

Welcome to PrimeCare Medical Group, your primary care facility following the Patient-Centered Medical Home model of care, which transforms the way primary care services are conveyed, focusing on prevention and wellness. This model follows a team-based approach with a fabulous care team that is committed to keeping you healthy, with you being the center of your care team! Your healthcare team includes your primary care provider of choice and takes on the responsibility for coordinating care across multiple settings in the broad health care system.

Being part of a Patient-Centered Medical Home comes with many wonderful additions which include comprehensive and coordinated care, patient-centered with you being a responsible contributor, accessible services, as well as safety and quality improvement. As your medical home, we request you provide your current medication list, regular updates to your medical history, update us with any changes in your health status, inform us of recent test results, share your self-care information, and update us on any recent hospitalizations, specialty care, or emergency department visits.

Receiving comprehensive and continuous coordinated care is one of our goals of PrimeCare, focusing on physical and mental health care needs. This includes, but is not limited to preventive care, acute care, chronic care, wellness care, behavioral and mental healthcare or end-of-life care. Our team-based care might contain physicians, physician assistants, nurses, educators, nutritionists, pharmacists, care coordinators and social workers within the practice as well as throughout the community. The primary care medical home coordinates care across multiple settings in the healthcare system including hospitals, specialty care, home health care, and community resources.

PrimeCare recognizes that you as the patient and your family are the center of your care team. As your medical home, we support all of our patients by educating them on organizing and managing their own individual care. Your care team provides you and your family access to self-management support and evidence-based care tools to assist with your health. Your medical home is about you, completely patient-centered!

As a medical home, providing accessible services is very important to us. Our practice follows open scheduling by reserving time for same day appointments. When calling for a same day appointment after 3pm, we may not be able to accommodate you but can schedule an appointment the following day or refer you to one of our urgent care clinics. We make every effort to accommodate requests for routine visits within fourteen days.

At PrimeCare, you have access to a member of the care team around the clock along with access to urgent care providers. At any time, during or after business hours, you may contact our office and receive clinical advice. When calling after business hours, your call will be answered by a live person at our answering service who will put you in touch with the provider on-call. In addition, PrimeCare has developed a relationship with Doctors on Duty to provide hands on care for our patients after normal business hours.

PrimeCare is committed to demonstrate safety and quality improvements. Patient-Centered Medical Homes are to allow whole-person care, at the same time as, improving quality measures. Quality improvements allow patients to rest assured that their healthcare is at the highest level of standards. Continuous quality improvement involves setting goals based on each patient's unique level of care. Safety is an extremely important part of PrimeCare's daily duties. As your primary care home, we strive to achieve improved performances as a whole.

PrimeCare encourages you to use the tools that the Patient-Centered Medical Home program provides. The Patient-Centered Medical Home model places you, as the patient, at the center of a team-based, physician-led approach to deliver healthcare. PrimeCare Medical Group is also working to achieve Level 3, National Committee for Quality Assurance (NCQA) certification for its Patient-Centered Medical Home program. We welcome this initiative and encourage you to engage in this journey with us.

Sincerely,

Your PrimeCare Team

Patient Information:

Last Name:		First Name:		Middle Initial:	
Gender:	Social Security#:	-	-	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other:	
Birthdate: / /		Race:		Ethnicity:	
Mailing Address:		Zip:		City: State:	
Home Phone: ()		Cell Phone: ()		Work Phone: ()	
Email Address:			Name of your Primary Care Physician:		
Preferred Pharmacy:		City:		Street:	

If Patient Is A Minor Please Complete:

Name of Parent/Guardian:		Guarantor Date of Birth:			
Mailing Address:		Zip:		City: State:	
Social Security#:		Relationship to Patient:		Phone:	

Primary Insurance Name:

Name of Insured:		Date of Birth:		Social Security #:	
Relationship to Insured:					

Secondary Insurance Name:

Name of Insured:		Date of Birth:		Social Security #:	
Relationship to Insured:					

Person to Notify in Case of Emergency:

Name (Not in Same Household):					
Street Address:		Zip:		City:	
Home Phone:		Relation to Patient:			

Please describe your illness/injury/symptoms and date of onset: _____

Work Related: Yes _____ No _____

Release of Information and Financial Responsibility

We request payment at the time of service. We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance card. If a co-payment/deductible is part of your plan, we require that your portion is paid at the time of service. We will make every effort to provide you with the accurate amount due at the end of your visit today. However, your medical and billing records will be reviewed within 1-2 business days of your visit. If there are any discrepancies in the coding and billing, you will receive an additional bill or a refund if overcharged.

PrimeCare Medical Group and affiliates, in compliance with the California Business and Professions Code, hereby notify you of your right to either have your prescription filled by our medical provider or of obtaining a written prescription for filling at a pharmacy of your choice. Please advise the prescribing provider if you elect NOT to have your prescription filled and a written prescription will be provided to you.

I hereby authorize the release of any medical information to insurance carriers needed to process a claim and request payment be sent to PrimeCare Medical Group for medical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that I will be expected to pay if insurance has not paid within 60 days. I agree to a \$25.00 service charge on any check I present which is returned unpaid. I hereby consent to treatment at PrimeCare Medical Group.

Patient email Address

By providing my email address, I give PrimeCare Medical Group permission to email me directly or through a third party to survey me regarding my visits for the purpose of patient satisfaction and quality assessment. PrimeCare Medical Group will not share my email address or medical records with others.

Lab Service Disclosure

Please be advised that Laboratory Services are provided by Salinas Valley PrimeCare Lab, Salinas Valley Memorial Hospital Laboratory, Quest, and/or another outside laboratory. If you wish to select a laboratory other than the ones mentioned, please inform the medical staff. The lab that receives your specimen(s) will bill you separately for its services.

Signature: _____ **Relationship:** _____ **Date:** _____

History and Physical

Name _____ Date _____
 Birth Date _____ Occupation _____
 Chief Complaint _____

DRUG ALLERGIES

FAMILY HISTORY

(Check all that apply)

	Father	Mother	Father's Parents	Mother's Parents	Sibling	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ (Other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDICATIONS

Medication	Dose	How Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

MAJOR ILLNESS, HOSPITALIZATION AND SURGERIES

Date	Reason	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Women Only: Last Menstrual Period Age Onset reg irreg Days of Flow Length of Cycle
 Birth Control Method No. of Pregnancies No. of Births Menopause

PAST MEDICAL HISTORY (Check all that apply)

Headache	Gall bladder disease	Chronic rashes	Shortness of breath
Prostate disease	Rheumatic fever	Heart palpitations	Bowel irregularity
Heart murmur	Chest pain	Venereal disease	Dizziness/Fainting
Frequent infections	Hepatitis	Allergies / Hay Fever	Anemia
Asthma	Arthritis	Bronchitis	Nervousness
Pneumonia	Depression	Gout	GI disorder
Ulcer	Peripheral vascular disease	Sexual/Menstrual dysfunction	Kidney diseases / infections:

IMMUNIZATIONS

Mumps	____/____/____	Measles	____/____/____
Rubella	____/____/____	Polio	____/____/____
Diphtheria	____/____/____	Tetanus	____/____/____
Flu	____/____/____	Hib	____/____/____
Other: _____	____/____/____	Other: _____	____/____/____

HABITS

Smoke: Packs Daily: _____ How Long: _____ When Stopped: _____
 Exercise routine: _____ Coffee: Cups Daily: _____ Other caffeine's: _____
 Alcohol: Type/Amount: _____ Sleep Pattern: _____ Diet: Salt Intake: _____
 Fat Intake: _____ Contact w/blood or body fluid at work: _____