Terrisa Ha, M.D.

5451 La Palma Ave. #49, La Palma, CA 90623

Ph: (714) 736-9918 Fax: (714) 736-9952

Patient Registration Form

Patient's Name: _____ _____ _____
Last *First* *Middle*

Date Of Birth: _____ Age: _____ Gender: M / F

Address: _____ _____ _____ _____ _____
Street *Apt.* *City* *State* *Zip*

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____

Email: _____@_____

Social Security Number: _____ Drivers License Number: _____

Martial Status: _____ Drug Allergies: _____

Occupation: _____ Work Phone: (____)_____-_____

Do you have a preferred pharmacy for prescriptions?

Pharmacy Name: _____ Phone Number: _____

How were you referred to Dr. Terrisa Ha?

☐ Yelp ☐ Google ☐ Insurance ☐ Patient: _____ ☐ Other: _____
(Patients name)

Emergency Contact

Contact Name: _____ Relation to Patient: _____

Home Phone: (___)_____-_____ Cell Phone: (___)_____-_____ Work Phone: (___)_____-_____

Primary Insurance Holder *(If not self)*

Guarantor's Name: _____ Date Of Birth:_____ Relation to Patient:_____

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____

Address: _____ _____ _____ _____ _____
Street *Apt.* *City* *State* *Zip*

Social Security Number: _____ Drivers License Number: _____

Financial Agreement

I understand that fees are payable when service is rendered unless prior arrangements have been made. I also understand that all fees and charges are based upon time, amount, and nature of services. I understand I am responsible for my own benefits. Payment of services rendered to me and/or my dependents will not be delayed or withheld, because of pending insurance claims. For per-approved insurance claims, I authorize the release of any medical information necessary to process and claims. And I authorize payment of medical benefits to Dr. Terrisa Ha for services rendered. If I am unable to keep my scheduled appointment, I must notify the staff of Dr. Terrisa Ha within 24 hours or I may be assessed a no show fee of $30.

Signature: _____ Date: _____
(Guardians signature if patient is a minor)

PATIENT HEALTH HISTORY FORM

Information contained here will be treated with a confidential manner and not released without our authorization. Please take the time to answer all questions to the best of your knowledge, as this information is very important to your doctor in his decisions regarding your care.

Date: _____ Name: _____

Age:_____ Date of birth: _____ Sex:_____ Marital Status: _____ Hgt: _____ Wgt: _____ Ideal Body Wgt:_____

Family/Personal Physician: _____ Address: _____ Date of Last Visit: _____

Referring Physician:_____ Address: _____ Date of Last Visit: _____

SURGICAL HISTORY

List all previous operations, date and any complications:_____

_____

_____

_____

MEDICAL HISTORY	Yes	No		Yes	No		Yes	No
Serious Illness	☐	☐	Breast Disease	☐	☐	Breast Cancer	☐	☐
Serious Injuries	☐	☐	Stomach/Bowel Problems	☐	☐	Other Cancer	☐	☐
Bleeding Problems	☐	☐	Liver/Kidney Disease	☐	☐	Heart Attack	☐	☐
Anesthesia Problems	☐	☐	Bladder Infections	☐	☐	Stroke	☐	☐
Scarring Problems	☐	☐	Eye Problems	☐	☐	Bronchitis	☐	☐
Diabetes	☐	☐	Nervous Disorder	☐	☐	Pneumonia	☐	☐
Asthma	☐	☐	Nerve Injury/Paralysis	☐	☐	Alcoholism	☐	☐
High Blood Pressure	☐	☐	Fainting Spells	☐	☐	Drug Addiction	☐	☐
Heart Disease	☐	☐	Seizures	☐	☐	AIDS	☐	☐
Lung Disease	☐	☐	Arthritis	☐	☐	Other	☐	☐

Explain and give dates for each of above "Yes" response: _____

_____

_____

Do/Have You Smoked?: _____ Avg # packs per day: _____ # of years ___ Date Quit: ____

Do You Drink Beer or Alcohol?: _____ How Much?: _____ Date of last Chest X-ray: ____

Date/Result Last Mammogram: _____ Date Last Menstrual Period: _____ Are you pregnant?: _____

MEDICATIONS	Yes	No		Yes	No		Yes	No
Aspirin Products	☐	☐	Diabetic Pills	☐	☐	Weight Loss Pills	☐	☐
Headache Pills	☐	☐	Insulin	☐	☐	Water Pills	☐	☐
Arthritis Pills	☐	☐	Thyroid Pills	☐	☐	Tranquilizers	☐	☐
Blood Thinners	☐	☐	Digitalis	☐	☐	Sleeping Pills	☐	☐
Anticoagulants	☐	☐	Dilantin	☐	☐	Laxatives	☐	☐
Cortisone/Steroids	☐	☐	Phenobarbital	☐	☐	Antibiotics	☐	☐
Hormones	☐	☐	Barbiturates	☐	☐	Birth Control Pills	☐	☐

List all names of meds (with amounts and how often) taken during the past 6 months: _____

_____

ALLERGIES/SENSITIVITIES	Yes	No		Yes	No		Yes	No
Penicillin	☐	☐	Aspirin	☐	☐	Iodine	☐	☐
Sulfa Drugs	☐	☐	Aspirin Substitutes	☐	☐	Phisohex/Betadine	☐	☐
Other Antibiotics	☐	☐	Novacaine	☐	☐	Adhesive Tape	☐	☐
Tetanus	☐	☐	Other Anesthetics	☐	☐	Other	☐	☐

List reactions which have occurred for each above "Yes" response: _____

_____

FAMILY HISTORY	Yes	No		Yes	No		Yes	No
Bleeding Problems	☐	☐	Diabetes	☐	☐	Breast Cancer	☐	☐
Anesthesia Problems	☐	☐	Stroke	☐	☐	Other Cancer	☐	☐
High Fever from Surgery	☐	☐	Heart Disease	☐	☐	Arthritis	☐	☐
Scarring Problems	☐	☐	High Blood Pressure	☐	☐	Other	☐	☐

List family member and explanation if necessary for each above "Yes" response: _____

_____

_____

Patient Signature: _____ Physician Signature: _____