardiovascular

Chest pain or angina pectoris	❑Yes ❑No
shortness of breath with walking or lying down	❑Yes ❑No
Difficulty walking 2 blocks	❑Yes ❑No
Heart trouble or heart attacks	❑Yes ❑No

Gastrointestinal

Swelling of hands, feet, ankles	❑Yes ❑No
Heart murmer	❑Yes ❑No
Awakening in the night	❑Yes ❑No
Peptic ulcer (stomach)	❑Yes ❑No
Vomiting blood or food	❑Yes ❑No
Gallbladder disease	❑Yes ❑No
Liver trouble	❑Yes ❑No
Hepatitis	❑Yes ❑No
Does food stick in throat	❑Yes ❑No
Painful bowel movements	❑Yes ❑No
Black stools	❑Yes ❑No
Hemorrhoids or piles	❑Yes ❑No
Recent change in bowel habits	❑Yes ❑No
Cramping or indigestion	❑Yes ❑No
Frequent diarrhea	❑Yes ❑No
Heartburn or indigestion	❑Yes ❑No

Genitourinary

Loss of urine	❑Yes ❑No
Frequent urination	❑Yes ❑No
Nighttime urination	❑Yes ❑No
Bright's disease	❑Yes ❑No
Burning or painful urination	❑Yes ❑No
Blood in urine	❑Yes ❑No
Kidney stones	❑Yes ❑No
Kidney trouble	❑Yes ❑No

Locomotor-Musculoskeletal

Varicose veins	❑Yes ❑No
Weakness of muscles or joints	❑Yes ❑No
Any difficulty walking	❑Yes ❑No
Pain in calves or buttocks	❑Yes ❑No

Neuro-Psychiatric

Have you ever had psychiatric care	❑Yes ❑No
Have you ever been advised to see a psychiatrist	❑Yes ❑No
Do you ever have or had fainting spells	❑Yes ❑No
Convulsions	❑Yes ❑No
Paralysis	❑Yes ❑No

Hematologic

Slow to heal after cuts	❑Yes ❑No
Blood disease	❑Yes ❑No
Anemia	❑Yes ❑No
Phlebitis	❑Yes ❑No
Excessive bleeding after a tooth extraction or surgery	❑Yes ❑No
Bruising or bleeding	❑Yes ❑No

Endocrine

Thyroid disease	❑Yes ❑No
Hormone therapy	❑Yes ❑No
Changes in hat or glove size	❑Yes ❑No
Change in hair growth	❑Yes ❑No
Skin is colder than before or dryer	❑Yes ❑No

Allergies & Sensitivities

Penicillin or other antibiotics	❑Yes ❑No
Morphine, codeine, demerol, or other narcotics	❑Yes ❑No
Aspirin, empirin, etc.	❑Yes ❑No
Iodine or merthiolate	❑Yes ❑No
Other drug or medication	_____

Drugs taken recently

Cortizone	❑Yes ❑No
ACTH	❑Yes ❑No
Anticoagulants	❑Yes ❑No
Tranquilizers	❑Yes ❑No
Blood pressure medicines	❑Yes ❑No
Treatment for asthma	❑Yes ❑No
Aspirin	❑Yes ❑No

Other_____

_____

_____

_____

_____

Gynecological (Women only)

Age periods started_____

How long do periods last _____

Number of pregnancies_____

Number miscarriages_____

Date of last cancer smear & results_____

Any pain with your periods_____

Number of children_____ Ages_____

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FINANCIAL POLICY AND AGREEMENT
SELF-PAY & HEALTH INSURANCE COVERAGE

Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. Should you be a cash patient, we may not ask for full payment at the time of service, although you will remain responsible for the full payment of all fees for services provided. If you have health insurance and even if we bill your insurance company directly, you may be responsible for copayment, coinsurance, deductible, and noncovered amounts. For your convenience, our office accepts personal checks, credit cards, and cash, and when appropriate, can provide you with mutually agreed upon payment plan. It's also important to note that all cosmetic treatments are not covered by any health insurance plan and are due at the time of service. Please read the following carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, and disallow procedure codes, and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" changes – the amount they are willing to cover. The insurance company usually reduces the actual reimbursement further by the individual policy's annual deductible, copayment or coinsurance.

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes that the insurance company will likely reduce, combine, or simply deny. This system in fact, has the insurance company determining our fees. If we have a contract with your insurance company, we writeoff the amount over the "reasonable and customary", and bill you for your coinsurance and deductible. If we do not have a contract with your insurance carrier, you are responsible for that amount as well as any deductible and coinsurance.

We are required by all insurance carriers to collect from patients any deductible and copayment or coinsurance amounts. These fees can be reduced only in those cases where true financial hardship can be demonstrated. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of NonSufficient Funds or your account is turned over to Collections, you will responsible for all related costs.

I have read and understand Samer Kanaan, M.D., A Prof Corp. financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Valley View Wellness Medical Center.

In the event Samer Kanaan, M.D., A Prof Corp. agrees to seek payment initially from my insurance company, I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize Valley View Wellness Medical Center to release all information necessary to secure payment of benefits.

Patient Legal Name (please print clearly) _____

Patient Signature_____

Date_____

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STANDARD PATIENT/PHYSICIAN ARBITRATION AGREEMENT

1) It is understood that any dispute as to medical malpractice, that is, as the whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, this arbitration agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2) ALL CLAIMS MUST BE ARBITRATED. I understand that all claims for damages arising from medical services rendered by Valley View Wellness Medical Center, and/or associate or substitute physicians, nurses or employees must be arbitrated. This includes any claim of a spouse, heir, child (born or unborn), or other successor in interest to any such claim.

3) ARBITRATION PANEL. Within 30 days of a demand to arbitrate a dispute, which must be made in writing, the parties shall agree of three medical arbitrators. Each party will bear the costs for their own legal counsel, and other expenses incurred for their own benefit, as well as their pro rata share of arbitration expenses.

4) APPLICABLE LAW. I agree that the California Code of Civil Procedure relating to arbitration shall apply without any exception.

5) REVOCATION OF THE AGREEMENT. This agreement may be revoked and canceled by written notice delivered to Valley View Wellness Medical Center within 30 days of the signing of this agreement. If notice of revocation of this agreement is not received within 30 days of its signing, the right to cancel the agreement is forever waived.

6) RETROACTIVE EFFECT. If the signing party intends this agreement to cover all services rendered before the date of the signing of this agreement (including, but not limited to, prior consultations or treatment), the signing party must initial here:_____

7) ACKNOWLEDGEMENT. By signing this agreement, the signing party acknowledges he/she discussed to his/her satisfaction any questions he/she may have had regarding the arbitration agreement with Valley View Wellness Medical Center, Inc. an associate physician, or authorized legal representative of Valley View Wellness Medical Center, and he/she has freely negotiated all terms herein set forth.

8) If any provision of this arbitration agreement should be held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: YOUR SIGNATURE INDICATES YOU AGREE TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Dated:_____

Patient, Parent, Guardian, or Authorized Representative_____

If signed by someone other than the patient, indicate relationship:_____

Physician's agreement to arbitrate: Inconsideration of the foregoing execution of the Patient Physician Arbitration Agreement, Samer Kanaan, M.D., A Prof Corp. and Staff likewise agree to be bound by the terms set forth in agreement.

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Patient Authorization to Use or Disclose Protected Health Information

I,_____ , understand Dr. Samer Kanaan is not authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of Samer Kanaan, M.D., A Prof Corp., or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Names of person(s) other than myself authorized by this form to use and disclose my protected health information (family members, etc)_____

_____

Description of the information to be used or disclosed (check all that apply)

❑ The patient's entire medical record (NOTE: This requires an explanation why the entire record may be disclosed).

The patient's demographic information (check all that apply)

- ❑ Name
- ❑ Address
- ❑ State/Zip Code only
- ❑ Telephone
- ❑ Age
- ❑ Gender
- ❑ Race
- ❑ Other: _____

Medical Data / Information as related to

❑ Specific condition(s)

❑ Specific professional service(s)

❑ Specific medication(s)

❑ Other_____

_____

_____

I authorize Samer Kanaan, M.D., A Prof Corp. to contact me by mail, fax or phone regarding information or services that may be helpful or beneficial to you:

Signature:_____ Date: _____

MEDICATIONS

Name **Dose**

ALLERGIES

SMOKING HISTORY

Are you a smoker?

_____

Are you a former smoker?

_____

When did you quit?

_____

How many packs a day did you smoke prior to quitting?

_____

OTHER

Do you have an Advanced Directive? _____

Is it OK to leave a message for you? _____

If so, Cell or Home number? _____

If so, Brief or Extended message? _____