HERBERT H. LEE, M.D., M.P.H., INC.
MEDICAL CLINIC

15785 Laguna Canyon Rd, Suite #230, Irvine, CA 92618
TEL: (949) 552-9628 FAX: (949) 329-3958

PATIENT REGISTRATION

Name **Social Security #**

Last MI First

Date of Birth **Marital Status** **Email**

Address **Telephone**

Street City State Zip

INSURED PERSON (IF NOT PATIENT)

Name **Social Security #**

Last MI First

Date of Birth **Marital Status** **Email**

Address **Telephone**

Street City State Zip

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT 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 the place of the original.

Signature Date

Print Name

I hereby authorize Dr. Herbert Lee to apply for benefits on my behalf for covered services rendered by him. I request that payment from my insurance company be made directly to Dr. Herbert Lee (or to the party who accepts this assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for knowing my benefits/coverage and will be financially responsible for all charges not covered by my insurance company. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke the authorization at any time of writing.

Signature Date

Print Name

Note: Incomplete insurance information may cause billing delay and become your responsibility

HERBERT H. LEE, M.D., M.P.H.
113 WATERWORKS WAY, SUITE 315
IRVINE, CA 92618
TEL: 949.552.9628
FAX: 949.329.3958

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law according to professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
    - Treatment
    - Payment
    - Health Care Operations
    - Notifications
    - Special Circumstances and the Law
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number shown at the top of this page to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements.

If, after reviewing the notice, you decide that you do not want to retain your paper copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices.

_____	_____	_____
Signature	Printed Name	Date

HERBERT H. LEE, M.D., M.P.H

15785 Laguna Canyon Road, Suite 230
Irvine, CA 92614
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HISTORY AND PHYSICAL

NAME	SS#	DATE OF BIRTH
ADDRESS		OCCUPATION
PHONE	CELL	EMAIL
CHIEF COMPLAINT		DATE

DRUG ALLERGIES

CURRENT MEDICATIONS

HOSPITALIZATION OR SURGERY

REASON	DATE

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart disease						
High blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/convulsions						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Mental illness						
Osteoporosis						

WOMEN ONLY Pregnant? □ Yes □ No Planning pregnancy? □ Yes □ No

MEDICAL HISTORY

□ Headache
□ Hypertension
□ Stroke/TIAs
□ Epilepsy
□ Fatigue
□ Shortness of breath
□ Heart palpitations
□ Heart murmur
□ Chest pain/angina
□ Dizziness/fainting
□ Anxiety
□ Claudication
□ MI
□ Congenital heart disease
□ Orthopnea
□ Hyperlipidemia
□ Arrhythmia
□ Congestive heart failure
□ Allergies/hay fever
□ Asthma
□ COPD
□ Liver Disease
□ Ulcer
□ GI disorder
□ Lactose Intolerance
□ Renal disease
□ Sexual dysfunction
□ GU disorder
□ Menstrual dysfunction
□ Bowel irregularity
□ Prostate disease
□ Incontinence
□ Venereal disease
□ Anemia
□ Gout
□ Scarlet fever
□ Diabetes
□ Rheumatic fever
□ Endocrine disease
□ Arthritis
□ Osteoporosis

HABITS

□ **Smoke?** Amount daily _____
How long _____
□ **Exercise?** Frequency _____
Method _____
□ **Contact with blood or bodily fluid at work?**

□ **Coffee?** Amount daily _____
Other caffeine _____
□ **Alcohol** Amount/Frequency _____
□ **Diet** □ Fruits □ Vegetables □ Fruit Juice
□ Dairy □ Red Meat □ Soda □ Chocolate/Candy

□ **Sleep**
□ Difficulty falling asleep
□ Continuity disturbances
□ Snoring
□ Early morning awakening
□ Daytime drowsiness