PATIENT INFORMATION FOR MEDICAL RECORDS

La Jolla Village Family Medical Group
4520 Executive Dr #105, San Diego, CA 92121

SSN_____

NAME ☐ Mr. ☐ Mrs. ☐ Miss _____ DOB_____
LAST (PLEASE PRINT) FIRST M.I.

HOME ADDRESS _____
CITY STATE ZIP

MAILING ADDRESS _____
(If same as HOME ADRRESS write "SAME") CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

RELATIONSHIP STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOW/ER

EMERGENCY CONTACT _____ RELATION_____
PHONE _____

IF SOMEONE OTHER THAN PATIENT IS FINANCIALLY RESPONSIBLE PLEASE COMPLETE THIS SECTION

NAME OF RESP PARTY _____ SSN _____
LAST (PLEASE PRINT) FIRST M.I.

RELATIONSHIP TO PATIENT _____ HOME PHONE _____ WORK PHONE _____
(i.e., Father, Mother, Guardian, etc.)

PREFERRED METHOD OF COMMUNICATION: ☐ Home Phone ☐ Cell Phone ☐ Home Address

May we leave you a detailed message (will include personal health information)? YES NO If yes, at which phone number_____ *Please sign here to acknowledge your consent. _____

☐ Email* _____ ☐ PORTAL (Secure messaging method. Registration required)
***Email: Only information to confirm an appointment can be sent. We cannot attach or write any personal health information.**

PLEASE COMPLETE THE INFORMATION BELOW, SIGN BOTH STATEMENTS, AND RETURN TO RECEPTIONIST

I, the undersigned, have insurance coverage with _____ and assign directly to

_____ all surgical and /or medical benefits, if any, otherwise payable to me for services
(Name of Doctor)
rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. **I also acknowledge that there is a $25.00 no show/cancellation fee for all appointments not cancelled at least 24 hours before my scheduled appointment time.**

PRINT NAME _____ **SIGNATURE** _____ **DATE** _____

DISCLAIMER

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. The physician will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Your signature below serves only as acknowledgement that you have received and understand the above DISCLAIMER.

PRINT NAME _____ **SIGNATURE** _____ **DATE** _____

Health History Questionnaire

La Jolla Village Family Medical Group
4520 Executive Dr #105, San Diego, CA 92121

PHONE: Home_____
Work_____

Race_____ Ethnicity_____ Single___ Divorced____
NAME _____DOB _____ Age ____ Married____ Widower_____ Date _____
Address _____
Occupation _____ All previous occupations _____
Birthplace_____ All states lived in_____

Date of last physical examination? _____
Please list all current symptoms.
1._____
2._____
3._____
4._____
5._____
Routine check-up-no problems_____

Physician's Notes

Note: ***This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.***

Family History:	If Living		If Deceased		Has any blood Relative ever Had:	Please Circle No or Yes		Who
	Age	Health	Age at Death	Cause				
Father					Allergies	No	Yes	
Mother					Asthma	No	Yes	
Brother or Sister					Arthritis	No	Yes	
1.					Glaucoma	No	Yes	
2.					Cancer	No	Yes	
3.					Tuberculosis	No	Yes	
4.					Diabetes	No	Yes	
5.					Heart Trouble	No	Yes	
6.					High Blood Pressure	No	Yes	
Husband or Wife					Stroke	No	Yes	
Son or Daughter					Epilepsy	No	Yes	
1.					Substance Abuse	No	Yes	
2.					Depression	No	Yes	
3.					Emotional Problems	No	Yes	
4.					Suicide	No	Yes	
5.					Kidney Trouble	No	Yes	
6.					Thyroid Disease	No	Yes	

Personal History: Circle any of the items listed below that apply to you:

Measles (2 week)
German Measles (3 day)
Mumps
Chicken Pox
Whooping Cough
Scarlet Fever/Scarlantina
Diphtheria
Pneumonia
Influenza
Pleurisy
Rheumatic fever or any heart problem
Arthritis/Rheumatism
Any bone or joint disease
Neuritis or neuralgia
Bursitis, Sciatica, or Lumbago
Polio or Meningitis
Bladder or kidney infection
Gonorrhea, Syphilis, or Genital Herpes
Anemia
Yellow Jaundice or Hepatitis
Epilepsy
Migraine headaches
Tuberculosis
Mononucleosis
Diabetes
Cancer
High blood pressure
Low blood pressure
Nervous breakdown
Food, chemical or drug poisoning
Hay fever
Asthma
Hives
Eczema
Frequent infection of boils
Any other disease

ALLERGIES: Are you allergic to:
Penicillin or sulfa
Aspirin, codeine, or morphine
Mycins or other antibiotics
Merthiolate or Mercurochrome
Any other drugs
Any foods
Adhesive tape
Nail Polish or other cosmetics

INJURIES: Have you had any:
Broken or cracked bones
Recent Sprains
Severe lacerations
Dislocations
Concussion or head injury
Ever been knocked unconscious
Blood or Plasma transfusions

WEIGHT: Now_____ 1 year ago_____
Desired_____

HABITS:
Use of seatbelts_____
Alcoholic beverages:
Never, 1-2 drinks/wk 3-6 drinks/wk
7-24 drinks/wk., Over 24 drinks/wk
Have been treated for alcoholism
Use: Cigarettes(____) packs per day
Cigars, Pipe, Chewing Tobacco, Snuff
How long?_____
Do not smoke now but have in past
Diet_____

EXERCISE: Type_____
_____
_____
Frequency, distance or amount_____
_____

(PLEASE TURN OVER)

HOSPITALIZATIONS: List all hospitalizations (for illness or surgery), beginning with the most recent.

Date	Reason	Hospital	M.D.

Circle any of the items below that apply to you…other than those mentioned in the above hospitalizations.

SYSTEM REVIEW:

Any eye disease, injury, impaired sight
Any ear disease, injury impaired hearing
Any trouble with nose, sinuses, mouth, throat
Problems with your teeth
Fainting spells
Convulsions or seizures
Paralysis or numbness
Dizziness
Frequent or severe headaches
Difficulty remembering or concentrating
Difficulty sleeping
Frequent crying spells
Difficulty related to work or family problems
Thoughts about committing suicide
Enlarged glands
Enlarged thyroid or goiter
Skin problems
Lumps in your breasts
Chronic or frequent cough
Chest pain or angina pectoris
Spiting up of blood
Night sweats
Shortness of breath
Palpitation or fluttering heart
Heart murmur
Swelling of hand, feet or ankles
Extreme tiredness or weakness
Varicose veins
Kidney disease or stones
Bladder disease
Albumin, sugar, pus, blood in urine
Difficulty urinating
Get up at night to urinate
Abnormal thirst
Stomach trouble or ulcer
Indigestion or heartburn
Liver or gallbladder disease
Colitis or other bowel disease
Hemorrhoids or rectal bleeding
Constipation or diarrhea
Recent change in appetite or eating habits
Recent change in bowel habits or stools
Black bowel movements
Stiff, painful or swollen joints
Sexual difficulties
Sex is not entirely satisfactory

Have you had a sigmoidoscopy: Yes No Date_____

X-RAYS: Have you had X-rays of:

Chest Stomach (Upper GI)
Back Colon (Barium enema)
Extremities Gallbladder
Other _____

EKG: Have you had an electrocardiogram: Yes No

IMMUNIZATIONS: Have you had these immunizations:

Measles and Mumps
Smallpox
Tetanus (date of last shot)_____
Polio within last 10 years
Diphtheria within last 10 years
Influenza within last year
Pneumovax

DRUGS: Do you use:

Marijuana: Never Occasionally Regularly
Other drugs: e.g., LSD, other_____
Never Occasionally Regularly

DES Exposure: Yes No
Exposure to insecticides Yes No Type_____

Circle those used below:

Laxatives Aspirin
Vitamins Cortisone
Tranquilizers Appetite depressants
Sleeping pills Antacids

Have you been treated for drug abuse: Yes No
Have taken insulin or tablets for diabetes: Yes No
Have taken hormone shots or tablets: Yes No

Present medications: List all prescription drugs that you are presently taking:

Medication	**Dose**	**Frequency**

MEN ONLY

Have you ever had swelling of or lumps on testicles? Yes No
Current method of birth control_____

WOMEN ONLY

Menstrual History: Age of onset _____
Date of last period: _____/_____/_____
Cycle (from start to start) _____days
Usual duration of flow is _____days
Flow is: heavy medium light
Pain or cramps
Periods are irregular
Have had vaginal infections or frequent discharge Yes No
Have taken birth control pills or used an IUD Yes No
Have had abnormal PAP Yes No
Current method of birth control_____
Pregnancies: Total number _____
How many children born alive? _____
How many stillbirths? _____
How many premature? _____
How many Cesarean sections? _____
How many miscarriages? _____
How many abortions? _____
Date of last mammogram _____/_____/_____

Physician's Signature

Date Reviewed

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

La Jolla Village Family Medical Group is required, by law, to maintain the privacy and confidentiality of your protected health information (PHI) and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care InformationTreatment

We can use or share your health care information to provide, coordinate or manage your health care and any other related services. This includes the coordination or managemeent of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

It is our policy to provide a substitute health care provider, authorized by La Jolla Village Family Medical Group to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care providers absence due to vacation, sickness, or other emergency situation.

Payment

We can use and share your health information with your insurance provider for the purpose of payment or health care operations.

As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment for health care services La Jolla Village Family Medical Group rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received. **Workers' Compensation:** We can use or share health information about you for workers' compensation claims.

Emergencies and Death

We can use or share your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death. We can share health information about you with a coroner, medical examiner, or funeral director when an individual dies.

Public Health and Public Safety

As required by law, we may use or share health information about you to help with public health and safety for certain situations such as preventing or controlling disease, injury or disability, reporting child abuseor neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposures. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Judicial and Administrative Proceedings

We can use or share health information about you to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Specialized Government Agencies:

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Organ Donation and Research

We can use or share health information about you with organizations involved in procuring, banking, or transplanting organs and tissues. We can share health information about you to researchers conducting approved institutional Review Board research.

Notifications

As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Change of Ownership

In the event that La Jolla Village Family Medical Group is sold or merged with another organization, your health Information record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that La Jolla Village Family Medical Group is not required to agree to the restriction that you request. You have the right to inspect or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. You have a right to request that La Jolla Village Family Medical Group correct health information about you that you think is incorrect or incomplete. Ask us how to do this. Please be advised, that La Jolla Village Family Medical Group is not required to agree to your request. If your request is denied, we will tell you why in writing within 60 days. You will be provided with instructions on how you can appeal the denial. You have a right to receive an accounting of disclosures of your protected health information made by La Jolla Village Family Medical Group. You have a right to a paper or electronic copy of this Notice of Privacy Practices at any time upon request.

Our Responsibilities

La Jolla Village Family Medical Group is required by law to maintain the privacy and security of your health information. We will let you know promptly if a breach occurs that may have compromised the privacy and security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in wrting if you change your mind. Write to us at 4520 Executive Dr, Ste 105, San Diego, CA, 92121.

Complaints

Complaints about your Privacy rights, or how La Jolla Village Family Medical Group has handled your health information should be directed to Grace Macias by calling this office at 858-450-5900. If Grace Macias is not available, you may request an appointment for a personal conference by telephone or in person within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201

For more information go to **www.hhs.gov/ocr/privacy/index** and select **How to File a Complaint**. You may also call 1-877-696-6775.
We will not retaliate against you for filing a complaint.

Changes to this Notice of Privacy Practices

La Jolla Village Family Medical Group reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, La Jolla Village Family Medical Group is required by law to comply with this Notice. This notice is effective as of April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide La Jolla Village Family Medical Group with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in this Privacy Notice.

Patient's Name (print) _____

Patient's Signature _____ Date_____

Authorized Facility Signature_____ Date_____

Restrictions _____

_____