



Dear Prospective Patient,

I would like to personally welcome you to my practice, The Center for Optimal Health. With this letter, I would like to let you know what to expect. I would also appreciate you doing some preparation for your visit – please fill out the enclosed health questionnaire. Please bring any past medical records you have (especially any previous laboratory results). You will also find a medical records release form that you can send to any physicians you feel may have records that would be useful for our consultation. Please either make a list of all medications and supplements you take (including doses and timing), or bring the bottles along with you. Thank you

When you arrive at the Center, you will be greeted by my front office staff. You may tour the facility if you wish. Your vital signs (weight, blood pressure, pulse) will be measured by our medical assistant. I invite you to relax in our lounge and I will come to pick you up to escort you to my office. I will listen carefully to your concerns and I will conduct a thorough history and targeted physical examination so that I can get to know you. We will then discuss the plans for investigations and management together. Please expect to spend approximately 1.5 – 2 hours for the first consultation appointment.

At your follow-up appointment, we will go over your laboratory and other testing results in detail. You will receive a copy of your results for your records. You will receive a comprehensive set of recommendations including not only medical and pharmacological therapies, but also lifestyle (nutrition, exercise, stress management) and vitamin/herbal supplementation. We will always discuss a wide range of treatment options, ranging from natural and noninvasive methods to the most sophisticated medications and technologies.

Let me also take this opportunity to introduce the Center to you. In 2004 I founded the Center to pioneer Integrative Medicine in our community. We believe in treating each individual as a whole person, utilizing the best modalities from both Western medicine and complementary / alternative healthcare in order to optimize your health. Our other team members include a lifestyle educator and a marriage family therapist. We also have other health practitioners (internal medicine, family medicine) on site. We specialize in preventive care (reducing diabetes and cardiovascular risk, preventing osteoporosis, etc) and sexual health for men and women. We are also very active in community education and we invite you to sign-up to receive our e-newsletter.

Thank you for allowing us to be part of your healthcare team. I am confident that you will find unparalleled attention and quality integrated care at our center.

I look forward to meeting with you.

Sincerely,

Jannet Huang, MD, FRCPC, FACE, ABHM

The Center for Optimal Health, Inc.

PATIENT REGISTRATION FORM

Please Print

I would like to make an appointment to see: \_\_\_\_\_ Dr. Jannet Huang (Endocrinologist) \_\_\_\_\_ Dr. Grace Chang (Internal Medicine)

Today's date: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_ PCP's Phone No. \_\_\_\_\_

PATIENT INFORMATION

Patient's Name:  Mr  Mrs  Ms \_\_\_\_\_  
Last Name First Middle

Is this your legal name?  Yes  No If not, what is your legal name? \_\_\_\_\_

Martial Status:  Single  Married  Divorced  Wid Sex:  M  F Age: \_\_\_\_\_ Birth date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Street Address \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_ Cell Phone No. \_\_\_\_\_

Fax No. \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Empl Phone: \_\_\_\_\_

Referred to clinic by:  Dr. \_\_\_\_\_  Family/Friend  Website  Other \_\_\_\_\_

INSURANCE INFORMATION

Information used for any Pre-Authorizations needed

Person responsible for charges: \_\_\_\_\_ Birth Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Home Phone No. \_\_\_\_\_

Address (If different): \_\_\_\_\_

Is this Patient covered by Insurance:  Yes  No Primary Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Group No. \_\_\_\_\_ ID No. \_\_\_\_\_

Subscriber's S.S. No: \_\_\_\_\_ Subscriber's Birth Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Group No. \_\_\_\_\_ ID No. \_\_\_\_\_

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address) : \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone No: \_\_\_\_\_ Work Phone No. \_\_\_\_\_ Cell Phone No. \_\_\_\_\_

I understand that I am responsible for making payment in full of all charges at the time of service. It is my responsibility to submit the superbill provided to my insurance, and I understand that my insurance carrier will consider these charges out-of-network. The Center for Optimal Health does not do any insurance billing.

This above information is true to the best of my knowledge. I also authorize The Center for Optimal Health, Inc. to release any information required by my insurance carrier to process claims I have submitted.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name	Date of Birth	Today's Date
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**The Center for Optimal Health**

*Health and Wellness Questionnaire*

Who referred you or how did you hear about us?

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What health concerns/ interests would you like us to address on your initial visit?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Pharmacy name & number: \_\_\_\_\_

What major health problems or issues do you have or did you have in the past?

	Past	Present		Past	Present
Arthritis			Infertility / fertility treatments		
Asthma			Thyroid disease		
Cancer			Metabolic syndrome/ insulin resistance		
Diabetes			Mental health problems		
Digestive disease			Osteopenia, osteoporosis		
Fibromyalgia or chronic pain			Polycystic ovarian syndrome		
Fractures			<b>Other:</b>		
Heart Disease					
High blood pressure					
High cholesterol					

What major operations, procedures, or surgeries have you had? Please state.

Allergies (medication or seasonal – also description of reaction):

Any medication or food intolerances? (Please include description of reaction):



**Family Medical History:**

	List family members who have or had this illness.
Alcoholism/substance abuse	
Autoimmune conditions (rheumatoid arthritis, lupus, multiple sclerosis, etc)	
Cancer/tumors: Breast, ovary, colon, lung, skin, brain, etc.	
Depression, mental health conditions	
Diabetes, metabolic syndrome, insulin resistance	
Heart disease/condition (heart attack, angioplasty, stents, irregular heart rhythm, etc)	
High blood pressure	
High cholesterol	
Osteoporosis/osteopenia (thinning of bone)	
Stroke	
Thyroid problems (hypo- or hyperthyroidism, Hashimoto's, Graves disease, etc.)	
Other:	

**Substance Use**

Cigarettes	Never	Smoked in past: ___ years & amount ___ packs/day	Currently: ___ packs/ day
Other tobacco? _____			
Alcohol	Rare	Never	Past - number of drinks a day: _____ frequency: _____ times a week.
Reasons for quitting: _____			
Regular - currently: # drinks _____, frequency _____ times a week.			
Type of alcohol preferred: _____			
Any other recreational drugs (please indicate if use is current or in the past, as well as frequency of use)?			
Caffeine	Never	Past	Currently – amount/day : _____ X _____ times a week.
Do you drink (circle all that apply)? coffee / sodas (regular / diet) / tea (green tea / black tea / herbal tea)			
Do you eat chocolate? Yes/No			

**Relationships/Living arrangements**

With whom do you live? (alone, roommates, friends, partner, spouse, children, parents, relatives)
Marital status (please circle): single, married, separated, estranged, divorced, engaged, partnered, widowed
Are you sexually active? Yes / No If yes, Is your sex life satisfactory? Yes / No Do you have "safe sex"? Yes / No What forms of contraceptives do you use, if applicable?
Any pets? Yes / No
Any children or dependents? Yes / No
Are you a caretaker (i.e. –grandchildren, parents, spouse, friend, etc.)? If so, for whom?

**Occupation**

Educational background:
Current/past work or employment:

**Nutrition and Lifestyle**

**Height:** \_\_\_\_\_ **Lowest weight:** \_\_\_\_\_ **Highest weight:** \_\_\_\_\_ **Target weight:** \_\_\_\_\_  
 Describe any fluctuations: \_\_\_\_\_

**Do you follow any specific diets or have any dietary restrictions?** Yes / No; If yes, please explain:

**What do you usually eat throughout a typical day?** Please list timing and types of food consumed:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**How much time do you take for your meals?** Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

**Do you feel you now have or had in the past an eating disorder?** (if yes, what type?) \_\_\_\_\_

**What percentage of your food is:**

Leftovers \_\_\_\_\_ Frozen or packaged foods \_\_\_\_\_ Raw food \_\_\_\_\_ Cold foods \_\_\_\_\_ Red meat \_\_\_\_\_  
 Root vegetables (eg. potatoes, yams, beets) \_\_\_\_\_ Very spicy \_\_\_\_\_ Very Sour \_\_\_\_\_ Very salty \_\_\_\_\_

**How often do you eat out in a restaurant / have fast food?** \_\_\_\_\_

**Do you microwave your food or drinks?** \_\_\_\_\_

**Are there any foods that you are intolerant to?** Please list: \_\_\_\_\_

**About what percentage of your food is organically grown?** \_\_\_\_\_

**What kind of water (and what temperature) do you drink?** \_\_\_\_\_

**How much water do you drink per day?** \_\_\_\_\_ **How many sodas or diet sodas do you drink each week?** \_\_\_\_\_

**What other beverages (and how much) do you drink?**

Juice \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Milk \_\_\_\_\_ Yogurt / kefir drinks \_\_\_\_\_ Energy drinks \_\_\_\_\_ Sports drinks \_\_\_\_\_

How is your appetite? \_\_\_\_\_ How is your energy during the day? \_\_\_\_\_  
 Do you feel heavy or sleepy after eating? \_\_\_\_\_ How do you feel if you skip a meal? \_\_\_\_\_  
 How often do you have bowel movements? \_\_\_\_\_ Are they easy without strain? \_\_\_\_\_  
 What is the stool consistency? (circle all that apply): hard / firm / soft / loose / watery / bloody / with mucous  
 Do bowel movements occur about the same time each day? \_\_\_\_\_ Usually at what time(s)? \_\_\_\_\_  
 Do you regularly take laxatives or enemas? \_\_\_\_\_  
 Do you have hemorrhoids? \_\_\_\_\_ Do they bleed? \_\_\_\_\_  
 Do you do any cleanses / detox protocols? \_\_\_\_\_  
 How often and at what time(s) of day do you exercise? \_\_\_\_\_  
 What types of exercise do you do? \_\_\_\_\_

How many hours of sleep do you get a night? \_\_\_\_\_  
 What time do you go to bed? \_\_\_\_\_ What time do you get out of bed? \_\_\_\_\_  
 Do you have problems falling asleep or staying asleep? Yes / No; If yes, please describe: \_\_\_\_\_

Do you watch TV or use the computer within 1-2 hours of bedtime? \_\_\_\_\_  
 Is your cell phone on or off during the night? \_\_\_\_\_ Where do you place your cell phone at night? \_\_\_\_\_  
 Is there a TV in your bedroom? \_\_\_\_\_ Any computers or other electronic equipment in your bedroom? \_\_\_\_\_  
 Do you feel rested after sleeping? Yes / No Do you snore? Yes / No  
 Do you take naps during the day? if yes, describe: \_\_\_\_\_

**Stress / Environment**

How would you rate your stress level? None / Low / Moderate / High / Extremely High  
 What are the sources of your stress? \_\_\_\_\_  
 How do you react to stressful situations (eg. anger, anxiety, etc)? \_\_\_\_\_

Do you see a counselor / therapist? \_\_\_\_\_  
 Do you practice meditation or other relaxation techniques? (please list types and frequency): \_\_\_\_\_

Do you feel you take enough time for yourself? \_\_\_\_\_  
 How many hours per day do you use a computer? \_\_\_\_\_ How many minutes on a cell phone? \_\_\_\_\_  
 How many hours of TV do you watch per week? \_\_\_\_\_  
 What do you do for fun? \_\_\_\_\_  
 Please describe your social support network: \_\_\_\_\_

Are you exposed to any heavy metals or toxins? If so, please describe: \_\_\_\_\_

**Optional:**

What direction does your house face? \_\_\_\_\_  
 What direction does your main entrance face (What side of the house do you enter)? North South East West  
 What direction does your head of your bed point towards? \_\_\_\_\_  
 Do you use organic personal care products, laundry products, and non-toxic cleaning and lawn care products in your home or office? \_\_\_\_\_  
 Do you live near a power plant or high tension wires? \_\_\_\_\_

## Review of Systems

Do you have any of the following symptoms or problems?

<b>General</b>
Appetite change
Fever
Night sweats
Fluid retention
<b>Eyes</b>
Blurred vision
Contact lenses/glasses
Double vision
Eye dryness or discomfort
Protruding eyes
Pain in Eyes
Eye redness or irritation
<b>Ears / Nose / Throat / Sinuses</b>
Snoring
Sinus congestion
Difficulty swallowing
Gum problems
Hearing loss
Nose bleeds
Sore throat/ voice change
Ringing in ears
<b>Cardiovascular</b>
Chest pain
Fainting / blacking out
Dizziness/lightheadedness
Heart murmur
Irregular heartbeats/arrhythmias
Lower extremity swelling
Shortness of breath laying down
<b>Respiratory</b>
Asthma or wheezing
Cough
History of pneumonia
Shortness of breath
Recurrent respiratory tract infections
<b>Gastrointestinal</b>
Abdominal pain
Bleeding w/bowel movements
Bloating / Gas
Constipation
Frequent diarrhea
Heartburn or indigestion
Nausea
Irritable bowel syndrome

<b>Musculoskeletal</b>
Back pain/injuries
Joint pain
Muscle pain or cramps
Nerve compression / Pinged nerves
Skeletal deformities
Stiffness
<b>Neurologic</b>
Difficulty concentrating
Decline in memory
Head injuries
Headaches
Paralysis
Seizures
Tremors
<b>Psychiatric</b>
Anxiety
Depression
Irritability
<b>Endocrine</b>
Nipple discharge
Changes in stamina or sense of well-being
Hair loss
Heat/cold intolerance
Hypoglycemia
Loss of sex drive
Polydipsia (excessive thirst)
Polyphagia (excessive hunger)
Polyuria (excessive urination)
<b>Hematologic</b>
Previous blood transfusions
Anemia
Easy bruising
<b>Genitourinary</b>
Blood in urine
Frequent urination
Urine Incontinence
Kidney stones
Nighttime urination
Painful urination
Painful sexual intercourse
Erectile dysfunction
STD (sexually transmitted disease)
Urinary urgency



Skin
Abnormal pigmentation
Brittle nails
Dry, brittle hair

Skin (continued)
Frequent skin infections or boils
Hives/ Eczema / Rash
Excessive sweating

**Women Only:**

**At what age did you first have your menstrual period?** \_\_\_\_\_  
**Are you still having your menstrual periods?** Yes/No **If no, when did it stop?** \_\_\_\_\_  
**Flow:** Light / Medium / Heavy **Frequency of periods:** Regular / Irregular / Absent / Birth control pill

**What was the date of your last Pap smear?** \_\_\_\_\_ **Have you had an abnormal Pap smear?** Yes / No

**Are you trying to conceive/planning to conceive?** Yes / No / Uncertain  
**Have you ever breastfed?** Yes / No; If yes, please list durations: \_\_\_\_\_

**Number of pregnancies:** \_\_\_\_\_ **Number of births:** \_\_\_\_\_ **Number of terminated pregnancies:** \_\_\_\_\_  
**Number of miscarriages:** \_\_\_\_\_  
 How much weight did you gain during your pregnancy / each of your pregnancies? \_\_\_\_\_  
 Please list any complications during your pregnancy / pregnancies: \_\_\_\_\_

**Please list the birth weights of your child(ren):** \_\_\_\_\_  
 \_\_\_\_\_

**Do you have concerns regarding your sex drive?** Yes / No  
**Do you find sex pleasurable?** Yes / No  
**Do you have difficulty achieving orgasm?** Yes / No

**Do you have any of these symptoms or conditions?**

Painful menstrual periods	Yes/No
Excessive facial/body hair	Yes/No
Acne	Yes/No
Vaginal discharge	Yes/No
Endometriosis	Yes/No
Fibroids	Yes/No
Excessive menstrual bleeding	Yes/No

**Are you experiencing or have you experienced any of the following?**

Hot flashes	Yes/No
Night sweats	Yes/No
Vaginal dryness	Yes/No

**Have you ever had a mammogram?** Yes/No **Date of last mammogram:** \_\_\_\_\_

**Have you had a bone density scan?** Yes/No **Result:** \_\_\_\_\_  
**Calcium intake in childhood/young adulthood, please circle:** Good / Poor / Inconsistent

**Have you ever used hormone replacement therapy?** Yes/No  
 If yes, please list type and duration of hormone therapy: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## HIPAA Privacy Notice

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of this practice are entitled to the greatest degree of privacy possible. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient. Patients are advised that they have a right to review their medical files upon reasonable notice to the practice and during normal business hours, and to make comments to the same. Patients have the right to direct the methods of communication of their medical information and to specify the individuals to whom they wish their medical information released to, in addition to those indicated on the "consent to release medical information" form.

### **Practice Policies and Procedures**

- Before any records are released, staff will review to ensure that only the information necessary has been released.
- Before any records are released, staff will review to ensure that the release has been authorized by the patient or is otherwise permitted by law.
- Except in emergencies or as required by law, the patient (or the patients' agent) shall be notified before any records are released.
- Sign-in sheets used in the waiting room will not contain any medical information / reason for patient's visit.
- Only licensed health care professional members of the staff shall have access to medical records. Other staff members shall have access limited to portions of the records directly related to their duties (for example, the secretary shall have access to the pharmacy records for the purpose of refilling prescriptions).
- At the close of business each day, all medical information shall be secured in a protected area marked confidential or in the physician's office.
- Each patient chart shall include records of all releases of information, including the date, to whom the information was sent, and the material included.
- Oral PHI (Protected Health Information) should not be communicated in general patient areas. Except in emergencies, all discussions regarding patient care shall be conducted either in that patient's examination room or in the physician's private office.
- Oral PHI should not involve unnecessary parities. Discussions concerning patients should never be made in another patient's examination room.
- Common area conversations concerning patients are to be avoided.
- Out-of-office conversations regarding PHI are forbidden.
- Parents and Minors  
*Only the parent or legal guardian of a child has right to access records.*  
Exceptions include:
  - State law pre-emption (e.g., applicable state law concerning pregnancy or sexually transmitted diseases)
  - Court order
  - Potential abuse or neglect
  - With parent or guardian consent

### **Receipt of Privacy Notice**

By signing below, I confirm that I have received and read the privacy notice given to me in accordance to HIPPA.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If person other than patient is signing, please print full name and indicate relationship below.*

**Print Full Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

Any questions regarding this privacy notice should be directed to this practice's HIPPA compliance officer, Ms. Judy Klinger. Office: (949) 872-2850

## Consent Form for Medical Information Disclosures

Patient Name: \_\_\_\_\_

**Center Physicians / Providers: The Center for Optimal Health, Inc.**

- Jannet Huang, MD FRCPC, FACE, ABHM, and her employees / independent contractors who provide healthcare services

**Independent Practices:**

- Grace H. Chang, MD

In connection with the medical services that I am receiving from the above-named physician/provider, I hereby authorize that above-named physician/provider to disclose any / or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

- A. Any third party payor covering the medical services of the patient
- B. Other health care professionals and institutions involved in the delivery of health care to the patient
- C. The proponent of any legally sufficient subpoena, or in response to a court order
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services
- E. Pharmacies
- F. Other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given a copy of the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

Special Restrictions: \_\_\_\_\_

**I am consenting to receive my medical information by the following communication method-**

***Please check all that apply:***

- telephone conversation  telephone message on my home answering machine
- telephone message on my office voicemail
- leave telephone message with: (name of individuals who are authorized to receive your medical information by phone) \_\_\_\_\_
- email message / email address: \_\_\_\_\_
- facsimile (please provide fax numbers): \_\_\_\_\_

**Would you like to receive our Newsletter via email?   No   Yes (if yes, please provide email address above)**

**Please indicate your preferred method of communication: (please circle one):   Phone   Fax   Email**

I consent to have my medical information discussed with:

***Please check all that apply and include name:***

- spouse: \_\_\_\_\_  parents: \_\_\_\_\_
- children: \_\_\_\_\_  other: \_\_\_\_\_

This consent is valid from the date executed until revoked in writing by the patient.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Full Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

## **Cancellation Policy**

Cancellations and rescheduling of **follow-up appointments** require at least **2 business days (48 hours) notice IN ADVANCE** in order to avoid a fee. Because of the large block of time reserved for you, **cancellations or rescheduling for New Patient appointments** require a minimum of **three business days (72 hours) notice IN ADVANCE** to avoid a fee. If you do not give us advance notice to cancel or reschedule your appointment (new or follow-up), **50% of the appointment fee will be charged**. The full appointment fee will be charged in the case of appointments for psychological services.

Most people are considerate in providing us with advance notice to allow us to make the time available for other patients who need appointments. This policy is in place due to the unfortunate fact that we continue to encounter some patients who cancel at the last minute. We are making every effort to be “up front” and clear about our cancellation policy so there is no misunderstanding. Please keep in mind that unlike a lot of other medical offices, we never double book appointment slots. We reserve a significant time block for each individual patient, a time that is set aside only for you and your care.

We certainly understand that situations arise and patients need to change appointments. We are happy to work with you to reschedule appointments. All we ask is that you give us enough advance notice. We sincerely appreciate your consideration and cooperation.

**By signing below, I acknowledge that I have read and accept the above cancellation policy.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to patient

Your credit card number information will be collected when you schedule your appointment, in accordance with our cancellation policy.

**OFFICE USE ONLY:**

Policy Method:  Visa  Mastercard

Credit Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Name on card: \_\_\_\_\_

## Our Location

The Center for Optimal Health is conveniently located at the intersection of Paseo Westpark and Barranca Parkway, between Culver and Jamboree.

**From 405 going South:** Exit Jamboree; Make a Left at exit light; Turn Right onto Barranca Pkwy; Our Building will be on your Right

**From 405 going North:** Exit Culver; Make a Right at exit light; Turn Left onto Barranca Pkwy; Make a Left onto Paseo Westpark; Our building will be on your Right

**From 5 going North:** Exit Culver; Make Left at exit light, Left again onto Culver; Turn Right onto Barranca Pkwy; Make a Left onto Paseo Westpark; Our building will be on your Right

**From 5 going South:** Exit Jamboree; Make Right at exit light, Stay on Jamboree (stay in left lanes); Turn Left onto Barranca Pkwy; Our building will be on your Right

### The Center for Optimal Health

3500 Barranca Parkway, Suite 305, Irvine, CA 92606; Ph 949-872-2850



