

	Patient Packet	
Patient Name:	Date o	f Birth:
Address:	Αρ	pt. No.:
City:	State:	Zip:
Home Phone: Leave voicemails at:		
E-mail:	Employer: _	
Occupation:	Referred By:	
SSN: Driv	ver's License:	
Sex: M F Marital Status: Single	Married	Separated Divorced
Emergency Contact:		
Relationship to Patient:	Pho	one:
Responsib	ole Party (if different from	m above):
Responsible Party's Name:		Date of Birth:
Address:		Apt. No.:
City:	State:	Zip:
Home Phone:	Cell Phone:	
Please be advised that SMS text a	ippointment reminder i	s not a confidential transmission.
Please inform us if you would like to	opt out of SMS text app	pointment reminders. Opt out
•	• •	re unable to make your appointment, please you are not charged a \$299 NO SHOW fee.
I authorize and consent to examination and treatme Kinaly, M.D. and staff. I authorize the release of me of medical and/or surgical benefits to physician of s	edical information neces	ssary to process this claim. I authorize the payment
Signed:	Date:	
	949 . 398 . 7444	

Daily Lifestyle Procedures

Name:	
What time do your normally wake-up?	
What time do you normally fall asleep?	
Do you have trouble falling asleep or waking up through	the night?
How frequently do you exercise?	
Do you consume alcohol?	If yes, how often?
Do you smoke?	If yes, how often?
Average breakfast:	Time of breakfast:
Average lunch:	Time of lunch:
Average dinner:	Time of dinner:
Snacks throughout the day?	Time(s) of snacks:
Water intake (ounces daily):	Juice intake (ounces daily):
Soda intake (ounces daily):	Coffee intake (ounces daily):
	Initials

22 Odyssey #215 . Irvine . CA 92618 949 . 398 . 7444

Medication/Supplement/Allergy List

Name: _____

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Supplement		
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Allergies:

1: 3: 5:

Pharmacy Name/Phone Number:

22 Odyssey #215 . Irvine . CA 92618

949.398.7444

2:

4:

Initials _____

Medical & Family History

Name:					
Patient Medical History:					
Diabetes	Yes	No Conv	vulsions	Yes	No
Hypertension (high blood pressure)			e Infection	Yes	No
Cancer	Yes	No Vene	ereal Disease	Yes	No
Stroke	Yes	No Here	ditary Defects	Yes	No
Heart Trouble	Yes		erculosis	Yes	No
Heart Attack (Myocardial Infraction)	Yes	No Hepa	atitis	Yes	No
Arthritis/Gout	Yes	No Pept	ic Ulcer Disease	Yes	No
Last Menstrual Period Date:		Frequency of M	enstrual Cycle:		
Previous Surgeries/Dates:					
Hospitalizations/Serious Injuries/Dates:					
Patient Social History:					
-	married	separate	d divorced	widowed	
Use of Alcohol: never	rarely	moderat	e daily		
Use of Tobacco/Cigarettes: never	р	reviously, but qu	it Date quit:		
L	ength of use	e (current/previo	us) packs a	day	
Use of Illegal Drugs: never Typ	e/frequency		Date las	st used	
Use of Diet Drugs: never Typ	never Type/frequency Date last used				
Excessive exposure at home, or at work, to					
			steriais. no ye	s type	
Family Medical History:					
Family Member:	Age	Disea	se Ca	use of Death	
Father					
Mother					
Siblings					
Spouse					
Children					
22 Odyssey #215 . Irvine . CA 926	18	949.398.7	7444		

Goad General HealthNoYesJoint PainNoYesRecent Weight ChangeNoYesJoint Striffseo at Weildes or JointsNoYesFaverNoYesMuscle Pain of CrampsNoYesFatigueNoYesBack Pain of CrampsNoYesFatigueNoYesBack Pain of CrampsNoYesFyesEnd State Pain of CrampsNoYesState Pain of CrampsNoYesFyesIntegumentary (Stin, Recart)NoYesState Pain of CrampsNoYesBack Pain of NainNoYesRath of Indian Or NaisNoYesBard Nool (VisionNoYesBrack David VisionNoYesEar/Nase/Mouth/ThroatNoYesBrack David VisionNoYesHoring Loss Of RingingNoYesBrack David VisionNoYesNoce BleddsNoYesBreak David VisionNoYesNoce BleddsNoYesBreak David VisionNoYesSo EleddsNoYesBreak David VisionNoYesSo EleddsNoYesState Pain Actae David VisionNoYesSo EleddsNoYesBreak David VisionNoYesSo EleddsNoYesState Pain Actae David VisionNoYesSo EleddsNoYesState Pain Actae David VisionNoYesSo EleddsNoYesState Pain Acta	Constitutional Symptoms			Musculoskeletal		
FeverNoYesWeakness of Muscles or JointsNoYesFatgueNoYesBuckle Pain or CrampsNoYesHeadachesNoYesDiffully WalkingNoYesEve Dissase or InjuryNoYesDiffully WalkingNoYesBurred/Double VisionNoYesDiffully WalkingNoYesBurred/Double VisionNoYesChange in Skin ColorNoYesEars/Nose/Mouth/ThroatTChange in Skin ColorNoYesEars/Nose/Mouth/ThroatNoYesBreast DischargeNoYesEars/Nose/Mouth/ThroatNoYesBreast DischargeNoYesEars/Nose/Mouth/ThroatNoYesBreast DischargeNoYesEars/Nose/Mouth/ThroatNoYesBreast DischargeNoYesEars/Nose BleedinNoYesBreast DischargeNoYesMouth BleedinNoYesNoYesNoYesSore Throat or Voite ChangeNoYesConvolutions or SciurnesNoYesSore Throat or Voite ChangeNoYesParking Sis of ConfusionNoYesSore Throat or Voite	Good General Health	No	Yes	Joint Pain	No	Yes
FrigueNoYesMuscle Pain or CrampsNoYesHeadachesNoYesBack PainNoYesKeyBack PainNoYesDifficulty ValkingNoYesKard Glasses/ CrintaticsNoYesBack Pain functional State	Recent Weight Change	No	Yes	Joint Stiffness or Swelling	No	Yes
HeadachesNoYesBack PainNoVesEye Discase or InjuryNoVesOfficulty ValkingNoYesWaer disase/,ContactsNoYesIntegumentary (Skin, Breast)VesBlurred/Double VisionNoYesRah or ItchingNoYesBlurred/Double VisionNoYesChange in Skin ColorNoYesEars/Nose/Mouth/ThroatNoYesBreast PainNoYesHearing Loss of RaingNoYesBreast PainNoYesBreast Sor DrainageNoYesBreast DurpNoYesChoncis Sinus ProblemsNoYesBreast DurpNoYesBeditag GumsNoYesBreast DurpNoYesBod Brasth or Bad TasteNoYesNorubidions or DiscinasisNoYesSore Throad or Voite ChangeNoYesNorubidions or SelzuresNoYesSore Throad or Voite ChangeNoYesParalysisNoYesSore Throad or Voite ChangeNoYesParalysisNo </td <td>Fever</td> <td>No</td> <td>Yes</td> <td>Weakness of Muscles or Joints</td> <td>No</td> <td>Yes</td>	Fever	No	Yes	Weakness of Muscles or Joints	No	Yes
EyesCold ExtremitiesNoYesBye Disease or injuryNoYesDifficutty ValkingNoYesBurred/Double VisionNoYesRash or ItchingNoYesBlured/Double VisionNoYesChange in Skin ColorNoYesBarred/Double VisionNoYesChange in Skin ColorNoYesHearing Loss of RingingNoYesBreast PainNoYesEarches or DrainageNoYesBreast Dish ColorNoYesNous BleedsNoYesBreast Dish TimpNoYesNous BleedsNoYesBreast Dish TimpNoYesBad freath or Data TasteNoYesBreast Dish TimpNoYesSore Throat or Voice ChangeNoYesParelyeast Plateadeness or Dizzh TessNoYesSore Intra or Voice ChangeNoYesParelyeast Plateadeness or Dizzh TessNoYesSore Intra or Voice ChangeNoYesParelyeast Plateadeness or Dizzh TessNoYesSore Intra or Angina PectorisNoYesParelyisisNoYesSore Intra or An	Fatigue	No	Yes	Muscle Pain or Cramps	No	Yes
Per Disease or InjuryNoYesDifficulty WalkingNoYesWar disses/ContactsNoYesRaho ritchingNoYesBlurred/Doubled VisionNoYesRaho ritchingNoYesGlaucomaNoYesChange in Skin ColorNoYesEars/Mose/Mouth/Throat-Change in Skin ColorNoYesHearing Loss of RingingNoYesBreast PainNoYesEaraches or DrainageNoYesBreast DischargeNoYesChronic Sinus ProblemsNoYesBreast DischargeNoYesMouth BleddsNoYesReurologicalYesSore Throat Or Vice ChangeNoYesConvulsions or SeizuresNoYesSore Throat or Vice ChangeNoYesNoYesYesSore Throat or Vice ChangeNoYesNoYesYesParilytianNoYesStrokeNoYesChrodoscular-TremorsNoYesParilytianNoYesParilytianNoYesShortnes of Breath (when lying or walking)NoYesParilytianNoYesShortnes of Breath (when lying or walking)NoYesParilytianNoYesShortnes of Breath (when lying or walking)NoYesParilytianNoYesShortnes of Breath (when lying or walking)NoYesParilytianNoYesSh	Headaches	No	Yes	Back Pain	No	Yes
Wear Glasses/ContactsNoYesIntegumentary (Skin, Breast)Blurred/Double VisionNoYesRash or tichingNoYesBlarted/Double VisionNoYesChange in Skin ColorNoYesEars/Nose/Mouth/ThroatChange in Skin ColorNoYesHearing Loss of RingingNoYesBreast PainNoYesBreast DationageNoYesBreast LumpNoYesNoce BleedsNoYesBreast DationageNoYesMoute BleedsNoYesBreast DationageNoYesBleeding GumsNoYesBreast DationageNoYesSore Throat or Volce ChangeNoYesConvulsions or SeizuresNoYesSore Throat or Volce ChangeNoYesParolysisNoYesCardiovascularTermorsNoYesYesYesHeart TroubleNoYesParolysisNoYesShortness of Breath (when lying or walking)NoYesYesYesShortness of Breath (when lying or w	Eyes			Cold Extremities	No	Yes
Blurred/Double VisionNoYesRash or ItchingNoYesGlaucomaNoYesChange in Jsún ColorNoYesBardy Nose/Mouth/ThroatKange in Jsún ColorNoYesHearing Loss of RingingNoYesBreast Dain or NalisNoYesBaraches or DrainageNoYesBreast DainNoYesEaraches or DrainageNoYesBreast DischargeNoYesMouth BleedsNoYesBreast DischargeNoYesMouth BleedsNoYesBreast DischargeNoYesBedling GumsNoYesUghtheadedness or DizinessNoYesSore Throat or Volce ChangeNoYesConvulsions or SeizuresNoYesSore Throat or Volce ChangeNoYesConvulsions or SeizuresNoYesSore Throat or Volce ChangeNoYesNoYesYesSore Throat or Volce ChangeNoYesYesYesSore Throat or Volce ChangeNoYesYesYesSoullen Glands in NeckNoYesYesYesSoullen Glands in NeckNoYesYesYesPalpitationNoYesYesStockeNoYesSouthes of Freath (when lying or walking)NoYesHeadin JunyNoYesSouthes of Freath (when lying or walking)NoYesHeading or Hormonal ProblemNoYesShortnes of	Eye Disease or Injury	No	Yes	Difficulty Walking	No	Yes
SieucomaNoYesChange in Shin ColorNoYesEars/Nosc/Mouth/ThroatChange in Hair or NailsNoYesEaraches or DrainageNoYesBreast DainNoYesEaraches or DrainageNoYesBreast LumpNoYesChronic Sinus ProblemsNoYesBreast DischargeNoYesMose BleedsNoYesBreast DischargeNoYesBleeding GumsNoYesFrequent/Recuring HeadachesNoYesBleeding GumsNoYesConvolisions or SeizuresNoYesSore Throat or Voice ChangeNoYesUightheadedness or DizinessNoYesSoullen Glands in NeckNoYesParalysisNoYesCardiovascularTermorsNoYesYesHeart TroubleNoYesParalysisNoYesChronic or Frequent CoughsNoYesParalysisYesShortners of Greath (when lying or walking)NoYesParonicular OrdinationNoYesShortners of Greath (when lying or walking)NoYesIesmonianNoYesShortners of Greath (when lying or walk	Wear Glasses/Contacts	No	Yes	Integumentary (Skin, Breast)		
Ears/Nose/Mouth/ThroatNoVesChange in Hair or NailsNoVesHearing Loss of RingingNoNoVesBreast PainNoVesChronic Sinus ProblemsNoVesBreast LimpNoVesNose BleedsNoVesBreast DischargeNoVesMouth BleedsNoVesBreast DischargeNoVesBleeding GumsNoVesHeurologicalVesSore Throat or Voice ChangeNoVesConvulsions or SelzuresNoVesSore Throat or Voice ChangeNoVesConvulsions or SelzuresNoVesSore Throat or Voice ChangeNoVesConvulsions or SelzuresNoVesSore Throat or Agina PectorisNoVesParalysisNoVesHeart TroubleNoVesStrokeNoVesPaiplationNoVesHead InjuryNoVesSoleng of Feath (when lying or walking)NoVesHead InjuryNoVesShortness of Breath (when lying or walking)NoVesInsomniaNoVesShortness of Breath (when lying or walking)NoVesInsomniaNoVes <td>Blurred/Double Vision</td> <td>No</td> <td>Yes</td> <td>Rash or Itching</td> <td>No</td> <td>Yes</td>	Blurred/Double Vision	No	Yes	Rash or Itching	No	Yes
Hearing Loss of RingingNoYesVaricose VeinsNoYesEaraches or DrainageNoYesBreast PainNoYesNoce BleedsNoYesBreast LiumpNoYesNoce BleedsNoYesBreast DischargeNoYesMouth BleedsNoYesBreast DischargeNoYesBedeling GumsNoYesFrequent/Recurring HeadachesNoYesBad Breath or Bad TasteNoYesLightheadedness or DizinessNoYesSore Throat or Volce ChangeNoYesNumbness or Tingling SensationsNoYesSore Throat or Volce ChangeNoYesParalysisNoYesCardiovascularNoYesParalysisNoYesHeart TroubleNoYesParalysisNoYesChest Pain or Angina PectorisNoYesParalysisNoYesShortness of Breath (when lying or walking)NoYesHeard TroubieNoYesChronic or Frequent CoughsNoYesInsominaNoYesShortness of Breath (when lying or walking)NoYesHeardrineNoYesShortness of Breath (when lying or walking)NoYesInsominaNoYesShortness of Breath (when lying or walking)NoYesInsominaNoYesChronic or Frequent ChughsNoYesInsominaNoYesShortness of Breath Mowe	Glaucoma	No	Yes	Change in Skin Color	No	Yes
Earaches or DrainageNoYesBreast PainNoYesChronic Sinus ProblemsNoYesBreast LimpNoYesMose BleedsNoYesBreast DishargeNoYesMouth BleedsNoYesBrequent/Recurring HeadachessNoYesBleeding GumsNoYesLightheadechess or DizzinessNoYesBad Breath or Bad TasteNoYesConvulsions or SeizuresNoYesSore Throat or Voice ChangeNoYesConvulsions or SeizuresNoYesSwollen Glands in NeckNoYesParalysisNoYesCardiovascularTremorsNoYesStrokeNoYesPalpitationNoYesStrokeNoYesSortness of Breath (when lying or walking)NoYesHemory Loss or ConfusionNoYesSplitting of Feet, Ankles, or HandsNoYesHemory Loss or ConfusionNoYesSplitting up BloodNoYesIsominiaNoYesShortness of Breath (when lying or walking)NoYesIsominiaNoYesShortness of Breath (when lying or walking)NoYesIsomini	Ears/Nose/Mouth/Throat			Change in Hair or Nails	No	Yes
Chronic Sinus ProblemsNoYesBreast DischargeNoYesNose BleedsNoYesBreast DischargeNoYesBededing GumsNoYesNorequent/Recurring HeadachessNoYesBad Breath or Bad TasteNoYesLightheadedness or DizznessNoYesBad Breath or Dad TasteNoYesConvulsions or SeizuresNoYesSore Throat or Voise ChangeNoYesConvulsions or SeizuresNoYesSwallen Glands in NeckNoYesParlynisions or SeizuresNoYesHeart TroubleNoYesParlynisNoYesChest Pain or Angina PectorisNoYesStrokeNoYesPalpitationNoYesHead InjuryNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesDepressionNoYesShortness of Breath (when lying or walking)NoYesEndocrineNoYesShortness of Breath (when lying or walking)NoYesDepressionNoYesShortness of BreathNoYesGladuil or Hormonal ProblemNoYesShortness of BreathNoYesGladuil or Hormonal ProblemNoYesShortness of Breath (when lying or NoYesGladuil or Hormonal ProblemNoYesShartness of BreathNoYe	Hearing Loss of Ringing	No	Yes	Varicose Veins	No	Yes
Nose BleedsNoYesBreast DischargeNoYesMouth BleedsNoYesNeurologicalBleeding GumsNoYesFrequent/Recurring HeadachesNoYesBall Breath or Bad TasteNoYesLightheadachess or DizznessNoYesSore Throat or Voice ChangeNoYesConvulsions or Shejures sor DizznessNoYesSwollen Glands in NeckNoYesConvulsions or Shejures sor DizznessNoYesCardiovascularTerrorsNoYesYesHeart TroubleNoYesParalysisNoYesShortness of Breath (when lying or walking)NoYesHead InjuryNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesDepressionNoYesShortness of Breath (when lying or walking)NoYesDepressionNoYesChronic or Frequent CoughsNoYesDepressionNoYesShortness of BreathNoYe	Earaches or Drainage	No	Yes	Breast Pain	No	Yes
Nouth BleedsNoYesNeurologicalBleeding GumsNoYesFrequent/Recurring HeadachessNoYesBad Breath or Bad TasteNoYesLightheadedness or DizzinessNoYesSore Throat or Voice ChangeNoYesConvuisions or SeizuresNoYesSoullen Glands in NeckNoYesNumbness or Tingling SensationsNoYesHeart TroubleNoYesParalysisNoYesChest Pain or Angina PectorisNoYesHeard TiroubleNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesNorousnessNoYesShortness of BreathNoYesIsocrineNoYesShortness of BreathNoYesIsocrineNoYesShortness of BreathNoYesIsocrineNoYesShortness of BreathNoYesIsocrineNoYesShortness of BreathNoYesIsocrineNo <td>Chronic Sinus Problems</td> <td>No</td> <td>Yes</td> <td>Breast Lump</td> <td>No</td> <td>Yes</td>	Chronic Sinus Problems	No	Yes	Breast Lump	No	Yes
Bleeding GumsNoYesFrequent/Recurring HeadachesNoYesBad Breath or Bad TasteNoYesLightheadedness or DizznessNoYesSore Throat or Voice ChangeNoYesConvulsions or SeizuresNoYesSore Throat or Voice ChangeNoYesNumbers or Tingling SenationsNoYesSore Throat or Voice ChangeNoYesNumbers or Tingling SenationsNoYesCardiovascularTermorsNoYesParalysisNoYesChest Pain or Angina PectorisNoYesHead InjuryNoYesShortness of Breath (when lying or walking)NoYesMenory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesMenovulenssNoYesShortness of BreathNoYesIndoorineNoYesShortness of BreathNoYesIndoorineNoYesShortness of BreathNoYesGlandular or Hormonal Problem <td>Nose Bleeds</td> <td>No</td> <td>Yes</td> <td>Breast Discharge</td> <td>No</td> <td>Yes</td>	Nose Bleeds	No	Yes	Breast Discharge	No	Yes
Bad Breath or Bad TasteNoYesLightheadedness or DizzinessNoYesSore Throat or Voice ChangeNoYesConvulsions or SigzuresNoYesSwollen Glands in NeckNoYesNumbness or Tingling SensationsNoYesCardiovacularImerorsNoYesParalysisNoYesHeart TroubleNoYesParalysisNoYesPalpitationNoYesStrokeNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesMemory Loss or ConfusionNoYesShortness of Breath (when lying or walking)NoYesBadoular or Hormonal ProblemNoYesShortness of BreathNoYesGlandular or Hormonal ProblemNoYesShortness of BreathNoYesGlandular or Hormonal ProblemNoYesLoss of AppetiteNoYesBacesine HoreeNoYesLoss of AppetiteNo	Mouth Bleeds	No	Yes	Neurological		
Sore Throat or Voice ChangeNoYesConvulsions or SeizuresNoYesSwollen Glands in NeckNoYesNumbness or Tingling SensationsNoYesCardiovascularTermorsPremorsNoYesHeart ToubleNoYesStrokeNoYesChest Pain or Angina PectorisNoYesStrokeNoYesPalpitationNoYesHead InjuryNoYesShortness of Breath (when lying or walking)NoYesPsychiatricSwelling of Feet, Ankles, or HandsNoYesMemory Loss or ConfusionNoYesRespiratoryNoYesInsomniaNoYesChronic or Frequent CoughsNoYesInsomniaNoYesSpitting up BloodNoYesGlandular or Hormonal ProblemNoYesShortness of BreathNoYesGlandular or Hormonal ProblemNoYesChange in Bowel MovementsNoYesDiabetesNoYesNausea and/or VomitingNoYesPsecessive Thirst or UrinationNoYesPainful Bowel Movements/ConstipationNoYesNoYesNoYesPainful Bowel Movements/ConstipationNoYesSlow to Heal After CutsNoYesPainful Bowel Movements/ConstipationNoYesSlow to Heal After CutsNoYesPainful Bowel Movements/ConstipationNoYesSlow to Heal After CutsNo<	Bleeding Gums	No	Yes	Frequent/Recurring Headaches	No	Yes
Swollen Glands in NackNoYesNumbness or Tingling SensationsNoYesCardiovascularTremorsTremorsNoYesHeart TroubleNoYesParalysisNoYesChest Pain or Angina PectorisNoYesStrokeNoYesPalpitationNoYesHead InjuryNoYesShotness of Breath (when lying or walking)NoYesPsychiatricVesSwelling of Feet, Ankles, or HandsNoYesMemory Loss or ConfusionNoYesRespiratoryNoYesDepressionNoYesChronic or Frequent CoughsNoYesInsomniaNoYesShotness of BreathNoYesGlandular or Hormonal ProblemNoYesShotness of AppetiteNoYesDiabetesNoYesChange in Bowel MovementsNoYesDiabetesNoYesChange in Bowel MovementsNoYesDiabetesNoYesPainful Bowel Movements/ConstipationNoYesHeat or Cold InteleranceNoYesPainful Bowel Movements/ConstipationNoYesSlow to Heal After CutsNoYesPainful Bowel Movements/ConstipationNoYesSlow to Heal After CutsNoYesPainful Bowel Movements/ConstipationNoYesBleeding or Bloodin StoolNoYesPainful Bowel Movements/ConstipationNoYesBleeding or Bloodin StoolNo <td>Bad Breath or Bad Taste</td> <td>No</td> <td>Yes</td> <td>Lightheadedness or Dizziness</td> <td>No</td> <td>Yes</td>	Bad Breath or Bad Taste	No	Yes	Lightheadedness or Dizziness	No	Yes
Cardiovascular Tremors No Yes Heart Trouble No Yes Paralysis No Yes Chest Pain or Angina Pectoris No Yes Stroke No Yes Palpitation No Yes Bead Injury No Yes Shortness of Breath (when lying or walking) No Yes Psychiatric Ves Swelling of Feet, Ankles, or Hands No Yes Psychiatric No Yes Shortness of Breath (when lying or walking) No Yes Psychiatric No Yes Shortness of Breath (son Hands No Yes Insominia No Yes Shortness of Breath No Yes Insominia No Yes Change In Bowel Movements	Sore Throat or Voice Change	No	Yes	Convulsions or Seizures	No	Yes
Heart TroubleNoYesParalysisNoYesChest Pain or Angina PectorisNoYesStrokeNoYesPalpitationNoYesHead InjuryNoYesPalpitationNoYesHead InjuryNoYesShortness of Breath (when lying or walking)NoYesPsychiatricVesSwelling of Feet, Ankles, or HandsNoYesMemory Loss or ConfusionNoYesRespiratoryNoYesDepressionNoYesChronic or Frequent CoughsNoYesInsomniaNoYesSpitting up BloodNoYesGlandular or Hormonal ProblemNoYesShortness of BreathNoYesGlandular or Hormonal ProblemNoYesAsthma or WheezingNoYesDiabetesNoYesCharge in Bowel MovementsNoYesDiabetesNoYesNausea and/or VomitingNoYesDry SkinNoYesPainful Bowel Movements/ConstipationNoYesSlow to Heal After CutsNoYesPainful Bowel Movements/ConstipationNoYesSlow to Heal After CutsNoYe	Swollen Glands in Neck	No	Yes	Numbness or Tingling Sensations	No	Yes
Chest Pain or Angina PectorisNoYesStrokeNoYesPalpitationNoYesHead InjuryNoYesShortness of Breath (when lying or walking)NoYesPsychiatricSwelling of Feet, Ankles, or HandsNoYesMemory Loss or ConfusionNoYesRespiratoryNoYesDepressionNoYesChronic or Frequent CoughsNoYesDepressionNoYesShottness of BreathNoYesInsomniaNoYesShottness of BreathNoYesEndocrineNoYesShottness of BreathNoYesEndocrineNoYesShottness of AppetiteNoYesDiabetesNoYesChange in Bowel MovementsNoYesHeat or Cold IntoleranceNoYesNatifuel Bowel Movements/ConstipationNoYesParto Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesHeatologic/LymphaticVesSlow I Heat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesSlow I Heal After CutsNoYesSlow I Heal After CutsNoYesBeleding or Blood in StoolNoYesHeatologic/LymphaticNoYesSlow I Heal After CutsNoYesBurning or Painful UrinationNoYesAnemiaNoYesSlow I Heal After CutsNoYesBlood in UrineNoYes	Cardiovascular			Tremors	No	Yes
PalpitationNoYesHead InjuryNoYesShortness of Breath (when lying or walking)NoYesPsychiatricSwelling of Feet, Ankles, or HandsNoYesMemory Loss or ConfusionNoYesRespiratoryNoYesDepressionNoYesChronic or Frequent CoughsNoYesInsomniaNoYesSpitting up BloodNoYesInsomniaNoYesShortness of BreathNoYesGlandular or Hormonal ProblemNoYesAsthma or WheezingNoYesGlandular or Hormonal ProblemNoYesGastrointestinalThyroid DiseaseNoYesLoss of AppetiteNoYesDiabetsNoYesChange in Bowel MovementsNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesHeat or Glove SizeNoYesPainful Bowel Movements/ConstipationNoYesHeat or Glove SizeNoYesPainful Bowel Movements/ConstipationNoYesBleeding or Blood in StoolNoYesPatter Uter (Stomach or Duodenal)NoYesHeat or Glove SizeNoYesPeptic Uter (Stomach or Duodenal)NoYesBleeding or Bruising TendencyNoYesFrequent UrinationNoYesAnemiaNoYesBurning or Painful UrinationNoYesPattransfusionsNoYes	Heart Trouble	No	Yes	Paralysis	No	Yes
Shortness of Breath (when lying or walking)NoYesPsychiatricSwelling of Feet, Ankles, or HandsNoYesMemory Loss or ConfusionNoYesRespiratoryNoYesNervousnessNoYesChronic or Frequent CoughsNoYesDepressionNoYesSpitting up BloodNoYesInsomniaNoYesShortness of BreathNoYesEndocrineNoYesAsthma or WheezingNoYesGlandular or Hormonal ProblemNoYesCharge in Bowel MovementsNoYesDiabetesNoYesChange in Bowel MovementsNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesSlow to Heal After CutsNoYesPainful Bowel Movements/ConstipationNoYesHeat or Glove SizeNoYesPetic Ulcer (Stomach or Duodenal)NoYesHeat or Glove SizeNoYesBleeding or Blood in StoolNoYesSlow to Heal After CutsNoYesFrequent UrinationNoYesPainering TendencyNoYesBleeding or Blood in StoolNoYesPainering TendencyNoYesBleeding or Blood in StoolNoYesAnemiaNoYesBleeding or Blood in UrinationNoYesPainering Ten	Chest Pain or Angina Pectoris	No	Yes	Stroke	No	Yes
Swelling of Feet, Ankles, or HandsNoYesMemory Loss or ConfusionNoYesRespiratoryNoYesNervousnessNoYesChronic or Frequent CoughsNoYesDepressionNoYesSpitting up BloodNoYesInsomniaNoYesShortness of BreathNoYesEndocrineNoYesAsthma or WheezingNoYesGlandular or Hormonal ProblemNoYesCastrointestinalThyroid DiseaseNoYesSecondar Secondar	Palpitation	No	Yes	Head Injury	No	Yes
RespiratoryNoNervousnessNoYesNervousnessNoYesChronic or Frequent CoughsNoYesDepressionNoYesSpitting up BloodNoYesInsomniaNoYesShortness of BreathNoYesEndorrineNoYesAsthma or WheezingNoYesGalandular or Hormonal ProblemNoYesGastrointestinalThyroid DiseaseNoYesSibetesNoYesChange in Bowel MovementsNoYesHeat or Cold IntoleranceNoYesNausea and/or VomitingNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesChange in Hat or Glove SizeNoYesPatient Bleeding or Blood in StoolNoYesSlow to Heal After CutsNoYesPeric Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesBuening or Painful UrinationNoYesAnemiaNoYesBuod in UrineNoYesPaintguising TendencyNoYesBlood in UrineNoYesPaintguisionsNoYesBlood in UrineNoYesPaintguisionsNoYesBlood in UrineNoYesPaintguisionsNoYesBlood in UrineNoYesPaintguisionsNoYesBlood in UrineNoYesPaintguisionsNoYesBlood	Shortness of Breath (when lying or walking)	No	Yes	Psychiatric		
Chonic or Frequent CoughsNoYesDepressionNoYesSpitting up BloodNoYesInsomniaNoYesShortness of BreathNoYesEndocrineNoYesAsthma or WheezingNoYesGlandular or Hormonal ProblemNoYesGastrointestinalThyroid DiseaseNoYesYesLoss of AppetiteNoYesDiabetesNoYesChange in Bowel MovementsNoYesDiabetesNoYesNausea and/or VomitingNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesSlow to Heal After CutsNoYesPeptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesBurning or Painful UrinationNoYesPheeding or Bloodi n StoolNoYesBurning or Painful UrinationNoYesAnemiaNoYesBurning or Painful UrinationNoYesPheeding or Bruising TendencyNoYesBlood in UrineNoYesPast TransfusionsNoYesIncontinence or DribblingNoYesPast TransfusionsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesKidney StonesNoYesPhencillinNoYesSexual Diffic	Swelling of Feet, Ankles, or Hands	No	Yes	Memory Loss or Confusion	No	Yes
Spittling up BloodNoYesInsomniaNoYesShortness of BreathNoYesEndocrineNoYesAsthma or WheezingNoYesGlandular or Hormonal ProblemNoYesGastrointestinalThyroid DiseaseNoYesSoletesNoYesLoss of AppetiteNoYesDiabetesNoYesChange in Bowel MovementsNoYesExcessive Thirst or UrinationNoYesNausea and/or VomitingNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesSlow to Heal After CutsNoYesPeptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesBurning or Painful UrinationNoYesAnemiaNoYesBlood in UrineNoYesPait TransfusionsNoYesBlood in UrineNoYesPait TransfusionsNoYesIncontinence or DribbilingNoYesAllergic/ImmunologicYesKidney StonesNoYesAllergis/Reactions to:NoYesSexual DifficultyNoYesPencillinNoYes	Respiratory			Nervousness	No	Yes
Shortness of BreathNoYesEndocrineNoYesAsthma or WheezingNoYesGlandular or Hormonal ProblemNoYesGastrointestinalThyroid DiseaseNoYesLoss of AppetiteNoYesDiabetesNoYesChange in Bowel MovementsNoYesExcessive Thirst or UrinationNoYesNausea and/or VomitingNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesDry SkinNoYesRectal Bleeding or Blood in StoolNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesHematologic/LymphaticYesYesPeptic Ulcer (Stomach or Duodenal)NoYesBleeding or Bruising TendencyNoYesBurning or Painful UrinationNoYesPast TransfusionsNoYesBurning or Painful UrinationNoYesPast TransfusionsNoYesBlood in UrineNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPencillinNoYes	Chronic or Frequent Coughs	No	Yes	Depression	No	Yes
Asthma or WheezingNoYesGlandular or Hormonal ProblemNoYesGastrointestinalThyroid DiseaseNoYesLoss of AppetiteNoYesDiabetesNoYesChange in Bowel MovementsNoYesExcessive Thirst or UrinationNoYesNausea and/or VomitingNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesDry SkinNoYesRectal Bleeding or Blood in StoolNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesHematologic/LymphaticYesYesPeptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesBrequent UrinationNoYesAnemiaNoYesBlood in UrineNoYesPalbitisNoYesBlood in UrineNoYesPaltarfasfusionsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesKidney StonesNoYesAllergis/Reactions to:NoYesSexual DifficultyNoYesPencillinNoYes	Spitting up Blood	No	Yes	Insomnia	No	Yes
GastrointestinalThyroid DiseaseNoYesLoss of AppetiteNoYesDiabetesNoYesChange in Bowel MovementsNoYesExcessive Thirst or UrinationNoYesNausea and/or VomitingNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesDry SkinNoYesRectal Bleeding or Blood in StoolNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesSlow to Heal After CutsNoYesPeptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesGenitourinaryNoYesAnemiaNoYesFrequent UrinationNoYesPhlebitisNoYesBlood in UrineNoYesPast TransfusionsNoYesBlood in UrineNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicVesKidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Shortness of Breath	No	Yes	Endocrine	No	Yes
Loss of AppetiteNoYesDiabetesNoYesChange in Bowel MovementsNoYesExcessive Thirst or UrinationNoYesNausea and/or VomitingNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesDry SkinNoYesRectal Bleeding or Blood in StoolNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesHematologic/LymphaticVersYesPeptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesGenitourinaryNoYesAnemiaNoYesFrequent UrinationNoYesPhebitisNoYesBlood in UrineNoYesPhebitisNoYesBlood in UrineNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesKidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Asthma or Wheezing	No	Yes	Glandular or Hormonal Problem	No	Yes
Change in Bowel MovementsNoYesExcessive Thirst or UrinationNoYesNausea and/or VomitingNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesDry SkinNoYesRectal Bleeding or Blood in StoolNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesHematologic/LymphaticNoYesPeptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesGenitourinaryVesBleeding or Bruising TendencyNoYesFrequent UrinationNoYesPhlebitisNoYesBlood in UrineNoYesPhlebitisNoYesBlood in UrineNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesKidney StonesNoYesPenicillinNoYesSexual DifficultyNoYesPenicillinNoYes	Gastrointestinal			Thyroid Disease	No	Yes
Nause and/or VomitingNoYesHeat or Cold IntoleranceNoYesPainful Bowel Movements/ConstipationNoYesDry SkinNoYesRectal Bleeding or Blood in StoolNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesHematologic/LymphaticVoYesPeptic Ulcer (Stomach or Duodenal)NoYesBleeding or Bruising TendencyNoYesGenitourinaryVYesAnemiaNoYesFrequent UrinationNoYesPhlebitisNoYesBlood in UrineNoYesPast TransfusionsNoYesChange in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesYesKidney StonesNoYesPenicillinNoYesSexual DifficultyNoYesPenicillinNoYes	Loss of Appetite	No	Yes	Diabetes	No	Yes
Painful Bowel Movements/ConstipationNoYesDry SkinNoYesRectal Bleeding or Blood in StoolNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesHematologic/LymphaticYesPeptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesGenitourinaryNoYesBleeding or Bruising TendencyNoYesFrequent UrinationNoYesAnemiaNoYesBlood in UrineNoYesPhlebitisNoYesChange in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesSexual DifficultyNoYesSexual DifficultyNoYesPenicillinNoYesYes	Change in Bowel Movements	No	Yes	Excessive Thirst or Urination	No	Yes
Rectal Bleeding or Blood in StoolNoYesChange in Hat or Glove SizeNoYesAbdominal Pain or HeartburnNoYesHematologic/LymphaticVesPeptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesGenitourinaryVesBleeding or Bruising TendencyNoYesFrequent UrinationNoYesAnemiaNoYesBlood in UrineNoYesPhlebitisNoYesBlood in UrineNoYesEnlarged GlandsNoYesChange in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesYesKidney StonesNoYesPenicillinNoYesYesSexual DifficultyNoYesPenicillinNoYes	Nausea and/or Vomiting	No	Yes	Heat or Cold Intolerance	No	Yes
Abdominal Pain or HeartburnNoYesHematologic/LymphaticPeptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesGenitourinaryNoYesBleeding or Bruising TendencyNoYesFrequent UrinationNoYesAnemiaNoYesBurning or Painful UrinationNoYesPhlebitisNoYesBlood in UrineNoYesPast TransfusionsNoYesChange in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Painful Bowel Movements/Constipation	No	Yes	Dry Skin	No	Yes
Peptic Ulcer (Stomach or Duodenal)NoYesSlow to Heal After CutsNoYesGenitourinaryNoYesBleeding or Bruising TendencyNoYesFrequent UrinationNoYesAnemiaNoYesBurning or Painful UrinationNoYesPhlebitisNoYesBlood in UrineNoYesPast TransfusionsNoYesChange in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesNoYesKidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Rectal Bleeding or Blood in Stool	No	Yes	Change in Hat or Glove Size	No	Yes
GenitourinaryBleeding or Bruising TendencyNoYesFrequent UrinationNoYesAnemiaNoYesBurning or Painful UrinationNoYesPhlebitisNoYesBlood in UrineNoYesPast TransfusionsNoYesChange in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesYesKidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Abdominal Pain or Heartburn	No	Yes	Hematologic/Lymphatic		
Frequent UrinationNoYesAnemiaNoYesBurning or Painful UrinationNoYesPhlebitisNoYesBlood in UrineNoYesPast TransfusionsNoYesChange in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicYesNoYesKidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Peptic Ulcer (Stomach or Duodenal)	No	Yes	Slow to Heal After Cuts	No	Yes
Burning or Painful UrinationNoYesPhlebitisNoYesBlood in UrineNoYesPast TransfusionsNoYesChange in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicVesYesKidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Genitourinary			Bleeding or Bruising Tendency	No	Yes
Blood in UrineNoYesPast TransfusionsNoYesChange in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicVesVesKidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Frequent Urination	No	Yes	Anemia	No	Yes
Change in Force of Strain when UrinatingNoYesEnlarged GlandsNoYesIncontinence or DribblingNoYesAllergic/ImmunologicVesVesKidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Burning or Painful Urination	No	Yes	Phlebitis	No	Yes
Incontinence or DribblingNoYesAllergic/ImmunologicKidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Blood in Urine	No	Yes	Past Transfusions	No	Yes
Kidney StonesNoYesAllergies/Reactions to:NoYesSexual DifficultyNoYesPenicillinNoYes	Change in Force of Strain when Urinating	No	Yes	Enlarged Glands	No	Yes
Sexual Difficulty No Yes Penicillin No Yes	Incontinence or Dribbling	No	Yes	Allergic/Immunologic		
		No	Yes	Allergies/Reactions to:	No	Yes
Nale Testisulan Dein	Sexual Difficulty	No	Yes	Penicillin	No	Yes
Male - Testicular Pain No Yes Sulfa No Yes	Male - Testicular Pain	No	Yes	Sulfa	No	Yes
Female - Pain with PeriodsNoYesMorphine, Demerol, NarcoticsNoYes		No	Yes		No	Yes
Female - Irregular PeriodsNoYesNovocain, AnestheticsNoYes	Female - Irregular Periods	No	Yes	Novocain, Anesthetics	No	Yes
Female - Vaginal DischargeNoYesAspirinNoYes		No	Yes		No	Yes
Female - # Pregnancies No Yes					No	Yes
Female - # Miscarriages Iodine, Antiseptics No Yes					No	Yes
Female - Date of last pap smear Other Drugs/Medications	Female - Date of last pap smear			Other Drugs/Medications		

Initials _____

22 Odyssey #215 . Irvine . CA 92618

949.398.7444

Name: _____

Procedure	Date	Facility
Full Blood Test		
EKG		
Chest X-Ray		
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density		
Other		

Vaccine	Date	Facility
Flu Vaccine		
Pneumonia Vaccine		
Shingles Vaccine		
Tetanus Vaccine		
H1N1 Vaccine		
Other		

Initials _____



PAYMENT POLICY

We recognize and appreciate that health care can involve a major financial commitment. We aim to provide you with effective services and treatments. As a patient of Integrative Medicine Orange County, you are responsible for the total charges incurred for each visit. Charges for services are to be paid at the time of services being rendered.

We accept all Major Credit Cards, personal checks and cash as forms of payment. There will be a **\$50.00** charge for all returned checks. We are an **out-of-network provider** for all insurance providers; including but not limited to Medicare, Medi-Cal, HMOs, EPOs, PPOs and other private insurance providers & co-operatives.

Patient will be given an Insurance Claim Form reflecting the services rendered after each visit and is the patient's responsibility to submit the claim to their insurance provider for reimbursement. If the claim is denied or payment is not made, it is the patient's responsibility to contact their insurance provider to resolve the issue.

Please remember that the patient has the primary relationship with their insurance provider and are responsible for the total amount due at the time of the visit.

All follow-up appointments are confirmed one day in advance and appointments not cancelled within **at least 24hours notice** will be charged a **\$99.00 no-show fee**. All new patient appointments are confirmed one day in advance and appointments not cancelled within **at least 72-hours notice** will be charged a **\$299.00 no-show fee**. This charge is directly payable by you and cannot be submitted to your insurance.

Phone consultations payment is required at the time of the scheduled appointment. Payment for all supplements & treatments is due at the time of service or purchase. Insurance providers may not cover these services. You have the right to refuse any service recommended by our staff.

If you fail to pay for services or products on the date received, Integrative Medicine Orange County will charge the credit card on file, unless alternative payment arrangements are made within 24 hours after the date of service or receipt of products.

By signing below, I acknowledge that I have read, understand and agree to the above stated policies of Integrative Medicine Orange County:

Signature:	Date:	
Printed Name:		
Relationship to Patient:		



CREDIT CARD POLICY

It is a policy of Integrative Medicine Orange County for all patients to have a credit card on file.

For expediting the payment process, you may authorize Integrative Medicine Orange County to use the credit card listed below for future appointments, treatment or supplement payments.

If you fail to pay for services or products on the date received, Integrative Medicine Orange County will charge the credit card on file, unless alternative payment arrangements are made within 24 hours after the date of service or receipt of products.

******Please Print Clearly *****
Patient's Name
Cardholder's Name As It appears On The Card:
Cardholder's Relationship to Patient:
Credit Card: VISA MC AMEX OTHER
Credit Card Number:
Exp. Date: CVV (3-4 digit code):
Address (number) Affiliated With Card Zip Code
Cardholder's Signature & Authorization To Use For Patient: Date:



Acknowledgement of Privacy Notice

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Mae Kinaly, MD, Integrative Medicine Orange County. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at www.drkinaly.com and in our office. You may request a copy of the Notice of Privacy.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

Restoring Your Healthy Balance www.myintegrativedoc.com 22 Odyssey #215 . Irvine . CA 92618 (949) 398 7444



CONSENT TO USE ELECTRONIC COMMUNICATIONS

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using electronic communications. However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications maybe disclosed in accordance with a duty to report or a court order.
- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing. If the email or text is used as an e-communication tool, the following are additional risks:
- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.
- While the Physician will attempt to review and respond in a timely fashion to your electronic communication, the Physician cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters.
- If your electronic communication requires or invites a response from the Physician and you have not received a



response with in a reasonable time period, It is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.

- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
- You agree to inform the Physician of any types of information you do not want sent via electronic communication by notifying the Physician in writing.
- The Physician is not responsible for information loss due to technical failures associated with your software or Internet service provider.

INSTRUCTIONS FOR ELECTRONIC COMMUNICATION

- Reasonably limit or avoid using an employer's or other third party's computer.
- Inform the Physician of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate electronically.
- Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to the physician.
- Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing "read receipts" to be sent.
- Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to the Physician.
- If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on electronic communication. Rather, you should call the Physician's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.



I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of electronic communication more fully described in this consent form. I understand and accept the risks outlined in this consent form, associated with the use of electronic communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined above, as well as any other conditions that the Physician may impose on electronic communications with patients.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either the Physician or I may, at any time, withdraw the option of communicating electronically upon providing written notice.

I HAVE REVIEWED AND UNDERSTAND ALL THE RISKS, CONDITIONS, AND INSTRUCTIONS DESCRIBED IN THIS CONSENT FORM.

Patient/Guardian email address:	
Patient/Guardian Signature:	Date:
Patient Name:	_ Date of Birth:
Parent/Guardian Name (Relation to patient):	



INFORMED CONSENT FOR TELEMEDICINE SERVICES

I hereby consent to engage in telemedicine as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine may also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

By signing this form, I understand and agree to the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine that identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time
- I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
- I understand that it is my duty to inform IMOC of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of Dr. Kinaly and IMOC, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if Dr. Kinaly believes I would be better served by another form of treatment (e.g. face-to-face services) I may be referred to another medical



facility or doctor who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of IMOC, my condition may not be improve, and in some cases may even get worse.

- I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
- Finally, I understand that if I engage in telemedicine I will be required to pay in advance, via credit card. By signing this agreement I agree to provide my credit card information and to have the agreed upon charges charged to the provided card.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

DATE

PATIENT/REPRESENTATIVE SIGNATURE

PATIENT NAME (PRINTED)

REPRESENTATIVE'S RELATION TO PATIENT