PATIENT INFORMATION

Referred By:_____

Date: _____ Pharmacy Name, Phone & Location: _____
Last Name: _____First Name: _____Middle Name:_____
Date of Birth: _____ Gender: ____ SSN: _____ Marital Status: _____
Drivers License: _____ Primary Language: _____

Race:

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Nat Hawaiian/Native Islander
- ☐ White
- ☐ Other Race
- ☐ Decline

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline

Address: _____ Apt #_____
Zip: _____ City: _____ State: _____
Preferred Primary Phone: (____) _____Type:_____ Second: (____)_____Type: _____
Employer Name:_____ Occupation:_____
Emergency Contact: _____ Relationship: _____ Phone: (___)_____

Patient Portal ☐ Yes Email Address:_____
☐ No

INSURANCE INFORMATION

Primary Ins. Co:_____

Ins Type: (Check one) HMO PPO WC MVA EPO OTHER _____ Effective Date: _____
Policyholder:_____ DOB: _____

Relationship to Patient:_____ ID #: _____ Group #: _____

Policyholder SS#: _____ Policyholders Employer: _____Address:_____

Secondary Ins. Co:_____

Ins Type: (Check one) HMO PPO WC MVA EPO OTHER _____ Effective Date: _____
Policyholder:_____ DOB: _____

Relationship to Patient:_____ ID #: _____ Group #: _____

Policyholder SS#: _____ Policyholders Employer: _____Address:_____

Assignment of Benefits, Eligibility Guarantee and Missed Appointment Policy

I request that payment of authorized insurance benefits be made on my behalf to San Diego Sports Medicine and Family Health Center (SDSMFHC) for any services rendered. I authorize SDSMFHC to release to my insurance plan and its agents any information needed to determine these benefits. I hereby certify that I am eligible for the above named health plan and, if applicable, have chosen a physician from SDSMFHC to be my primary care physician. I understand that if I am not eligible under the terms of my health plan, I am liable for all charges for services rendered. I also agree to pay in full for all non-covered services within 30 days of notification of non-coverage. I authorize SDSMFHC to obtain information as needed from other medical providers and pharmacies in order to provide safe and comprehensive health care. I understand that SDSMFHC will charge a $25.00 fee for missed appointments scheduled that are not cancelled with at least 24 hours notice.

_____ _____
Signature of Patient or Parent/Guardian/Policyholder Date

AUTHORIZATION TO TREAT A MINOR
For patients under age 18

In the event of a medical emergency, I authorize the physicians and staff of San Diego Sports Medicine and Family Health Center to provide necessary medical care to the patient named on the reverse side of this paper, if the parent/guardian is unable to be reached for authorization.

I understand this authorization is revocable at any time by notifying San Diego Sports Medicine and Family Health Center in writing.

Please sign below *if* you would like this authorization on file:

_____ _____.

Signature of Parent/Guardian Date

ADVANCE DIRECTIVES
For patients age 18 and over

A federal law requires us to give you information about your rights to make health care decisions. Your doctor must tell you about your medical condition and about what different treatments can do for you, and how you can plan what should be done when you cannot speak for yourself. In the event you become too sick to make medical decisions, it is helpful if you say in advance what you want to happen with your medical treatment. There are several kinds of "advance directives" that you can use to say what you want and who you want to speak for you.

If you would like more information about advance directives, please notify your nurse or doctor. We have additional information to assist you in making these important decisions.

Please sign below acknowledging the availability of information regarding **Advance Directives.**

_____ _____.

Signature of Patient over age 18 Date

SAN DIEGO SPORTS MEDICINE
FAMILY HEALTH CENTER

First and Last Name:_____ **DOB:**__/__/____ **Gender:**_____ **Phone No.:**_____

Past Medical History

(Please check any of the following that you presently have or had in the past and write the approximate date)

☐ Asthma	_____	☐ Arthritis	_____	☐ Allergies	_____
☐ Anemia	_____	☐ Alcoholism	_____	☐ Cancer	_____
☐ Colitis	_____	☐ Depression	_____	☐ Diabetes	_____
☐ Epilepsy	_____	☐ Fractures	_____	☐ Headaches	_____
☐ High Blood Pressure	_____	☐ Heart Disease	_____	☐ Kidney Problem	_____
☐ Major Injuries	_____	☐ Mental Illness	_____	☐ Obesity	_____
☐ Osteoporosis	_____	☐ Strokes	_____	☐ Thyroid Problem	_____
☐ Tuberculosis	_____	☐ Ulcers	_____	☐ Other	_____
☐ No pertinent history					

Past Surgical History

(Please check all of the following surgeries you have had. For all surgeries, please enter date or surgery. If actual date is unknown, please put approximate date)

☐ Abdominal	_____	☐ Arm	_____	☐ Back	_____
☐ Brain	_____	☐ Breast	_____	☐ Caesarian	_____
☐ Cardiovascular	_____	☐ Eye	_____	☐ Finger	_____
☐ Foot	_____	☐ Hand	_____	☐ Head	_____
☐ Hip	_____	☐ Hysterectomy	_____	☐ Knee	_____
☐ Leg	_____	☐ Lung	_____	☐ Neck	_____
☐ Shoulder	_____	☐ Vasectomy	_____	☐ Other	_____
☐ No Surgeries	_____				

Current Medications

(Please list all current medications, including dosage and how often you take it)

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies

(Please list all current allergies to medications)

_____

_____

_____

☐ No Medication Allergies

Family Medical History

(Please check any of the following that any of your relatives have or had. For Family History, please indicate which family member has this and which side of your family they are from. Include any applicable dates and ages)

☐ Asthma	_____	☐ Arthritis	_____	☐ Allergies	_____
☐ Anemia	_____	☐ Alcoholism	_____	☐ Cancer	_____
☐ Colitis	_____	☐ Depression	_____	☐ Diabetes	_____
☐ Headaches	_____	☐ High Blood Pressure	_____	☐ Heart Disease	_____
☐ Kidney Problem	_____	☐ Mental Illness	_____	☐ Obesity	_____
☐ Osteoporosis	_____	☐ Strokes	_____	☐ Suicide	_____
☐ Thyroid Problem	_____	☐ Tuberculosis	_____	☐ Ulcers	_____
☐ Other	_____				
				☐ No Pertinent History	

(please continue on reverse)

SAN DIEGO SPORTS MEDICINE FAMILY HEALTH CENTER

Reproductive History

Age Menarche: _____ Menses Duration: _____
Last Menstrual Period: _____ Menopause Status: _____
Method of Birth Control: _____ Age Menopause: _____
Breakthrough Bleeding: _____

Pregnancy Summary

Total: _____ Full Term: _____
Premature: _____ Abortion Induced: _____
Abortion Spontaneous: _____ Ectopic: _____
Living: _____

Birth History

(Please enter your personal history or your child's birth history if filling out for your child)

Full term(38-40 weeks): _____ Vaginal or Caesarian: _____
Infections during Pregnancy: _____ Birth Weight: _____
Gestational Diabetes: _____ Stay in NICU: _____
If Yes, Why: _____
Hypertension During Pregnancy: _____ Breast or Bottle Fed: _____

Social History

Current Diet: _____
Education Level: _____
Current Exercise: _____
Home Environment: _____
(Whom do you live with) _____
Marital Status: _____
Military History: _____
Occupation: _____
Parents _____
Siblings: _____
Sleep: _____
Stress: _____
Alcohol Use: _____
Caffeine Use: _____
Tobacco Use: _____
Other Substance Abuse: _____

Acknowledgement of Receipt of Notice of Privacy Practices

San Diego Sports Medicine and Family Health Center
6699 Alvarado Road, Suite 2100 and 2101, San Diego, CA 92120
4010 Sorrento Valley Blvd., Suite 300, San Diego, CA 92121
1945 Garnet Ave., San Diego, CA 92109
Privacy Officer: Office Manager, Phone No. 619-229-3909

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at future office visits as any amendments are made.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship: ☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

Methods of Communication Request

I request the use of the following methods of communication of information related to my personal health, treatment or payment for treatment. I acknowledge that I am responsible for updating this information as necessary. This request supercedes any prior request for methods of communication I may have made.

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

☐ **Phone** You may contact me by telephone at _____

May we leave messages concerning results of laboratory work, other diagnostic testing, or referrals to other providers on your answering machine or with someone in your household?

☐ **Yes** ☐ **No**

Do you wish for our physicians and staff to have detailed conversations concerning your health care and condition with family members or designated others?

☐ **Yes** **Name & Relationship** _____
Name & Relationship _____

☐ **No**

☐ **Mail** (at the address provided on the registration paperwork)

☐ **E-mail** You may contact me at the following e-mail address: _____

☐ **Fax** You may contact me at the following fax number: _____

(Not all physicians and/or staff have access to e-mail for the purposes of communicating with patients. By providing your e-mail address or fax number, you are authorizing our physicians and/or staff to communicate with you by e-mail or fax, the content of which may include protected health information. You agree that we are not responsible for the interception of those messages by others.)

Signed: _____ Date: _____

Print Name: _____