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

3500 Barranca Parkway, Suite 305 •Irvine, CA 92606 • Ph (949)872-2850 • Fax (949)872-2855 • www.thecenterforoptimalhealth.org

The Center for Optimal Health, Inc.
PATIENT REGISTRATION FORM
Please Print

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 [] Widowed **Sex** [] M [] F **Age:** ________ **Birth date**______/______/_______

Street Address____

City ____________________________________ **State** ________________________**Zip**____________________

Home Phone __________________________ **Work Phone** __________________________ **Cell Phone** ___________________

Fax __________________________ **E-Mail Address** ________________________________

Occupation ____________________ **Employer** ____________________________________ **Empl Phone**___________________

Referred to clinic by [] Dr. ________________________ [] Family/Friend [] Website [] Other ______________________________

INSURANCE INFORMATION (Used for any Pre-Authorizations needed)

Person responsible for charges ___________________ **Birth Date** ______/______/_______ **Home Phone** __________________

Address (If different) ____

Is this Patient covered by Insurance [] Yes [] No **Primary Insurance** ____________________________________

Subscriber's Name ____________________________________ **Group #** ______________________ **ID #** __________________

Subscriber's SSN _______________ **Subscriber's Birth Date** _________________ **Relationship to Patient** __________________

Secondary Insurance: __________________________________ **Group #**______________________ **ID #** __________________

IN CASE OF EMERGENCY

Name of local friend or relative ***(not living at same address)*** ______________________________**Relationship** ___________________

Home Phone __________________________ **Work Phone** __________________________ **Cell Phone** ___________________

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

The Center for Optimal Health ***Health and Wellness Questionaire***

Who referred you or how did you hear about us?

____

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			**Other:**		
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):

What medications are you taking? (Please include any over-the-counter-drugs you use.)

Medicine	Daily Dosage	Medicine	Daily Dosage

List all vitamins, minerals, herbs and other nutritional supplements. When possible, indicate the dosage and the form (e.g. calcium carbonate vs. calcium citrate). <u>You may bring in a copy of container labels.</u>

Supplement	Daily Dosage	Supplement	Daily Dosage

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?

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

Musculoskeletal
Back pain/injuries
Joint pain
Muscle pain or cramps
Nerve compression / Pinged nerves
Skeletal deformities
Stiffness
Neurologic
Difficulty concentrating
Decline in memory
Head injuries
Headaches
Paralysis
Seizures
Tremors
Psychiatric
Anxiety
Depression
Irritability
Endocrine
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)
Hematologic
Previous blood transfusions
Anemia
Easy bruising
Genitourinary
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	Skin (continued)
Abnormal pigmentation	Frequent skin infections or boils
Brittle nails	Hives/ Eczema / Rash
Dry, brittle hair	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:____
____
____

The Center For Optimal Health, Inc.

LAST NAME ______________________

FIRST NAME ______________________

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

The Center For Optimal Health, Inc.

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 herby 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):____

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** ________________

The Center For Optimal Health, Inc.

____
LAST NAME

____
FIRST NAME

Cancellation Policy

Cancellations and rescheduling of **follow-up appointments require at least 24 business 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 two business days 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 cooperative.

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 will our cancellation policy.

OFFICE USE ONLY:

Policy Method: ▯ **Visa** ▯ **MasterCard**

Credit Card Number: ________________________ **Exp. Date:**____________

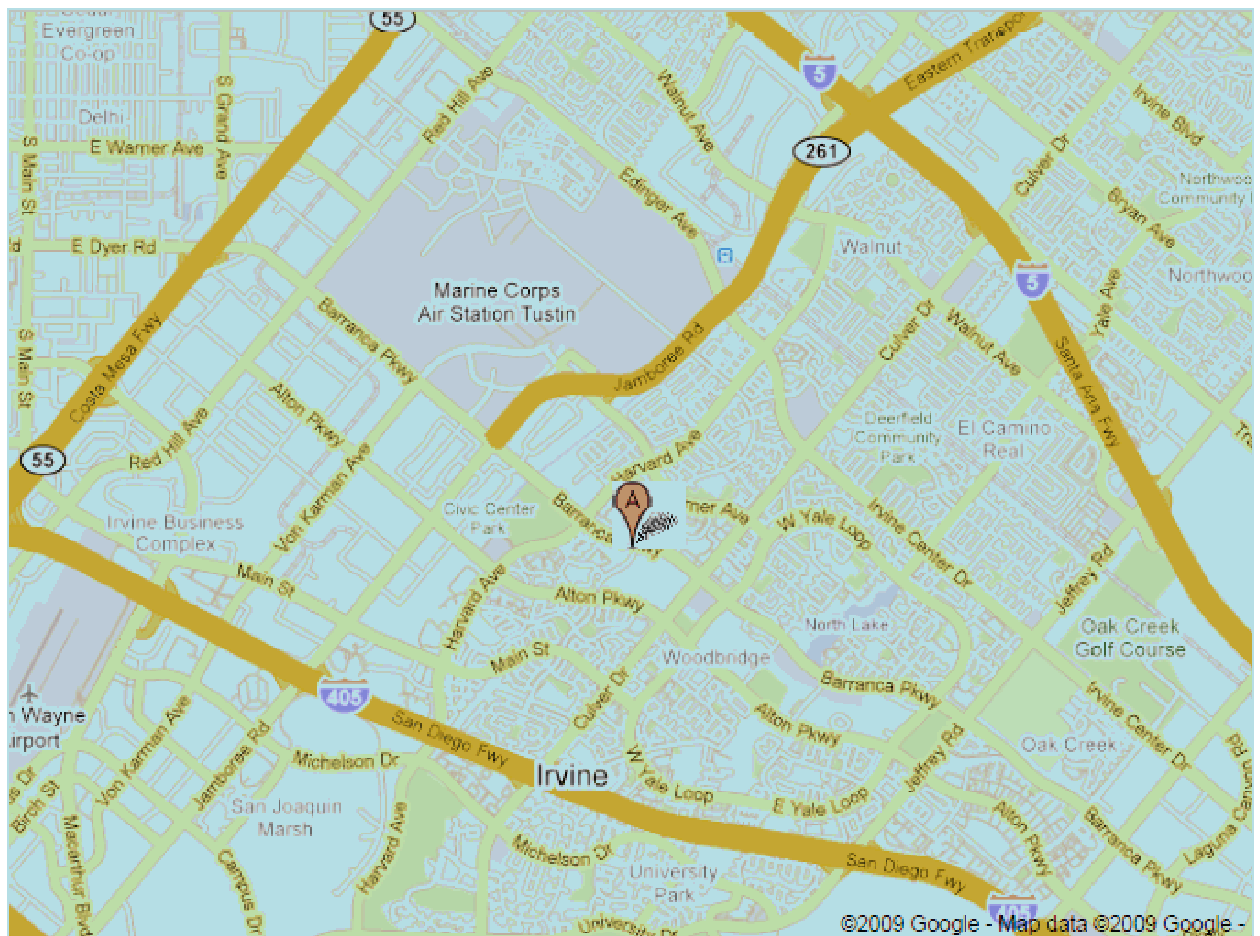
Name on card: ____

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



Whole Foods Market
Jamboree Rd
Barranca Pkwy
Construction Cir W
Construction Cir E
Warner Ave
Orchid
Cardamon
Columbus Dr
Larkspur St
Bonsai Wy
Jasmine Pl
Benavente
Paseo Westpark
Figaro
Pompeii
Arbusto
Irvine Center Dr
Vienne
Petra
Ponte
Sovente
Trieste
Vetrina
Ghiberti
Santa Corona
Avanzare
Altezza
Cipriani
Santa Rida
Culver Dr
Dulay Ct
Super Stallion Dr
Carter Ct
Tamayo Ct
Deetz Pl
Harvard Ave
Beckman Ave
Corporate Park
Festivo
Calavera
Del Trevi
Del Ventura
Avignon
Marsala
La Ronda
Santa Alicia
Plaza Park
Del Carlo
Blue Jay Park
Bluejay
Santorini
Santa Clara
Civic Center Park
Westpark
Santa Ynez
Cardiff
W Yale Loop
Solvay Aisle
Santa Rosa
Santa Barbara
Woodpine Park
Irvine Civic Center Plaza
Alton Pkwy
San Juan
Duranzo Aisle
San Remo
Cantata
San Leon
Tanglewood
Alderbrook
Sandpiper
Birdsong
Birdsong Park
Murica Aisle
San Marino
Capobella
Presidio
Monte Carlo
Comiso
Alexandria
Aprilia
Belcanto
Tiffany
Montelegro
Adagio
Alton Athletic Park
Partridge
Blackswan
Lake Rd
Terraza
San Mario Park
San Paulo