

Today's Date

PACIFIC COAST PHYSICIANS

689 Tank Farm Road, Suite 220, San Luis Obispo, CA 93401 (805) 541-1177 Fax (805) 541-4973

Patient Information - Please Print

Full Legal Name (First) (Middle) (Last) Name normally used (Nickname)

Address (Number) (Street) (Apt #)

City State Zip Code Social Security Number Home Phone

Date of Birth Age Sex Marital Status Occupation

Employer Name Employer Street Address City State Zip

Business Phone Ext Your Driver's License # State

Nearest Relative (Name, Address, Phone Number)

Spouse's Information

Full Legal Name (First) (Middle) (Last) Occupation

Address (If different from above) City State Zip Code Home Phone

Employer Name Street Address City State Zip Code Business Phone Ext

Insurance Information

Primary Insurance Company Name Group # ID/Certificate #

Subscriber Name Where to send claim

Secondary Insurance Company Name Group # ID/Certificate #

Other Insurance Information

Emergency Information

Person to Notify in Case of Emergency (NOT LIVING WITH YOU) Relationship

Address (Number) (Street) (Apt #)

City State Zip Code Home Phone

Other Information

Other Doctors you see

How did you hear about us?

Assignment of Benefits - Financial Agreement

Insurance will be billed for all PPO's, HMO's and EPO's with which you are contracted. Co-pays are payable at the time of service. PLEASE NOTE THAT YOU ARE RESPONSIBLE FOR PAYMENT OF ALL FEES FOR PROFESSIONAL SERVICE EVEN THOUGH YOU MAY HAVE INSURANCE COVERAGE- this means that should the insurer fail to pay any sums due, you are responsible for payment.

I understand that I am responsible for all laboratory, radiology or other outside costs including Pap smears, blood tests, pathology and cultures. I understand that if my insurance requires special handling or specific locations for testing, it is my responsibility to notify you before my exam or before going to the lab.

I HAVE READ AND UNDERSTOOD THE ABOVE _____

Signature

Date

PAYMENT OF SERVICES

I realize that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier.

PATIENT SIGNATURE (OR PARENT FOR MINOR)

DATE

INSURANCE BENEFITS AND INFORMATION RELEASE AUTHORIZATION

I hereby authorize the Doctor to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and hereby authorize payment of the insurance benefits directly to the Doctor for any services rendered that are not paid for directly by me.

PATIENT SIGNATURE

DATE

MEDICARE AUTHORIZATION

HEALTH INSURANCE # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to physician/provider _____ for any services furnished me by that physician/provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT SIGNATURE

DATE

AUTHORIZATION TO TREAT MINOR

As the parent/guardian of the above named child/minor, I hereby give permission to the Doctor above to treat the child/minor in the event that a medical emergency arises and I am unable to personally consent to the treatment. I also agree to be responsible to the Doctor for charges for medical services rendered.

PATIENT/GUARDIAN SIGNATURE

DATE

Name: _____ Age: _____ Date: _____

Medical:

Doctors you see now _____

Doctors you have seen in the past _____

Current Medical Problems _____

Other Medical Concerns you would like to discuss with the doctor _____

Medications:

List prescription medicines you take now (include dose, reason you take it & who prescribed it)

List over-the-counter medicines, vitamins and food supplements you take: _____

Allergies:

Sensitivities:

Medical History:

Do/did you exercise? _____ How much? _____ hrs/wk, # of years _____ Year quit _____

Do/did you smoke? _____ How much? _____ packs/day, # of years _____ Year quit _____

Do/did you drink alcohol? _____ How much? _____ drinks/week, # of years _____

Year quit _____ Previous/Current problems with alcohol? _____ AA? _____

Do/did you use (circle): caffeine NutraSweet Marijuana Cocaine Chewing Tobacco diet pills

Do you wear seatbelts? _____ Do you wear sunscreen? _____ Ride a motorcycle/bicycle _____

List Surgeries you have had (include year, surgeon, and hospital)

Describe Hospitalizations/Illnesses not included above (include year, hospital): _____

Have you had (circle)

- | | | | |
|----------------------|--------------------|---------------------|--------------------|
| 1. Migraines | 8. Drug Addiction | 15. Psoriasis | 22. Depression |
| 2. Hepatitis | 9. Gallstones | 16. Heart Murmur | 23. Gout |
| 3. Mono | 10. Tuberculosis | 17. Rheumatic fever | 24. Mental Illness |
| 4. Ulcer | 11. STDs | 18. Polio | 25. Alcoholism |
| 5. Bleeding Problems | 12. Seizures | 19. Shingles | 26. Hemorrhoids |
| 6. Blood Clots | 13. Memory Trouble | 20. Hearing Trouble | 27. Other: _____ |
| 7. Head Injury | 14. Arthritis | 21. Vision Trouble | |

WOMEN

Age of first period _____ Date of last normal period _____ #of pregnancies _____

of live births _____ # of children living with you _____ Birth control method _____

Date of last Pap _____ Done where _____ Date last Mammo _____ Done where _____

Do you have (circle):

- | | | | |
|-------------------------|--------------------|------------------------|------------------------|
| 1. Irregular periods | 5. Hot flashes | 10. Pelvic pain | 14. Vaginal odor |
| 2. Female trouble | 6. PMS | 11. Vaginal Discharge | 15. Abnormal Pap smear |
| 3. Vaginal Itching | 7. Heavy periods | 12. Abnormal Mammogram | |
| 4. Bad Menstrual cramps | 8. Vaginal Dryness | 13. Infertility | |
| | 9. Breast Problems | | |

Family History:

List diseases that run in your family _____

Who in your family has/had (circle if cause of death and write age at death)

- | | |
|-----------------------|---------------------------|
| Heart Disease _____ | Genetic Disorder _____ |
| Diabetes _____ | Cancer _____ |
| Thyroid Disease _____ | Alcoholism _____ |
| Mental Illness _____ | Arthritis _____ |
| Glaucoma _____ | Asthma _____ |
| Allergies _____ | Stomach Problems _____ |
| Tuberculosis _____ | High Blood Pressure _____ |

Personal Information:

Who lives in your household? _____

Where do/did you work? _____

Describe your education/upbringing, etc. _____

How much do you weigh? _____ How much would you like to weigh? _____ Heaviest Weigh? _____

When was your last:

- | | | |
|----------------------|-------------------------|-----------------------------|
| 1. Tetanus _____ | 5. Flu Shot _____ | 9. EKG _____ |
| 2. TB Test _____ | 6. HIV Test _____ | 10. Sigmoidoscopy _____ |
| 3. Chest X-ray _____ | 7. Pneumonia Shot _____ | 11. Hepatitis Vaccine _____ |
| 4. Rectal Exam _____ | 8. Blood Test _____ | |

Describe your diet: _____

Describe your skin problems: _____

Describe lung and breathing problems: _____

Describe heart problems: _____

Describe problems with your stomach, intestines, colon, digestions, bowel movements: _____

Describe any urinary trouble: _____

Describe sexual concerns: _____

Describe any bone, muscle or joint problems: _____

Describe and hormone problem: _____

Describe any problems with your thinking, concentration, moods, energy level, interest in life, etc.: _____

Describe any problems with strength, sensations, coordination, Neurologic function: _____

Anything else? _____

Sign: _____

Date: _____

