The Bethencourt Group
MEMORIALCARE
MEDICAL GROUP

Cardiac & Thoracic Surgery, Robotic & Minimally Invasive Specialists
PH: 562-988-9333 * FX: 562-424-1228
2865 Atlantic Ave., Ste. 205 Long Beach, CA 90806
18111 Brookhurst, Ste. 6300 Fountain Valley, CA 92708

Visit us at www.bethencourtgroup.com * www.Memorialcare.org/MedicalGroup

- Information about your physician
- Educational information
- Contact information
- Videos
- Office forms
- Driving directions
- Post your story
- And much more!

To make your visit as informative and beneficial as possible please take some time to review and complete the attached forms in their entirety prior to your appointment.

Patient Check List *(be sure to bring the following to your appointment)*

____ Patient Information Sheet – **Completely Filled Out, Signed & Dated**

____ Name, Address, and Phone number for **ALL** physicians included in your care

____ Patient History and Physical Questionnaire - **Completely Filled Out, Signed & Dated**

____ Patient Eligibility Waiver & Confirmation of receipt of "Privacy Practices"– **Signed & Dated**

____ **ALL** Insurance Information Forms – **Signed & Dated**

____ **Insurance Card**

____ **Picture ID**

____ **CD or films** as instructed by the office staff *(if applicable)*

Upon your arrival to our office, hand the forms, insurance card and your picture ID to the front desk attendant. Thank you for helping our physicians and office staff continue to provide excellent care and service.

PLEASE FILL OUT ALL ITEMS COMPLETELY
ON THE FRONT & BACK

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INFORMATION AND POLICY'S FOR PATIENTS

OFFICE HOURS
8:30 AM – 5:00 PM Monday – Friday

AFTER OFFICE HOURS
Medical Emergency – Call 911
Non-Emergency – Call 562-988-9333 *(you will be connected to our phone exchange service)*
Ask for the physician on call to be paged
Leave a non-urgent message for the office staff
All messages are retrieved from the exchange on the next business day

OFFICE CELEBRATED HOLIDAYS
The Bethencourt Group will be closed for business on the following holidays:
Holidays that fall on a weekend will be celebrated on the Friday prior or the Monday following the legal holiday.

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Day

PRESCRIPTION REFILLS
Upon discharge from the hospital *(if applicable)* you may receive prescriptions from The Bethencourt Group staff. Most commonly these medications are only for when you are discharged and to be taken per discharge instructions until your follow-up appointment with your cardiologist, pulmonologist, or other attending physician who will then re-evaluate you and your need for the medications prescribed. They will refill, change, or discontinue medications depending upon their evaluation of you after surgical intervention by The Bethencourt Group.

ASSISTANTS IN SURGERY
Most procedures performed by The Bethencourt Group require the help of an Assistant Surgeon or Physician Assistant. This is normal practice in many surgical practices and required by law in most of the surgical interventions performed by The Bethencourt Group physicians. We want to assure you that the assistants operate under the direction and supervision of your surgeon. It is highly unusual that the assistant meets with the patient prior to the surgery or after surgery; this is a normal practice and hopefully will ease any possible anxiety.

OUTSIDE ENTITY BILLING
When or if you are scheduled for a procedure you may, depending upon your insurance, receive statements or claims from entities outside of The Bethencourt Group. The entities include, but are not limited to the following: Pathology, Radiology, Anesthesiology, Assistants in Surgery, Hospital, Etc… If you should receive a bill from one of these outside entities, please contact them directly for any questions or problems.

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ASSIGNMENT OF INSURANCE BENEFITS, AUTHORIZATION TO PAY BENEFITS, AND RELEASE OF INFORMATION TO INSURANCE COMPANIES

Print Patient Name: _____

1) **ASSIGNMENT:** I hereby authorize payment to MemorialCare Medical Foundation, all benefits now due or becoming due under my group policy and I hereby direct my insurance carrier to pay such benefits to said physician. I authorize this practice to act as my agent to help me secure payment from my insurance companies.

2) **MEDICAL PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I hereby certify that the above information given by me in applying for the payment under Title XVIII of the Social Security Act is correct. I request payment of any authorized benefits to be made on my behalf. Any holder of medical/other information about me is authorized to release it to the Social Security Administration or its intermediaries or carriers as well as any information needed for this or a released Medicare claim.

3) **RELEASE OF INFORMATION:** I also authorize said assignee to release information to the insurance carrier and other specialists involved in my care related to these services and in reference to the settlement of this claim.

4) **WAIVER:** I agree that should it be determined that I am ineligible for services rendered and/or ineligible due to lack of pre-authorization by my primary care provider, I will be responsible for payment to Memorialcare Medical Foundation or its agent for those services deemed ineligible or not covered. I acknowledge that it is my responsibility to ensure pre-authorization has been obtained for services rendered by The Bethencourt Group or its agents.

5) **NOTICE TO CONSUMERS:** Medical Doctors are licensed and Regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

6) **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED WHETHER OR NOT PAID BY MEDICARE OR SAID INSURANCE.**

Patient Signature: _____ Date: _____

PRIVACY PRACTICES

I understand that a copy of MemorialCare Medical Foundation's Notice of Privacy Practices will be made available to me upon request.

Signature: _____ **Date:** _____

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PATIENT DEMOGRAPHICS **Today's Date:**

PLEASE FILL OUT COMPLETELY

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

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PATIENT SS # _____ **DOB:** _____ **Male**___ **Female**___

HOME # _____ **OTHER #** _____ **EMAIL** _____

MARITAL STATUS Single Married Separated Divorced Widowed

OPTIONAL:

Race: *(circle one)* White Black / African American American Indian / Alaska Native Asian Native Hawaiian / Other Pacific Islander Other Race

Ethnicity: *(circle one)* Hispanic or Latino Not Hispanic or Latino

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____ **STATUS:** **FT PT RETIRED**

SPOUSE'S NAME: _____

EMERGENCY CONTACT: _____

PHONE # _____

HOW DID YOU HEAR ABOUT US? Physician Referral Patient Referral Website / Internet Other _____
(Circle One)

PRIMARY INSURANCE: _____

ID# _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE: _____

ID # _____ **GROUP NUMBER:** _____

REFERRING PHYCISIAN: _____ PHONE: _____

CARDIOLOGIST: _____ PHONE: _____

PULMONOLOGIST: _____ PHONE: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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PATIENT HISTORY QUESTIONAIRRE **Today's Date:** _____

PLEASE FILL OUT COMPLETELY

Patient Name: _____ **Date of Birth:** _____

History of Current Problem: _____

_____

Allergies & Reaction? _____

Your current weight? _____ Your current height? _____

RISKS

Do you currently have High Blood Pressure? YES NO Do you currently have Diabetes Mellitus? YES NO

Do you currently have high Cholesterol? YES NO Have you ever had a Blood Transfusion? YES NO

SOCIAL

Marital Status Single Married Separated Divorced Widowed **Children** #_____Sons #_____Daughters

Tobacco Use _____ Packs/day. Quit*(when)* _____ Used to Smoke _____ Packs/day. Never Smoked

Alcohol Use Yes No Never _____ Drinks Daily Weekly Other _____ Type of Drink *(e.g. wine, beer, etc)* _____

Drug Use Yes No Never _____ Frequency Daily Weekly Other _____ Type of Drug *(e.g. marijuana, cocaine , etc)* _____

What is or was your occupation? _____

PAST HISTORY *(use addt'l sheet if needed)*

	DESCRIPTION	DATE
Major Illnesses		
Major Injuries		
Childhood Diseases		
Operations		
Hospitalizations		

Physician Initial/Signature _____

PERSONAL HISTORY

Do you currently have or ever had any of the following

CONSTITUTIONAL SYMPTOMS				Comments
Recent Weight Change	No	Past	Currently	
Fevers	No	Past	Currently	
Headaches	No	Past	Currently	
Night Sweats	No	Past	Currently	
Fatigue	No	Past	Currently	
Other	No	Past	Currently	
EYES				**Comments**
Blurry Vision	No	Past	Currently	
Eye Pain	No	Past	Currently	
Discharge	No	Past	Currently	
Dry Eyes	No	Past	Currently	
Decreased Vision	No	Past	Currently	
Other	No	Past	Currently	
EARS/NOSE/THROAT/MOUTH				**Comments**
Sore Throat	No	Past	Currently	
Tinnitus	No	Past	Currently	
Bloody Nose	No	Past	Currently	
Hearing Loss or Ringing	No	Past	Currently	
Sinusitis	No	Past	Currently	
Other	No	Past	Currently	
RESPIRATORY				**Comments**
Shortness of Breath	No	Past	Currently	
Chronic of Frequent Cough	No	Past	Currently	
Spitting up Blood	No	Past	Currently	
Asthma or Wheezing	No	Past	Currently	
Other	No	Past	Currently	
CARDIOVASCULAR				**Comments**
Chest Pain or Angina	No	Past	Currently	
Heart Murmur	No	Past	Currently	
Shortness of Breath	No	Past	Currently	
Palpitations	No	Past	Currently	
Swelling of Feet & Ankles	No	Past	Currently	
Syncope	No	Past	Currently	
Other	No	Past	Currently	
GASTROINTESTINAL				**Comments**
Nausea or Vomiting	No	Past	Currently	
Loss of Appetite	No	Past	Currently	
Frequent Diarrhea	No	Past	Currently	
Blood in Stool	No	Past	Currently	
Peptic Ulcer	No	Past	Currently	
Other	No	Past	Currently	
GENITOURINARY				**Comments**
Frequent Urination	No	Past	Currently	
Burning / Painful Urination	No	Past	Currently	
Urine Hesitancy	No	Past	Currently	
Blood in Urine	No	Past	Currently	
Incontinence	No	Past	Currently	
Kidney Stones	No	Past	Currently	
Other	No	Past	Currently	

Physician Initial/Signature _____

MUSCULOSKELETAL				**Comments**
Joint Stiffness or Swelling	No	Past	Currently	
Joint Pain	No	Past	Currently	
Muscle Pain	No	Past	Currently	
Muscle or Joint Weakness	No	Past	Currently	
Other	No	Past	Currently	
SKIN/INTEGUMENTARY				**Comments**
Rash or Itching	No	Past	Currently	
Sores or Skin Lesions	No	Past	Currently	
Nail Changes	No	Past	Currently	
Skin Thickening	No	Past	Currently	
Other	No	Past	Currently	
NEUROLOGICAL				**Comments**
Migraines	No	Past	Currently	
Numbness/Tingling	No	Past	Currently	
Seizures or Convulsions	No	Past	Currently	
Vertigo	No	Past	Currently	
Stroke	No	Past	Currently	
Paralysis	No	Past	Currently	
Other	No	Past	Currently	
ENDOCRINE				**Comments**
Goiter	No	Past	Currently	
Thyroid Problems	No	Past	Currently	
Diabetes	No	Past	Currently	
Other	No	Past	Currently	
PSYCHIATRIC				**Comments**
Depression	No	Past	Currently	
Anxiety	No	Past	Currently	
Insomnia	No	Past	Currently	
Other	No	Past	Currently	
HEMATOLOGICAL/LYMPHATIC				**Comments**
Easy Bruising	No	Past	Currently	
Blood Clots	No	Past	Currently	
Swollen Glands	No	Past	Currently	
Slow Healing After Cut	No	Past	Currently	
Anemia	No	Past	Currently	
Other	No	Past	Currently	
ALLERGIC/IMMUNE				**Comments**
Allergic Rhinitis	No	Past	Currently	
Hay fever	No	Past	Currently	
Asthma	No	Past	Currently	
Positive TB Test	No	Past	Currently	
Hives	No	Past	Currently	
Other	No	Past	Currently	

Physician Signature / Date

Patient Signature

Date

Physician Initial/Signature _____

FAMILY HISTORY

Relationship	AGE	LIVING	DECEASED	If Deceased - Cause
Mother				
Father				
Sibling *(Circle One)*				
Brother Sister				
Brother Sister				
Brother Sister				
Brother Sister				

RELATIONSHIP	Illness						
MS = Mother Side FS = Father Side	Heart Problem	Stroke	Diabetes	High BP	Mental Illness	Cancer	Comment / Type
Mother							
Father							
Grandmother (MS)							
Grandfather (MS)							
Grandmother (FS)							
Grandfather (FS)							
Brother Sister							
Brother Sister							
Brother Sister							

Patient Signature _____ Date _____

Physician Initial/Signature _____

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LIST OF PATIENT CURRENT MEDICATIONS

PATIENT: Please list ALL usual medications, including prescription drugs, pain medications, blood thinners & all over the counter drugs (herbals, diet pills, & food supplements).

- ☐ *Check this box if this form is not applicable; not on any home medications.*
- ☐ *Check this box if there are no known allergies*

DESCRIBE ALLERGIES & REACTIONS :

MEDICATIONS *(use additional sheets as needed)*	**Dose**	**Route**	**Frequency**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

LIST NON-PRESCRIPTION DRUGS BELOW *(including herbals, diet pills, food supplements, & pain pills)*

Medication	Dose	Route	Freq
1.			
2.			
3.			
4.			
5.			
6			
7.			
8.			

Form completed by *(Print Name & Sign)* _____ Date Completed _____

Physician Initial/Signature _____