PATIENT INFORMATION FOR MEDICAL RECORDS:

La Jolla Village Family Medical Group
8950 Villa La Jolla Dr. Suite C129, La Jolla CA 92037

SSN _____

NAME _____ **DOB**_____
(PLEASE PRINT) LAST FIRST M.I.

HOME ADDRESS _____
CITY STATE ZIP

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

HOME PHONE_____ **CELL PHONE**_____ **WORK PHONE** _____
(Please circle which of the above you consider primary)

EMAIL* _____
*In compliance with HIPPA protections, no personal health information may be transmitted via direct email. We may only use direct email to confirm appointments and/or transmit other non-protected information. See page 2 regarding our secure patient portal.

SEX: • MALE • FEMALE **GENDER IDENTITY: • MALE • FEMALE • OTHER** _____

ARE YOU CURRENTLY EMPLOYED? • YES • NO If yes, please complete the information below:

NAME OF EMPLOYER _____

EMPLOYER ADDRESS _____
CITY STATE ZIP

RELATIONSHIP STATUS: **• SINGLE • MARRIED • DIVORCED • SEPARATED • WIDOW/ER**

EMERGENCY CONTACT NAME_____ **RELATIONSHIP**_____

EMERGENCY CONTACT PHONE_____ **May we discuss your medical care with this person? • YES • NO**
*If you would like to authorize other individuals we may discuss your record with, please ask the receptionist for an additional form.

IF SOMEONE OTHER THAN PATIENT IS FINANCIALLY RESPONSIBLE PLEASE COMPLETE:

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

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

PRIMARY HEALTH INSURANCE INFORMATION: (Please have insurance cards available for receptionist to scan)

NAME OF PLAN _____

MEMBER NAME _____ **MEMBER ID** _____**EFFECTIVE DATE** _____

ARE YOU: • PRIMARY MEMBER • SPOUSE • CHILD

SECONDARY HEALTH INSURANCE INFORMATION, IF APPLICABLE: (Please have insurance cards available for receptionist to scan)

NAME OF PLAN _____

MEMBER NAME _____ **MEMBER ID** _____**EFFECTIVE DATE** _____

ARE YOU: • PRIMARY MEMBER • SPOUSE • CHILD

PATIENT PREFERENCES:

PREFERRED METHOD OF COMMUNICATION: • Home Phone • Cell Phone • Home Address • Secure Portal*

* Our secure patient portal, which requires registration, allows you secure access to your private health information as well as the ability to communicate directly with your preferred medical provider and other individuals at our office. May we email you a registration link? • YES • NO (If yes, please be sure to provide email address above)

If we contact you via telephone and you are not available to answer, may we leave a detailed message which may include personal health information? • YES • NO
If yes, at which phone number(s)? _____

PREFERRED METHOD(S) OF APPOINTMENT REMINDERS (may choose multiple): • Automated call • Email • Text

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PLEASE TELL US HOW YOU LEARNED ABOUT OUR MEDICAL PRACTICE:

I WAS REFERRED BY SOMEONE: • A FRIEND • MY INSURANCE CARRIER • ANOTHER HEALTH CARE PROVIDER

IF YOU HEARD ABOUT US IN SOME OTHER WAY, PLEASE SELECT:

- I FOUND YOU ON THE INTERNET
- I SAW YOU ON ANOTHER HEALTH SITE (PLEASE SPECIFY WHICH SITE) _____
- I CHOSE YOU FROM A LIST PROVIDED BY MY HEALTH PLAN
- I SAW A REVIEW ON YELP, GOOGLE, HEALTHGRADES OR A SIMILAR SITE (PLEASE SPECIFY) _____
- I SAW AN ADVERTISEMENT (PLEASE SPECIFY WHERE) _____
- OTHER (PLEASE SPECIFY) _____

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

ASSIGNMENT OF HEALTH INSURANCE BENEFITS:

I, the undersigned, assign all surgical and/or medical benefits that would otherwise be payable to me by my Health Insurance Plan for services rendered by the physicians and staff of La Jolla Village Family Medical Group directly to Daniel Michaels, M.D., Inc. D/B/A La Jolla Village Family Medical Group and authorize the medical group to release any information necessary to secure the payment of those benefits. I understand that I am financially responsible for all charges whether or not paid by insurance and acknowledge that there is a $25 no show/cancellation fee for all appointments not cancelled at least 24 hours before my scheduled appointment time.

SIGNATURE _____ **DATE** _____

NO GUARANTEE OF PRACTICE ACCEPTANCE DISCLAIMER:

I, the undersigned, understand that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice and that my health history will be reviewed and an initial evaluation will be completed to determine whether the practice can adequately serve my health care needs before accepting me as a patient. I further understand that should it be determined that La Jolla Village Family Medical Group cannot adequately address my needs, I will be referred to another medical provider or back to my insurance plan.

SIGNATURE _____ **DATE** _____