Loraine Diego, MD
1711 W. Temple St #7643,Los Angeles, CA 90026
(Located in Silverlake Medical Center)
Tel: 213-388-2229
Fax: 213-388-1507

PATIENT REGISTRATION

Email :_____ SSN# : _____-_____-_____

Name (Last, First, MI) _____

Home Address_____

City, State,Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Nickname _____ Birthday _____ Age _____

Single ____ Married ____ Separated ____ Divorced ____ Occupation _____

Employer / Work Address _____

In an emergency, who should we call? (Relationship)_____

Their Phone_____ How did you hear of Dr. Diego?_____

Preferred Pharmacy Name_____ Phone_____

Pharmacy's Address or Cross streets _____

PRIMARY INSURANCE	***SECONDARY INSURANCE (if applicable)***
Guarantor	Guarantor
Relation to Patient	Relation to Patient
Address	Address
Phone Birthdate	Phone Birthdate
Soc.Sec.# Insurance tel	Soc.Sec. # Insurance tel
Insurance Company	Insurance Company
Group # Subscriber #	Group # Subscriber #

- I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.
- I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to the practice of Dr. Loraine Diego and associates.
- I understand that I am responsible for all copayments, deductibles, and non-covered services as determined by my insurance policy.

SIGNED_____ DATE_____

1711 W. Temple st, Suite7643., Los Angeles, CA 90026

Loraine Diego, MD (Located in Silverlake Medical Center 7th Floor) Tel: 213-388-2229
Fax: 213-388-1507

****I acknowledge that I read / understand the Notice of Privacy Practices.**
(a copy is on website or in office)

Signature _____ Date: _____

*Instructions for the Communication of Private Health Information

Print Patient Name: _____

How would you like us to contact you?
Please check off and fill in all the appropriate blanks:

* ***To Confirm Appointments by Phone***

( ) Home #: _____ Can we leave a detailed message? ( ) yes ( ) no
( ) Work #: _____ Can we leave a detailed message? ( ) yes ( ) no
( ) Cell #: _____ Can we leave a detailed message? ( ) yes ( ) no
( ) Other #: _____ Can we leave a detailed message? ( ) yes ( ) no

* ***To Report Test Results***

( ) Mail to: _____
( ) Fax to: _____
( ) Email: _____

(please note: our email address is only to relay results and not to make appointments, contact doctor! staff, health problems, etc.)

Telephone:

( ) Home #: _____ Can we leave a detailed message? ( ) yes ( ) no
( ) Work #: _____ Can we leave a detailed message? ( ) yes ( ) no
( ) Cell #: _____ Can we leave a detailed message? ( ) yes ( ) no
( ) Other #: _____ Can we leave a detailed message? ( ) yes ( ) no

Signature of Patient: _____ Date: _____

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MEDICAL HISTORY FORM

Primary Doctor: _____ **Tel:** _____ **City/State:** _____

Current & Past Medical Problems (Year): _____

_____

Past Surgeries/Hospitalizations (Year): _____

_____

Allergies (Drug/Food & what reaction): _____

Family Medical Problems (Who/ Disease): _____

_____

Menstrual History: Age of 1st Period: _____; Duration (# days): _____; Flow: Heavy/ Light; Cramps: Yes/ No

1st Day of Last Period (or age of Menopause): _____; Hysterectomy? Yes / No

Pregnancy History: # Total Pregnancies: _____; # Children born: _____; # Miscarriages: ___; # Abortions: ___

Please list in order of your pregnancies: (Check here ___ if more on the back of page)

Date	Where/Hospital	Miscar/Vag/C-S	Sex	#wks preg.	Birth Wt	Any Complications?

When was last Pap Smear: _____ Who/Where? _____ Result? _____

Any past abnormal paps? Yes/No; If yes, what was diagnosis/treatment? (Year) _____

When was last Mammogram? _____ Where? _____ Result? _____

Any past abnormal mammos? Yes/ No; If yes, diagnosis/treatment? (Year) _____

Current & Past Birth Control (Year) _____

Do you smoke? (# packs per day, how long?) _____; Alcohol (# glasses/cans): _____

Drugs: Current or Past Use _____; Are you still a virgin? Yes/ No; Age you lost virginity?

Are you currently sexually active? Yes/ No; How many sex partners in your whole life? ____

Lesbian? __ Bisexual? __ Have you received the Gardasil (HPV) vaccine? Yes/ No.

- If Yes: __ all 3 doses; __ only 1st dose; __ only 2 doses. Date of last injection: _____ (mo/yr).
- If No: Do you want to discuss this with Dr. Diego today? __ Yes __ No, I already know about it.