Tim K. Cha, M.D. Diplomate, American Board of Psychiatry and Neurology
3440 Lomita Blvd. Ste #138, Torrance, CA 90505

WELCOME TO OUR OFFICE

PATIENT REGISTRATION - CONFIDENTIAL

Patient Name: _____
Last, First Middle Initial

Date of Birth: _____ **Sex: Female ___ Male___**

Race: White ___ Black ___ Hispanic ___ Asian ___ Indian ___ Pacific Islander ___ Others____

Language: _____ **Marital Status: S___ M___ W___ Sep___ D___**

Address: _____
Street **Apt / Unit #**

_____ _____ _____
City **State** **Zip Code**

Last 4 digits of Social Security # :_____ **Driver's License # :** _____

Home Phone # : _____

Cell Phone # : _____

E-mail : _____

Referred By: _____

Name of Pharmacy you will fill the Rx medication: _____

Pharmacy's Address: _____

Phone Number: _____

Patient's Employer: _____

Work Phone # : _____ Is it okay to contact you at work? Yes ___ or No___

Patient's Occupation: _____

Name of Employer: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Request for Confidential Communications:

I authorize the following people may discuss my protected health information with your office and may be in the room with me for my office visits.

_____ _____

First & Last Name Relationship

_____

Identity info. needed for verification (i.e., date of birth, address, phone number, etc.)

AUTHORIZATION FOR INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.
I hereby authorize Dr. Tim Cha to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Dr. Tim Cha. I understand that I am financially responsible for any balance not covered by my insurance.

BILLING AND COLLECTION POLICY

We will bill your insurance first and then send you three consecutive monthly billing statements which should allow you a reasonable amount of time to pay off your remaining balance.
Please note that there are payment installment plans available without interest and any service fees. Call us for further assistance if you have financial difficulty.
If you fail to make payments on your account despite our courteous efforts to cooperate with you, your account shall be taken to a collection agency and this action will accrue an additional 18% service charge of your remaining balance for our hiring of the collection service. So it is in your best interest to pay it off or to call us in a timely fashion to arrange a payment plan to avoid this additional charge.

RELEASE OF MEDICATION HISTORY

To ensure your medications are up-to-date, and minimize the chance of duplication or causing potential interactions with other medications, this authorization will allow our office to utilize the ePrescribe Program to transmit prescriptions to your pharmacy and also to obtain your medication history from your pharmacy.
I authorize Dr. Cha to obtain information from my pharmacy regarding my medications.
This informed consent has been made freely and without coercion.
You may decide not to consent on this. Your choice will not affect your ability to get medical care.

NO SHOW FEE

A No Show Fee of $25.00 is charged to any patient who has an appointment and does not keep the appointment or cancel the appointment 24 hours prior to the appointment.

I certify that the information I have reported with regard to my insurance coverage is correct.
I have read the terms and conditions in the aforementioned office policy and accepted them.

Date: _____ **Signature:** _____

(Patient, parent, or guardian)

Thank you.

TIM K. CHA, M.D. Diplomate in Neurology, American Board of Psychiatry and Neurology

3440 LOMITA BLVD., SUITE 138, TORRANCE, CA 90505 TEL: (310) 372-2821

Name of Patient: **Date:**

If you bring the list of the following items,
please give it to the receptionist and skip this column. Thank you.

Significant Health Issues Addressed:

Medical Problems:	

Operations / Hospitalization: If yes, Reasons and Years

Family Medical History

Family History UNKNOWN ( )

	Living	Deceased	Diagnosis History (Ex: diabetes, stroke, dementia, brain aneurysm, migraine, etc.)
Mother			
Father			
Sister			
Brother			

Allergies: Known Drug Allergies: No ___, Yes ___, If yes,
Name of Medicines you are allergic to:

Official Use:

Blood Pressure:	Body Weight:
Pulse Rate:	Body Height:

Smoking: Heavy smoker ☐, Light smoker ☐, Current every day smoker ☐,
Current some day smoker ☐, Former smoker ☐, Never smoker ☐
Frequency: ____cigarettes per day ☐, week ☐, or month ☐
Pack Years: ____

Alcohol: Never ☐, Former ☐, Current ☐
Type: Beer ☐, Wine ☐, Liquor ☐, other ☐
Frequency: ____ drinks per day ☐, week ☐, or month ☐

Medical History: Please, mark "X" if you have the following symptoms.

Fatigue ☐, unexplained weight loss ☐, heat intolerance ☐, cold intolerance ☐
Feels off balance ☐, abnormal vision ☐, tunnel vision ☐, droopy eyelid ☐
Watery eye ☐, blurred vision ☐, sensitivity to light ☐, transient visual loss ☐
Difficulty hearing ☐, ringing in the ears ☐, snoring ☐, hoarseness ☐
Chest pain ☐ rapid or irregular heart beat ☐ chest pressure with exertion ☐
Shortness of breath ☐, blood in sputum ☐, difficulty breathing ☐
Nausea ☐, vomiting ☐, diarrhea ☐, constipation ☐, blood in stool ☐
Vomiting blood ☐, jaundice ☐ reflux ☐, difficulty in swallowing ☐
Bowel incontinence ☐, blood in urine ☐, urinary urgency ☐, frequent urination ☐
Urinary incontinence ☐, ankle swelling ☐, joint stiffness ☐, neck stiffness ☐
Joint pain ☐, joint swelling ☐, muscle cramps ☐, difficulty walking ☐
Hair loss ☐, skin rash ☐ dizziness ☐, headache ☐, seizure ☐,
Fainting ☐, involuntary movement ☐, tremor ☐, memory loss ☐
Depression ☐, substance abuse ☐, behavioral problem ☐,
Personality change ☐, mood swings ☐, sleep problem ☐
Alcohol abuse ☐, anxiety ☐, poor concentration ☐, auditory hallucination ☐
Nervousness ☐ enlargement of lymph nodes ☐, bleeding tendency ☐
Easy bruising ☐, anemia ☐, hives ☐, food allergy ☐