# Efren F. Wu, MD Inc.

*44100 Jefferson Street, #507, Indio, CA 92201*
*Phone: (760) 360-1000, Fax: (760) 610-6171*
*www.FamilySportsMD.com*

## Patient Demographics

| Patient Name | Date of Birth | Social Security # |
|---|---|---|
| | / / | - - |

| Address: Street | City/Town | State/Province | ZIP/Postal Code |
|---|---|---|---|
| | | | |

( ) _____ Phone Number

_____@_____ e-mail address

☐ Male
☐ Female

_____ Emergency Contact

( ) _____ Emergency Phone #

**To whom may we, as your medical provider, release information regarding your medical condition(s):**

_____ Name of party

_____ Relationship

***Who may we thank for referring you to our office?*** _____

**If patient is a minor please complete:**

| Responsible Party | Relationship | Contact Phone # |
|---|---|---|
| | | ( ) |

**INSURANCE INFORMATION**

| Name of Insurance Carrier | Member ID # | Name of Subscriber |
|---|---|---|
| | | |

| Secondary Insurance Carrier | Member ID # | Name of Subscriber |
|---|---|---|
| | | |

**Payment for services rendered is to be made as follows:**
*"I request that payment of authorized insurance benefits be made to* **Efren F. Wu, M.D. Inc.**, *for any services or items furnished to me by the physician/provider. I authorize the practice to release to the Health Care financing Administration (HCFA/CMMS), my insurance carrier, and/or its agent's appropriate information needed to determine these benefits or the benefits payable for related services, in accordance with HIPPA guidelines. Release of other information requires specific release authorization.*

***I am financially responsible for appropriate deductibles, co-payments, and non-covered items*** *(which have been explained to me from information supplied by my carrier). If this account has to be turned over to an attorney due to delinquency or non-payment, I will be responsible for all costs of collection including court costs and reasonable attorney fees".* ( ) ***initial***

_____ **Signature of Beneficiary** (*or Guardian if minor*)

_____ **Date**

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# Medical History

**Tobacco Use:** *Current / Previous / Never* # Packs per day: _____ # of years: _____

**Alcohol Use:** *Current / Previous / Never* # Drinks per day: _____

**Pharmacy** *(name, phone/address):* _____

## Current Medications

| Name | Dosage | Frequency |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

## Medical Conditions: *(please mark all that apply)*

| | |
|---|---|
| ☐ Hypertension (high blood pressure) | ☐ *Cancer: (specify)* _____ |
| ☐ High Cholesterol | ☐ *Other:* _____ |
| ☐ Diabetes | ☐ *Other:* _____ |
| ☐ Asthma / COPD | ☐ *Other:* _____ |

## Previous Surgeries: *(please mark all that apply and include dates)*

| | |
|---|---|
| ☐ Gallbladder | ☐ *Other:* _____ |
| ☐ Appendix | ☐ *Other:* _____ |
| ☐ Colon | ☐ *Other:* _____ |
| ☐ Hysterectomy | ☐ *Other:* _____ |

**Allergies:** _____

**Family History:** *(Please list any medical conditions to immediate family members and their relationship to you)*

_____

_____

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## Office Policies

***Please read through ALL of our office policies, as it contains pertinent information for ALL patients.***

*In response to the complexities within our healthcare industry, we have taken steps to optimize our operations in order to spend more time on patient care and less on administration. This will require your help. Please read **ALL of the items** listed below as they will be **Strictly Enforced**, to ensure high quality, compassionate and timely care is provided to all of our valued patients.*

1. **INSURANCE:** Please know the details of your insurance plan. Some visits and / or procedures may not be covered by your plan. **It is incumbent upon you to know what your benefits are.** If your insurance changes, it is your responsibility to notify our office of your new insurance. **(___) initial**
2. **PAYMENTS:** Co-payments **AND** deductibles are due at the time of your visit - **NO EXCEPTIONS**. All patients and family balances are excepted to be paid in full so any further care can be provided. We accept cash, debit, check and Visa or Master Card as form of payments. **(___) initial**
3. **LATE / No Show Policy:**
   If you are more than **15 minutes late** to your scheduled appointment, you have missed your appointment and are responsible for our **$25.00 no show fee. (___) initial** . If you are running late, Please call our office. If you **"No-Show" for three (3) appointments in a calendar year, you will be dismissed from our practice. (___) initial**
4. **After Hours / Phone Consultation:**
   Telephone calls to on-call physician/provider during after hours or weekends requesting a phone consultation will be subject to **a $25.00 phone consultation fee.** please note you will be notified via call-service of charges prior to service being rendered, and you will have the option to accept or decline services at that time. Acceptance of services is binding and your account will be billed **(___) initial.** Please note that these services are exclusive to your insurance coverage, **(___) initial** and you will be contacted for payment the next business day and / or next visit. **(___) initial**
5. **Medication Refill:**
   Medication refills are prescribed electronically whenever possible. Please allow **48 hours** for all medication refills to be reviewed. You may be requested to make an appointment if you have not been seen in **6 Months** or if there is a request in dosage change in your medication. **(___) initial.** For **ALL CONTROLLED** medications you are subjected in having a appointment **Every 3 Months.**
6. **Forms Completion:**
   There is a charge of **$25.00** for **ALL Forms** to be completed by the physicians. **(___) initial**
7. **Same Day Appointments:**
   We will try to accommodate all of our patients, however, same day visits are on a **"FIRST COME, FIRST SERVE"** basis. **We are Not A Walk-In Clinic**, and you may be recommended to go to an Urgent Care if we cannot accommodate you that day. **(___) initial**

I have read, understood and **AGREE** to adhere to the above mentioned office policies / guidelines.

| _____ | _____ | _____ |
|---|---|---|
| Patient's Name (please print) | Patient / Guardian Signature | Date |

**EMAIL:**_____