

Dear Patients:

In Order to expedite the conversion of your records to our new Electronic Medical Records System we need the following paperwork filled and out mailed back to the office:

1. PATIENT REGISTRATION: Please fill out completely, even if there are no changes.
2. HILLCREST INTERNAL MEDICINE: This is our company policies, sign and date; keep the yellow copy for your records.
3. HIPPA RELEASE AUTHORITY: This gives the office the authority to talk to the person of your choice regarding your medical care.
4. PRESCRIPTION HISTORY CONSENT: This gives the office consent to refill your medications.
5. ADVANCE DIRECTIVES AND DO NOT RESUSCITATE ORDERS: Please read the enclosed explanation, everyone should have one regardless of your age.
6. E-MAIL: Signing this gives the office permission to send letters, results etc. to your e-mail.

Also, please include a legible list of all your medications, including dosage and how you are taking them, for example:

Lipitor 80mg 1 tablet a day at bedtime
Diovan 160mg ½ tab daily

Also if you have a pharmacy you use exclusively please give us the name and phone number.

We appreciate your time and cooperation in helping us make this change.

The cost to you to mail back to the office will be .68

Thank-You

Hillcrest Internal Medicine

Health Questionnaire

Name :

Date of Birth :

Please list prior medical problems, hospitalizations, surgeries:

~~Which medications do you take? Please fill in or bring medication list.~~

Also list "as needed" medications, over-the-counter medications, herbal medications, vitamins, birth control pills.

<u>Name of medication:</u>	<u>Strength of dose:</u>	<u>How often taken:</u>
/	/	/
/	/	/
/	/	/
/	/	/
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Do you have any allergies?

no yes

To which medication/s: _____ Reaction: _____

Current/Prior occupation: _____ retired

What is your marital status: _____

List age and gender of children: _____

Do you exercise regularly (describe): _____

Are you following a special diet (describe): _____

What is your height: _____

What is your weight: _____

please turn page to continue

Do you or did you ever use tobacco? no yes
From age: _____ Quit date: _____ Amount per day on average: _____

Do you or did you ever drink alcohol? no yes
Number of drinks per week: _____

Have you ever used recreational/illegal drugs? no yes
Name of drug: _____ Last used: _____

What is your sexual orientation? Homosexual Heterosexual
Are you sexually active? no yes
Do you or your partner use birth control? no yes
Do you or your partner use condoms regularly? no yes

Please list health problems in your family members:

Father: alive at age _____ deceased at age _____ List health problems: _____

Mother: alive at age _____ deceased at age _____ List health problems: _____

Siblings: Please list health problems: _____

Children: Please list health problems: _____

Other Family: Please list relevant health problems: _____

Have you received the following immunizations?

Tetanus never yes Last shot: _____

Hepatitis B never yes Last shot: _____

Flu shot never yes Last shot: _____

Pneumonia shot never yes Last shot: _____

Have you ever had a colonoscopy (tube exam of large bowel): no yes

Date: _____ Result: _____

Do you have advance directives (living will or other): no yes

Female patients only: Last Mammogram: _____ Result: _____

Last Pap Smear: _____ Result: _____

Are you planning a pregnancy? no yes

HILLCREST INTERNAL MEDICINE

To better serve you, our patients, we have implemented the following prescription and office policies:

Prescription refills:

If you have refills remaining on your prescription please contact your pharmacy to request additional refills.

Please plan ahead, refills usually require 48 hours to process.

Call your pharmacy to check on the status of your prescription before you call our office.

For written prescriptions and mail order pharmacies, including but not limited to, Prescription Solutions, Express Scripts, Medco, CareMark, please notify us in writing. Include the:

Name of the medications

Dosages

Number of tablets you take per day

How many days supply your insurance will cover

Please include a self addressed stamped envelope for all prescriptions that need to be mailed back to your home.

Lab slip request:

For all non urgent lab slip requests, please submit in writing; please include a self addressed stamped envelope.

Phone calls:

All urgent phone calls will be returned as promptly as possible. Please recognize that on some very busy days we may not be able to return calls until the end of the day. A medical assistant will call you when urgent prescription requests, such as antibiotics, have been called to your pharmacy.

All non-urgent calls after 4:00 p.m. will be handled the following work day.

After Hours:

Please do not request routine refills after hours or on weekends. Controlled substances will not be refilled after office hours, as the doctor does not have access to your chart.

It is the patient's responsibility to make Co-pays at the time of service.

There will be a \$25 fee for missed appointments without a 24 hour notice.

If you're late for your appointment you may have to re-schedule.

It is the patient's responsibility to make sure we have all your updated information, i.e.: current phone number, address, insurance information, etc.

I understand as a patient that if I decline or fail to do diagnostic tests the practitioner can not be responsible for the consequences. I understand that if I do not hear about tests after two weeks, it is my responsibility to contact my practitioner for results.

Signature _____ Date _____

Hillcrest Internal Medicine
4060 Fourth Ave
Suite 505
San Diego, CA 92103

WHEN THIS FEATURE BECOMES AVAILABLE

E-MAIL CONSENT

I hereby grant permission to Hillcrest Internal Medicine to send correspondence; which may include test results, letters regarding results, appointment confirmation, questions regarding medication, health issues, etc. to my E-mail.

E-mail address: _____

Name Print _____

Signature _____ Date _____

Hillcrest Internal Medicine
4060 Fourth Ave
Suite 505
San Diego, CA. 92103

Prescription History Consent

I hereby grant permission to Hillcrest Internal medicine to obtain my external prescription history from all sources to better able my doctor's coordination of my external medical care.

As per the HIPPA regulations, this information will be kept strictly confidential.

Name (print)

Signature

Date

HIPPA RELEASE AUTHORITY:

I intend for the person named below to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by (HIPPA), 42 USC 1320d and 45 CFR 160-164. I Authorize:

- a. Any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc. or other health care clearing house that has provided me treatment or services, or that has paid for or is seeking payment from me of such services.
- b. To give, disclose and release to the person named below, without restriction: All of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

Name: _____

Address: _____

Telephone: _____

The authority given shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority, in writing, and deliver it to my health care provider.

Signature: _____

Address: _____

Telephone: _____

Date: _____

COMPLETE THIS PORTION OF ADVANCE DIRECTIVE FORM

I, _____ write this document as a directive regarding my medical care.

In the following sections, put the initials of your name in the blank spaces by the choices you want.

PART 1. My Durable Power of Attorney for Health Care

_____ I appoint this person to discuss my medical care with my doctor and make decisions about my medical care if there ever comes a time when I cannot make those decisions myself. I want the person I have appointed, my doctors, my family and others to be guided by the decisions I have made in the parts of the form that follow:

Name: _____

Home Telephone: _____

Work Telephone: _____

Address: _____

If the person above cannot or will not make decisions for me, I appoint this person:

Name: _____

Home Telephone: _____

Work Telephone: _____

Address: _____

_____ I have not appointed anyone to make health care decisions for me in this or any other document.

PART 2. My Living Will

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.

A. These are my wishes if I have a terminal condition.

Life-sustaining treatments

_____ I do not want life-sustaining treatment (including CPR) started. If life-sustaining treatments are started, I want them stopped.

_____ I want the life-sustaining treatments that my doctors think are best for me.

_____ Other wishes

Artificial nutrition and hydration

_____ I do not want artificial nutritional and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.

_____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.

_____ Other wishes

Comfort care

_____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.

_____ Other wishes

B. These are my wishes if I am ever in a persistent vegetative state.

PART 3. Other Wishes

A. Organ donation

_____ I do not wish to donate any of my organs or tissues.

_____ I want to donate all of my organs and tissues.

_____ I only want to donate these organs and tissues:

_____ Other wishes

B. Autopsy

_____ I do not want an autopsy.

_____ I agree to an autopsy if my doctors wish it.

_____ Other wishes.

C. Other statements about your medical care

If you wish to say more about any of the choices you have made or if you have any other statements to make about your medical care, you may do so on a separate piece of paper. If you do so, put here the number of pages you are adding: _____

PART 4. Signatures

You and two witnesses must sign this document before it will be legal.

A. Your signature

By my signature below, I show that I understand the purpose and the effect of this document.

Signature: _____ Date: _____

Address: _____

B. Your witnesses' signatures

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence and that he/she appears not to be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person making this advance directive.

Witness #1

Signature: _____ Date: _____

Address: _____

Witness #2

Signature: _____ Date: _____

Address: _____