Dr. Gonzalez-Werner

47250 Washington St Ste A
La Quinta, CA 92253

Please Initial

_____ I was given the order to go to West Pacific Lab for my blood/urine test. No fasting required. Located at 47110 Washington St #103, La Quinta, CA 92253. Phone Number (760)972-4667. Hours Monday-Friday 7am-4pm Closed 12pm-1pm for lunch.

_____I understand if my RPR/ GONORRHEA test is positive, it will be reported to our local Health Department. I will receive treatment, packet will be on hold until cleared.

_____If IGRA Test is positive, I understand it MUST BE reported to our local Health Department. I will be receiving a 3-6 month treatment, packet will be in hold until cleared.**NO EXCEPTIONS**.

_____**FLU SEASON IS HERE!** October 1st-March 31st .I understand I need to receive flu vaccine, I have the responsibility to go to my PCP, or to my nearest pharmacy to have it done. I will bring back the immunization card that will be given to me.

BLOOD TEST & URINE RESULT CAN TAKE 5-7 BUSINESS DAYS TO BE READY. WE WILL BE CALLING YOU ONCE RESULTS COME IN.

INS PICK UP HOURS

Monday 4:30pm - 5:00pm
Tuesday 9:30am – 12:00pm
Wednesday 4:30pm – 12:00pm
Thursday 4:30pm - 5:00 pm
Friday 1:45pm – 4:00pm

Signature_____ **Date**_____

Report of Medical Examination and Vaccination Record

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-693
OMB No. 1615-0033
Expires 02/28/2019

▶ **START HERE - Type or print in black ink.**

Part 1. Information About You (To be completed by the person requesting a medical examination, **NOT** the civil surgeon)

1. **Your Full Name**

Family Name (Last Name) | Given Name (First Name) | Middle Name

2. **Physical Address**

Street Number and Name | Apt. Ste. Flr. Number

City or Town | State | ZIP Code

3. **Other Information**

A. Sex ☐ Male ☐ Female

B. Date of Birth (mm/dd/yyyy)

C. City/Town/Village of Birth

D. Country of Birth

E. Alien Registration Number (A-Number) (if any)
▶ A-

F. USCIS Online Account Number (if any)
▶

Part 2. Applicant's Statement, Contact Information, Certification, and Signature

NOTE: Read the **Penalties** section of the Form I-693 Instructions before completing this Part. You must submit Form I-693 in a sealed envelope to USCIS as directed in the Form I-693 Instructions.

Applicant's Statement

NOTE: Select the box for either **Item A.** or **B.** in **Item Number 1.**

1. Applicant's Statement Regarding the Interpreter

A. ☐ I can read and understand English, and I have read and understand every question and instruction on this form and my answer to every question.

B. ☐ The interpreter named in **Part 3.** read to me every question and instruction on this form and my answer to every question in _____, a language in which I am fluent, and I understood everything.

Applicant's Contact Information

2. Applicant's Daytime Telephone Number

3. Applicant's Mobile Telephone Number (if any)

4. Applicant's Email Address (if any)

WERNER GONZALEZ FAMILY PRACTICE

Edith Gonzalez –Werner MD

2013

Name _____ Birthdate __/____/____
(Nombre)

Address _____
(Domicilio) (City) (State) (Zip code)

Phone # (____) _____ Cell Phone#(____) _____ Age _____
(Telefono) (Fecha de Nacimiento) (Edad)

Social Security #_____ Marital Status S M D W Sex __F____M
(Seguro Social) (Estado Civil) S C D V (Sexo)

Employer _____ Phone # (____) _____
(Empleo) (Telefono #)

Address _____
(Direccion) (City) (State) (Zip Code)

Occupation _____ Driver`s License # _____
(Ocupacion) (Licencia de manejar #)

Primary Insurance _____
(Nombre de Aseguranza)

Address _____
(Direccion) (City) (State) (Zip Code)

Phone # (____) _____ Group/Policy # _____
(Telefono) (Numero de Grupo)

Insured`s Name _____ Insured`s Birthdate ____/____/____
(Nombre del Asegurado) (Fecha de Nacimieonto)

Insured`s ID # _____ Relationship _____
(ID del asegurado) (Parentesco)

Secondary Insurance _____
(Nombre de Aseguranza)

Address _____
(Direccon) (City) (State) (Zip Code)

Phone # _____ Group/Policy # _____
(Telefono) (Numero de Grupo)

Insured`s Employer _____
(Empleo del Asegurado)

Person to contact in an emergency _____
(En caso de emergencia notifique a)

Relationship _____ Phone # _____
(Parentesco) (Telefono)

Referred By _____
(Quien lo Refirio)

Email _____@_____

AUTHORIZATION TO TREAT MINOR CHILD (AUTORIZACION PARA TRATAR AL MENOR)

Name _____
(Nombre)

Relationship _____
(Parentesco)

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non covered services. I also authorize the Physician to release any information required in the processing of any claim. I also authorize to the physician to release any information acquired in the course of my examination or treatment

_____ Date _____

Signed (Patient, or parent of minor)
(Firma del paciente o padre del menor)

PATIENT'S CHECK LIST FOR MEDICAL HISTORY

NAME: DATE:

PAST SURGERIES: None ☐ — or, list here any past surgeries with approximate age at which performed (include minor surgeries such as tonsilectomy, tumors, etc.)

ACCIDENTS: No injuries of consequence ☐ MEDICATIONS:

PAST ILLNESSES: No serious past illnesses ☐ — or, list illness with date of onset:

List childhood diseases:

FAMILY HISTORY: If any of the following have run in your family, check appropriate square:

Allergies ☐; Cancer ☐; Tuberculosis ☐; Diabetes ☐; Heart Disease ☐; Strokes ☐

Place a check mark in the appropriate squares in the following lists of symptoms.
If you have had a symptom in the past and do not have it now, check square like this: ☑
If you are having the symptom at the present time, encircle the square like this : (☑)

1. HEAD AND NECK

	Yes	No		Yes	No		Yes	No
Severe headaches?	☐	☐	Severe hearing loss?	☐	☐	Chronic nose obstruction?	☐	☐
Dizzy spells?	☐	☐	Ringing in ears?	☐	☐	Chronic sore tongue?	☐	☐
Failing vision?	☐	☐	Pain in ears?	☐	☐	Persistent sore gums?	☐	☐
Eye pain?	☐	☐	Discharge from ear?	☐	☐	Prolonged hoarseness?	☐	☐
Double vision?	☐	☐	Repeated nosebleeds?	☐	☐	Persistent neck rigidity?	☐	☐
See "floating lights"?	☐	☐	Toothache at present?	☐	☐	Swellings in neck?	☐	☐

2. HEART AND LUNGS

Chest pain on effort?	☐	☐	Sit up to breathe easy?	☐	☐	Have night sweats?	☐	☐
Skipping heart beats?	☐	☐	Have chronic cough?	☐	☐	Ankles swell?	☐	☐
Difficult breathing?	☐	☐	Spit up blood?	☐	☐	Any heart defects?	☐	☐

3. STOMACH AND INTESTINES

Chronic abdominal pain?	☐	☐	Vomit blood?	☐	☐	Any blood from rectum?	☐	☐
Persistent nausea?	☐	☐	Skin turn yellow?	☐	☐	Clay colored stools?	☐	☐
Heart burn?	☐	☐	Any chronic diarrhea?	☐	☐	Habitual constipation?	☐	☐
Appetite loss?	☐	☐	Any black tarry stools?	☐	☐	Have hemorrhoids?	☐	☐

4. URINARY TRACT — ETC.

						(For Women Only)		
Any excess urination?	☐	☐	Pain with urination?	☐	☐	Painful menstruation?	☐	☐
Any urinary shutdown?	☐	☐	Any leakage of urine?	☐	☐	Excess menstruation?	☐	☐
Scanty urination?	☐	☐	Passed any stones?	☐	☐	Bleed between periods?	☐	☐
Any blood in urine?	☐	☐	Any bedwetting?	☐	☐	Any missed periods?	☐	☐
Excess night urination?	☐	☐	Any retention of urine?	☐	☐	Number of pregnancies	.....	
						Number of living children	.....	

5. MUSCLES — JOINTS — NERVES

Any tingling sensations?	☐	☐	Any limited motions?	☐	☐	Speech disturbances?	☐	☐
Any numbness?	☐	☐	Any joint trouble?	☐	☐	Any seizures?	☐	☐
Disturbance in walking?	☐	☐	Nervous breakdown?	☐	☐	Any alcohol problem?	☐	☐
Any muscle jerking?	☐	☐	Any strokes?	☐	☐	Any drug problem?	☐	☐
Any paralysis?	☐	☐	Any memory loss?	☐	☐	Any mental problem?	☐	☐
Any shaking?	☐	☐	Personality changes?	☐	☐	Any varicose veins?	☐	☐

6. ALLERGIES

Any food allergy?	☐	☐	Inhalation allergy?	☐	☐	Adhesive tape allergy?	☐	☐
Any medication allergy?	☐	☐	Any contact allergy?	☐	☐	Subject to skin rash?	☐	☐

If there are any food or medication allergies, list here what they are:

IF THERE ARE ANY ADDITIONAL HEALTH FACTORS IN YOUR HISTORY
OR IF ANY OF THE ABOVE POINTS NEED CLARIFYING
USE THIS SPACE FOR ADDITIONAL COMMENTS.

Patient Registration Information (continued)

Federal regulations require us to ask about Race and Ethnicity. Please make your selections below:

Patient Name: _____

Primary Language: _____

Race (Circle one)

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic / Latino
- Multi Racial – Asian / White
- Multi Racial – Black / Asian
- Multi Racial – Black / White
- Multi Racial – Indian / White
- Multi Racial – Other
- Native Hawaiian or Other Pacific Islander
- White
- Decline to Answer

Ethnicity (Circle one)

- Hispanic
- Non-Hispanic
- Prefer not to answer

WERNER GONZALEZ FAMILY PRACTICE, INC.
47-250 WASHINGTON ST STE "A"
LA QUINTA, CA. 92253
(760) 771-9437 Fax (760) 564-8581

ACKNOWLEDGEMENT OF INFORMATION ON ADVANCE DIRECTIVES

1.- I am at least 18 year of age.

2.- I realize that I have the option of putting together Advance Directive for my healthcare. My physician has provided me written information concerning these. I understand that is my responsibility to provide my doctor with any documents that are required to carry out my Advance Directives.

3.- I am aware tht Advance Directives may be any one of the following:

a) A Durable Power of Attorney for Health Care
b) The Declaration in the Natural Death Act (Living Will)
c) I may write down my wishes, on a piece of paper, so that my family may use the document in deciding my medical treatment in the event I am unable to do so.

Patient Signature_____**Date**_____

Patient name (Print) _____ **DOB:**_____

HIPAA Notice of Privacy Practices

Werner Gonzalez Family Practice
47-250 Washington St. Ste. A
LaQuinta, CA 92253

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

DOB: _____