UCSD INTERNAL MEDICINE – VISTA
PATIENT REGISTRATION

Date ____________________ COMPLETED BY: ______________________

PATIENT NAME: ____ DOB: __________________ SEX: M F

ADDRESS: ____

CITY: ___________________________________ STATE: _______ ZIP ____

HOME PHONE: ___________________________ CELL # ___________________________ EMAIL ________________________

REFERRED BY: ___________________________ MAY WE LEAVE A TEST RESULT OR MESSAGE ON YOUR HOME PHONE: Y N

SOCIAL SECURITY _________________________ MARITAL STATUS __________________ U S CITIZENSHIP Y N

RACE (circle one)

Asian	Chinese	Japanese	Native Amer/Eskimo	Pacific Islander
Asian Indian	Filipino	Korean	Samoan	Other SE Asian
Black	Guamanian	Laotian	Vietnamese	Unknown
Cambodian	Hawaiian	Middle Eastern	White	

ETHNICITY: (circle one) Hispanic Non-Hispanic Refused/unknown

RELIGION: ____________________ PERFERED LANGUAGE _________________ INTERPRETER NEEDED Y N

PLACE OF BIRTH: City & State ____ VETERAN Y N

EMPLOYMENT STATUS: (circle one) Full time Part-Time Student Retired Unemployed Disabled

EMPLOYER: ____ WK PHPONE: ___________________________

WORK ADDRESS : ____ CITY _________________ ZIP _____________

EMERGENCY CONTACT: __________________________ PHONE ______________________ RELATIONSHIP ______________

Is Emergency Contact Hearing Impaired? Y N Is Emergency Contact Visually Impaired? Y N

FORM CONFIDENCE: (Understanding questions on form) VERY GOOD GOOD AVERAGE NOT GOOD

PRIMARY INSURANCE	**SECOND INSURANCE**
PRIMARY INS: ___________________________________	SECOND INS: ______________________________
PLAN TYPE: HMO PPO ________________	PLAN TYPE: HMO PPO ___________________
POLICY ID# ______________________________________	POLICY ID# _________________________________
GROUP # ____	GROUP # ____________________________________
SUBSCRIBER NAME: _______________________________	SUBSCRIBER NAME: ________________________
SUBSCRIBER DOB: _________________________________	SUBSCRIBER DOB: __________________________
SUBSCRIBER EMP: ________________________________	SUBSCRIBER EMP: __________________________
SUBSCRIBER SSN : ________________________________	SUBSCRIBER SSN: __________________________
RELATIONSHIP TO SUBSCRIBER : ______________________	RELATIONSHIP TO SUBSCRIBER: ________________

UC San Diego
HEALTH SYSTEM

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE
(Please Complete Both Pages)

Name __________________________________ Date of Birth __________ Age ______ Today's Date _______

SURGERIES (include skin, eye, orthopedic, etc.):

Type of Surgery	Month/Year	Type of Surgery	Month/Year
1. ______		4. ______	
2. ______		5. ______	
3. ______		6. ______	

MEDICAL HISTORY (i.e.: ulcers, stroke, high blood pressure, arthritis, thyroid, cholesterol, etc.):

Please list the medical problem(s) that prompted you to see the doctor.

Type of Problem	Approx. Date of Onset	Type of Problem	Approx. Date of Onset
1. ______		5. ______	
2. ______		6. ______	
3. ______		7. ______	
4. ______		8. ______	

Last Menstrual Period: ________________________ Number of Pregnancies: ____________ G P A L

Colonoscopy (date): __________________________ Last Mammogram Date: _______________________

Date of Last Pneumo Vaccination: ______________ Last Pap Test Date: ___________________________

Last FLU Vaccination.: ________________________ Last Bone Density: ____________________________

CURRENT MEDICATIONS (include over-the-counter medications):

Name	Dose (milligrams)	How Often/Day	Name	Dose (milligrams)	How Often/Day
1. ______			6. ______		
2. ______			7. ______		
3. ______			8. ______		
4. ______			9. ______		
5. ______			10. ______		

DRUG ALLERGIES:

Name of Drug	Type of Reaction (i.e. rash, hives, shortness of breath, upset stomach, etc.)
______	______
______	______

HABITS:

Please list any special dietary restrictions or diet followed: ______________________________________

How many cups of coffee or other caffeinated beverages do you drink per day? ______________________

Do you use tobacco? ________ Did you use tobacco in the past? ________ What year did you quit? ________

How many packs per day? ____________ How many total years have you used tobacco? ________________

Do you drink alcohol? _____________ How much per day? _____________ Type? ______________________

Have you ever used intravenous drugs? (this information will remain confidential) ______________________

Please check one: ☐ Heterosexual ☐ Bisexual ☐ Homosexual

Calcium Intake: Supplements/Dairy Products (amount, type, frequency) _______________________________

Exercise: Type ___________________________ Duration ____________________ Frequency________________

FAMILY HISTORY (Cancer, Diabetes, Dementia, Coronary Disease, Osteoperosis, Other):

	Deceased or Living	Age (current or at death)	Diagnosis or Cause of Death
Father	__________________	______________________	_________________________________
Mother	__________________	______________________	_________________________________
Brothers	__________________	______________________	_________________________________
	__________________	______________________	_________________________________
	__________________	______________________	_________________________________
Sisters	__________________	______________________	_________________________________
	__________________	______________________	_________________________________
	__________________	______________________	_________________________________

# of Sons __________________ Illnesses ____

# of Daughters __________________ Illnesses ____

SOCIAL HISTORY:

Occupation: ____

Marital Status: ______________________________________ How Long? ________________________________

Hobbies: ____

Toxic Chemical Exposures: ____

MEDICAL ILLNESSES AND SYMPTOM REVIEW:

Please check the box if you have had any of the following illnesses or symptoms.

1. Recent fever
2. Recent weight change
3. Excess fatigue or weakness
4. Diabetes
5. Thyroid or other hormonal problem
6. Any type of cancer
7. Anemia or other blood disorder
8. Previous blood transfusion
9. Skin rash or unusual mole
10. Glaucoma or other eye problem
11. Recent ear, nose, throat problem
12. Hay fever or sinusitis
13. Exposed to excess dust, toxic chemicals or fumes
14. Chronic lung disease or asthma
15. New or chronic cough
16. Unusual shortness of breath with moderate activity or exercise
17. Shortness of breath caused by lying flat
18. Swelling in feet or ankles
19. High blood pressure
20. High cholesterol/triglycerides
21. Any type of heart disease
22. Previous heart attack
23. Previous heart murmur
24. Recurrent chest pain/discomfort
25. Palpitation or irregular pulse
26. Leg cramps when walking
27. Blood clot in leg or lung
28. Recent abdominal pain
29. Recent nausea or vomiting
30. Change in bowel movements
31. Recent blood in stools/black stools
32. Heartburn
33. Stomach or duodenal ulcer
34. Spastic colon, diverticulosis, or recurrent colitis
35. Polyp or tumor of the colon
36. Hepatitis or liver disease
37. Any problem with urine flow, frequency
38. Kidney stones
39. Infection of kidney or bladder
40. Sexually transmitted disease
41. Sexual dysfunction
42. Prostate problem
43. Recent menstrual problem
44. Breast problems
45. Arthritis or painful joints
46. Chronic or new back pain
47. Difficulty walking
48. Recent dizziness
49. Fainting spells
50. Previous stroke
51. Seizures or tremor
52. Headaches
53. Feelings of depression
54. Insomnia

UC San Diego
HEALTH SYSTEM

Mary Jaramillo, M.D., Neil Levine, M.D., Charles Hergesherimer M.D.,
Karen Cadman M.D., Christine Nguyen M.D.

AUTHORIZED INDIVIDUALS FORM

Please list all individuals that are authorized to receive your medical information either verbal or written.

NAME	Phone	Relationship
______________________________	__________________	_______________________
______________________________	__________________	_______________________
______________________________	__________________	_______________________
______________________________	__________________	_______________________
______________________________	__________________	_______________________
______________________________	__________________	_______________________
______________________________	__________________	_______________________
______________________________	__________________	_______________________
______________________________	__________________	_______________________

____

Signature of Patient Print Name

____
Date

OUR OFFICE POLICIES

Welcome to U.C. San Diego Health System. We are pleased you have chosen us as your primary care physicians. The following is a brief description of our office policies. Please read to help insure all aspects of your medical care is handled effectively and without unnecessary delays.

OFFICE HOURS

The office is open from 8:15 am to 5:00 pm, Monday through Friday, except for major holidays.

LAB HOURS

Our Lab is open 8:30 am to 4:30 pm, Mondays through Thursdays, and Fridays 9:00 am to 4:30 pm. We are not open weekends.

PHONE CALLS DURING OFFICE HOURS

We can often meet your needs with advice over the phone. Each physicians has their own Medical Assistant and voicemail system. To save time, travel and the cost of an office visit, you may call the office and leave a message on the voicemail for the Medical Assistant to your physician. Your call will be returned in order of priority.

If you are ill and feel your condition may require an appointment, your call may be directed to our RN triage nurse. She will assess your symptoms to determine if a visit with your physician is necessary.

If your usual physician is not available to see you on a same day appointment, you will be offered an appointment with a physician who has available time in their schedule.

PLEASE DO NOT LEAVE EMERGENCY MESSAGES ON THE VOICE MAIL SYSTEM. If you feel you have an emergency, please inform the receptionist.

SCHEDULING APPOINTMENTS

WE SEE PATIENTS BY APPOINTMENT ONLY. Please make your follow-up appointment with our receptionist before you leave the office. If you are scheduling a yearly physical exam, most insurances require a full 12 months from your previous physical. Because we allow extra time for this type of appointment, we limit the number we schedule daily. There may be a wait of several weeks in the schedule for a routine physical exam.

COPAYS

Insurance co-pays are due payable at the time of your visit. We accept cash, check or MasterCard. There is a $25.00 administrative fee charge if you require us to bill you for your co-pay.

PRESCRIPTIONS AND REFILLS WE REQUIRE 48 HOURS FOR REFILLS**.**

If you need a new prescription called to a local pharmacy please leave your request on the medical assistant's voicemail. Be sure to include the pharmacy location and phone number, the medication name, strength or milligram, and how many times daily you take this medication. If you are requesting a written prescription to mail away, most mail away RX's are for 90 day supplies. Some types of medications require that you pick up the prescription at the front desk. Medications that require a prior authorization can take 1 to 2 weeks for approval to be obtained. If your request if for a medication that we have filled for you in the past, please have the pharmacy FAX us a request for a refill. This is the most direct and efficient way of obtaining a refill of a regular medication.

NARCOTICS OR SEDATIVES ARE NOT PRESCRIBED OR REFILLED AFTER OFFICE HOURS, OR ON WEEKENDS.

STATEMENT OF FINANCIAL POLICY

U.C. San Diego Health System is a provider for many insurance plans and will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and receive payment directly from them. However, to avoid any confusion, be aware that we do expect payment of any applicable deductible, copayments or co-insurance amounts at the time of service. Also, any services that your insurance will not cover are your responsibility.

If your insurance requires prior authorization for any of your treatment here, and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred. If your insurance subsequently authorizes today's services, your payment will be refunded upon receipt of insurance payment.

If we are not a participating provider for your insurance plan, we will still bill your insurance directly if you have provided us with complete information to do so. You may receive a statement for the entire charge prior to your insurance paying. You may wait to pay us until after the insurance has paid its portion providing the insurance company pays within 30 days.

If you do not have insurance, payment is expected at the time of service. We accept Visa and MasterCard for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

If you need our doctor to complete forms, (such as for disability, Department of Motor Vehicles, Assisted Living Admission Forms or other physician report forms), there will be a $75.00 fee per form.

Statements are mailed monthly to patients with an outstanding balance. We may assess interest at the rate of 1% per month on all accounts over 60 days. If you are unable to pay your balance within 30 days, please contact the Billing Office at (760) 598-1700 to make payment arrangements, unless a payment schedule already exists.

If you must cancel your appointment, please give us at least 24-hours' notice so we can schedule another person in your place. There is a Missed Appointment Fee of $40.00 charged for appointments not cancelled with 24-hours notice. This fee will be waived if a phone call is received within the specified timeframe or if documentation of an emergency can be provided.

Billing Office hours are 8:30 A.M. to 4:30 P.M., Monday through Friday. If you reach our voicemail, please leave a detailed message and we will return your call as soon as possible.

Thank you for choosing U.C. San Diego Health System.

I have read and understand the U.C. San Diego Health System financial and claims filing policies.

PRINT PATIENT NAME ____

Patient Signature ____ Date ________________

Responsible Party Signature _______________________________________ Date ________________

UC San Diego
HEALTH SYSTEM

Make Your Wishes Known

Imagine...

A drunken driver crashes into your car, causing severe head injuries and brain damage. For six months you are in a coma from which your doctors say you will never emerge. However, artificial feeding and other measures could keep you alive for years. Should your relatives ask that the feeding tubes be removed to allow you to die?

As a competent adult, you have the right to decide to accept or refuse any medical treatment. (Competent means you understand your condition and the results your decision will have). As long as you are competent, you are the only person who can decide what medical treatment you want and do not want to receive. Your doctors will give you information and advice about the pros and cons of different types of treatments, but it is your decision.

Someday you may become too sick to make your own decisions about your medical care. If that happens, the decisions will have to be made for you. It can be hard for doctors and your loved ones to know what kind of treatment you want when you are too sick to tell them. If you have not given any written instructions, no one will know what you want.

What is an Advance Health Care Directive?

An Advance Health Care directive is a free document giving direction to health care providers about treatment choices in certain situations. An "Advance Health Care Directive" allows you to do two things:

First, you may appoint another person to be your health care "surrogate". This person serves as your surrogate decision maker regarding health care decisions should you lose the capacity to make your own decisions. The person you choose should be the person who would be most familiar with your wishes and values and could speak for you.

Second, you may write down some of your own health care wishes in your Advance Directive. For example, if you become so ill that there is no realistic hope of recovering, you may not want doctors to continue treating you aggressively with treatments that might only result in prolonged suffering. You might also state that under those circumstances, you would want your pain treated sufficiently, even if that caused you to die sooner.

The best way to make sure your wishes are respected is to discuss them with your health care provider and your loved ones while you are healthy and then fill out an advance health care directive form. Once completed, copies should be given to your health care provider and those closest to you so they can carry out your wishes if necessary. You may change your mind or revoke your advance directive at any time, but you must be sure to discuss your wishes with the doctors who are caring for you.

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