JEFFREY M. JOHNSRUD, M.D.
A MEDICAL CORPORATION

1140 West La Veta, Suite 760, Orange, CA 92868,
714-541-4442 Tele, 714-835-9550 Fax

PATIENT REGISTRATION FORM

Date: _____

Patient Information

Patient Name _____ Social Security# _____

Address _____ City _____ State _____ Zip _____

Daytime Phone (Hm or Wk) _____ Evening Phone (Hm or Wk) _____

Date of Birth _____ Age _____ Ethnicity _____ Gender ❑ Male ❑ Female

Married _____ Single _____ Divorced _____ Widowed _____

Emergency Contact _____ Phone _____

Family Doctor/PCP _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employment Information

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Date of Birth _____ Social Security # _____

Insurance Information

Insurance Carrier _____ Policy# _____ Group# _____

Claims Mailing Address _____ Phone _____

Name of Primary Insured _____ Social Security# _____

Date of Birth _____ Relationship to Patient _____ Occupation _____

Employer _____ Business Phone _____

Secondary Insurance Carrier _____ Policy # _____ Group# _____

Claims Mailing Address _____ Phone _____

Name of Primary Insured _____ Phone _____

I hereby authorize payment directly to JEFFREY M. JOHNSRUD, M.D., of the medical and/ or surgical benefits otherwise payable to me for the servces, but not to exceed the charges as stated. I also do understand that I am financially responsible to the physician for all the charges not covered by this authorization.

Signature _____ Date _____

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FORMA DE REGISTRO DEL PACIENTE

Fecha: _____

Información del Paciente

Nombre del Paciente _____ # de Seguro Social _____

Dirección _____ Ciudad _____ Estado _____ Código Postal _____

Teléfono del día (Casa o Trabajo) _____ Teléfono del día (Casa o Trabajo) _____

Fecha de Nacimento _____ Edad _____ Raza _____ Sexo ❑ Hombre ❑ Mujer

Soltero _____ Casado _____ Divorciado _____ Enviudado _____

Contacto Emergencía _____ Teléfono _____

Médico Familiar/Médico Principal _____ Teléfono _____

Dirección _____ Ciudad _____ Estado _____ Código Postal _____

Información de Empleo

Empleo _____ Occupacíon _____

Dirección del Empleo _____ Ciudad _____ Estado _____ Código Postal _____

Nombre de Coñyuge _____ Fecha de Nacimento _____ # de Seguro Social _____

Información de Seguranza

Aseguradora _____ # de Póliza _____ # de Grupo _____

Dirección de los reclamos de seguranza _____ Telefóno _____

Nombre de la Asegurado Principal _____ # de Seguro Social _____

Fecha de Nacimento _____ Relación a Paciente _____ Occupación _____

Empleo _____ Telefóno de Empleo _____

Aseguradora Secundario _____ # de Póliza _____ # de Grupo _____

Dirección de los reclamos de seguranza _____ Telefóno _____

Nombre del Asegurado Secundario _____ Telefóno _____

Yo authorizo el pago directo de los beneficios medicos y sirugia a JEFFREY M. JOHNSRUD, M.D.,.De otra manera seria pagos a me siempre y no excedan los cargos por el servicio. Tambien entiendo que yo soy responsible al doctor por todos los cargos no incluidos por esta autorización.

Firma _____ Fecha _____

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NOTICE OF PRIVACY PRACTICE

HIPPA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our *Notice of Privacy Practice* and for you to sign as acknowledging receipt of this brochure.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____

How may we contact you and still provide the privacy and security you require as we protect your health and personal information.

Please check as many as apply

_____ Telephone and message to your answering machine.

_____ Telephone and message to another person.

_____ Please state name.

_____ Mail.

_____ Contact you at work.

_____ Please give phone number

_____ Designated caregiver, legal guardian or relative

_____ Please specify

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AVISO PRIVACIDAD DE LA PRÁCTICA

Las regulaciones de HIPPA (portabilidad del seguro médico y acto de la responsabilidad) nos requieren proporcionar a usted, el paciente o al representante responsable, una copia de nuestro aviso de la práctica de el aislamiento, para que usted como recibo del reconocimiento de este forma y estar acuerdo en firmarla.

Impresa su Nombre _____ Relación al paciente _____

Firma _____ Fecha _____

Mientras que protegemos su salud y informacíon personal, como podemos communicarnos y todavia proporcionar la privacidad y la seguridad del paciente.

Por favor marque los que aplican:

_____ Teléfono y mensaje a su contestador automático.

_____ Teléfono y mensaje a otra persona.

_____ Indique el nombre

_____ Correo.

_____ Contacto a su trabajo

_____ Por favor escribe el teléfono

_____ Cuidador designado, guardian legal o pariente.

_____ Por avor especifique el nombre y número de teléfono

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NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment of services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence medications we prescribe for the treatment process.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, your insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

OTHER USES AND DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIREING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions : You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment of health care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit you request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information complied for use is a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not a part of the information which you would be permitted to inspect or copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have a right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Statements of disagreements and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of you record.

Right to an Accounting of Non-Standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional list, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. To obtain a paper copy of the current Notice, please request one and it shall be given to you.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper left corner of the first page.

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PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits With My Doctor For Routine Physical Exams And Other Recommended Screenings:

I understand that my doctor will explain to me, which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visit with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments:

I understand that my doctor will want to know how my condition progresses after I leave the office. Retuning to my doctor on time gives him/her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order test, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and do not reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call The Office When I Do Not Hear The Results Of Labs And Other Test:

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor If I Decide Not To Follow His Or Her Recommended Treatment Plan:

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and test, or even asking me to return to the office within a certain period. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about you health or condition, please ask.

Patient Signature _____ Print Patient's Name _____ Date _____

Jeffrey M. Johnsrud, M.D. _____

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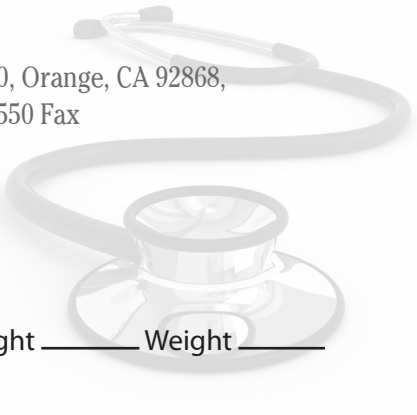

PATIENT HISTORY

Name _____ DOB _____ Age _____ Height _____ Weight _____

Chief Complaint (please state your problem in your own words)

_____

_____

_____

List Present of Past Medical Problem (s)

(i.e., heart disease, high blood pressure, diabetes, kidney or liver disease, other)

_____

_____

_____

_____

List Previous Hospitalizations (dates and reasons)

_____

_____

List Previous Surgical Procedures

_____

_____

List Medications (include dose and over the counter medication)

_____

_____

List Drug Allergies

_____

_____

Have you had any problems with General Anesthesia or Previous Operation? ❑ Yes ❑ No

Please explain _____

Have you had Previous Transfusions? ❑ Yes ❑ No If yes, estimate how many _____

Do you smoke? ❑ Yes ❑ No If yes, how many packs per day _____

If none, have you ever smoked _____ If yes, when did you quit? _____

Alcohol _____ ounces per month (i.e. 1 oz =1 can of beer or 8 oz glass of wine or 1 shot of hard liquor)

Have you ever been treated for Drug Abuse or Alcholism? ❑ Yes ❑ No

If yes, how long ago _____

Do you have any problems with bleeding? (i.e., bruise easily, recurrent nosebleeds, heavy menstrual flow, etc.)

❑ Yes ❑ No If yes, please describe _____

Do you take aspirin? ❑ Yes ❑ No

If yes, when is the last time you took aspirin? _____

Do you take Birth Control Pills? ❑ Yes ❑ No Type of Dosage _____

Have you ever had the following:

	Yes	No
Rheumatic Fever		
High Blood Pressure		
Shortness of Breath		
Asthma, Emphysema, Previous lung disease		
Diabetes		
Fainting or Blackout Spells		
Dentures, Bridges, Capped Teeth		
Cold or Flu in last two months		
Recent Headache or Blurred Vision		
Back Pain, Spine Trouble, Sciatica		
Kidney Trouble		
Do you wear a Hearing Aid?		

What diseases run in your family? (List disease, which relative, and their current status)

_____

_____

Date and place of most recent Chest X-Ray _____

Date of most Electrocardiogram or EKG _____

Date of most recent labs _____ Ordering Physician _____

Signature _____ Date _____

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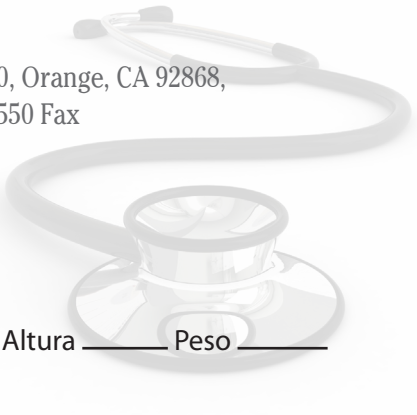

HISTORIA DEL PATIENTE

Nombre _____ Fecha de Nacimiento _____ Edad _____ Altura _____ Peso _____

Principal Queja (indique por favor su problema en sus propias palabras)

Indica problemas medicos del presente o del pasado (s)

(i.e., enfermeda cardíaca, presión alta, diabetes, enfernedad de riñon y higado, otro)

Hospitalizaciones anteriores: (por favor incluye fechas y razones)

Operaciones quirúrgicas anteriores

Medicamientos: (incluye dosis y medicamientos sin receta)

Alergias de medicamientos

¿Ha tendio usted cualquier problema con anestesia general? ❑ Sí ❑ No

Explique por favor _____

¿Ha tendio usted transfusiones de sangre anteriormente? ❑ Sí ❑ No

Si su respuesta es sí, estime cuantos _____

¿Fuma usted? ❑ Sí ❑ No ¿Paquetes por día? _____

¿Si su respuesta es no, ha fumado antes? _____

Sis u respuesta es sí, cuando dejo de fumar? _____

Alcohol _____ onzas por mes (i.e. 1 oz =1 bidón de cerveza o 8 oz copa de vino o 1 trago de licor fuerte)

¿Le han tratado a usted para el abuso de la droga o del alcholismo? ❑ Sí ❑ No

¿Sis u respuesta es sí, por cuanto tiempo? _____

¿Usted tiene problemas con la pérdida de sangre? (i.e., moratones con facilidad, hemorragia nasal, flujo menstrual, etc.)

❑ Sí ❑ No Sis u respuesta es sí, por favor explique _____

¿Usted toma aspirina? ❑ Sí ❑ No

¿Si su respuesta es sí, cuando fué la ultima vez que usted tomó aspirina? _____

¿Usted toma píldoras del control de la natalidad? ❑ Sí ❑ No Típo y dosis _____

Usted ha tenido los siguientes:

	Sí	No
Fiebre Reumatica		
Presion alta		
Falta de respiracion		
Asma, Enfisema, Enfermedades pulmonarias		
Diabetes		
Maredo o pérdida de conocimiento		
Dentadura postiza, puente dental, fudas en los dientes		
Catarro o gripe en los ultimos dos meses		
Dolor de cabeza o visión borroso		
Dolor de espalda, spína dorsal, Ciática		
Problemas de riñones		
Usted usa uno aparato para la sordes		

¿Que enfermedades hay en su familia? (Escriba las enfermedades, qual pariente, y su estado actual)

_____

_____

Fecha y lugar de la reciente radiografía del pecho _____

Electrocardiograma _____

Firma _____ Fecha _____