ROGER Y TAKLA M.D.
LEILA YOONESSI M.D.

ROGER Y TAKLA M.D. INC.

1040 ELM AVE STE 301
LONG BEACH,CA, 90813
562 491-9001(PH) 562 491-9283(FAX)

Today's Date: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

PARENT/GUARDIAN INFORMATION

PRIMARY FAMILY EMAIL: _____

PRIMARY FAMILY PHONE: (____) _____ (*OFFICE USE: LABEL AS "MAIN"*)

Mother Name: _____ Date of Birth: _____

Mobile Phone: (____) _____ **Work Phone:** (____) _____

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Father Name: _____ Date of Birth: _____

Mobile Phone: (____) _____ **Work Phone:** (____) _____

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Emergency Contact (relative or friend): _____

Alternate Contact Phone: (____) _____

Relationship to patient: _____

We are required to collect the following information for each patient.

Please complete this section before returning the form. Thank you.

Preferred Doctor/ARNP:

_____

Your Preferred Language:

_____

Your Child's Race/Ethnicity
(select one primary)

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multiracial
- ☐ Unknown
- ☐ Other _____
- ☐ Decline to answer

Patients or the patient's legal representative hereby consents to medical treatment rendered to me by Roger Y Takla M.D. Inc. That any information may be transferred to another facility, hospital, or clinic to further any treatment in my behalf.

FORM COMPLETED BY:

Name *(print)* _____ **Signature** _____

Date _____

***** Return this form to the Front Desk before leaving the office. Thank you. *****

Patient Eligibility Screening Record for Vaccines for Children Program

Patient Information

Patient Name Last	First	MI	Date

Date of Birth	Parent/Guardian (if applicable) Last	First	MI

Provider Name

Roger Y Takig

Eligibility Criteria

- **The patient named above qualifies for immunization through the VFC Program because he/she or his/her parent/guardian states the child is 18 years of age or younger and:**

  Choose only one of the following.

  (Note: If a child meets two or more of the eligibility qualifications, choose the first one that applies.)

  - ☐ is Medi-Cal or Child Health and Disability Prevention (CHDP) eligible; or
  - ☐ Is uninsured (does not have private health insurance); or
  - ☐ Is an American Indian or Alaskan Native.
  - ☐ Health insurance does not cover vaccines (only at federally qualified and rural health centers).

- **The patient named above does not qualify for immunization through the VFC Program because he/she has health insurance that pays for vaccines.**

Eligibility Status Verification

Screening Date	VFC Eligible				Not VFC Eligible
	Medi-Cal or CHDP Eligible	Uninsured	America Indian/ Alaskan Native	[Under-Insured (health insurance does not cover vaccine(s)]	

Notes

1. This form documents the eligibility status of the patient named above.
2. The health care provider must keep this record for the VFC-eligible child for no less than three (3) years and make it available to state or federal officials for inspection upon request.
3. This record may be completed by the patient (if he or she is an emancipated minor or 18 years of age), his or her parent or guardian or by the health care provider.
4. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status has not changed.
5. Verification of responses is not required.

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Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

State of California—Health and Human Services Agency

California Department of Public Health

CONSENT FOR DISCLOSURE AND/OR RELEASE OF CONFIDENTIAL INFORMATION FROM GDSP

The undersigned hereby authorizes the release of Newborn Screening Test Results from the records of the Genetic Disease Screening Program. **Fax completed form to: (510) 412-1559 or mail completed form to: Attention: NBS Results, Genetic Disease Screening Program, 850 Marina Bay Parkway, F175 Mail Stop 8200, Richmond, CA 94804**

REQUESTING NEWBORN SCREENING RESULTS FOR:

Name: _____

Gender: ☐ Male ☐ Female Date of Birth: _____

Hospital Of Birth: _____

Home Address on Date of Birth: _____

_____

Mother's Full Name: _____

Mother's Last Name on Date of Birth: _____

Mother's Date of Birth: _____

RELEASE RECORDS TO:

Name: ROGER Y TAKLA M.D

Address: 1040 ELM AVE STE 301

LONG BEACH, CA, 90813

Phone: 562 491 9001 Fax #: 562 491 9283

This authorization will expire on (Enter Date): _____.

You have the right to retain a copy of this consent. You have the right to revoke this consent at any time by writing to: Chief, Genetic Disease Screening Program at the address above as stated in our privacy notice. Revocation of this consent does not eliminate your responsibilities for payment for services received. The Genetic Disease Screening Program is not responsible for further disclosures of the information by other parties that may result from complying with this consent.

_____ _____

Signature Printed Name

(Parent or Legal Guardian should sign only if request is for a minor under 18 years of age)

Date signed: _____ Home phone: _____ Work phone: _____

I understand that any person who requests or obtains any record containing personal information from the California Department of Public Health under false pretenses will be guilty of a misdemeanor and fined up to $5,000 or imprisoned up to one year or both.
Please go to our website (see below) for our **Notice of Information & Privacy Practices**