

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 %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

DATE: _____

| | | | |
|----------------|------|-----|---------------|
| NAME | | AGE | DATE OF BIRTH |
| STREET ADDRESS | CITY | ZIP | TELEPHONE |

HISTORY OF PAST ILLNESS: (Please list prior medical problems requiring treatment, or hospitalization)

| | |
|--|--|
| | |
| | |
| | |
| | |

CHILDHOOD DISEASES: (Circle if you have had this illness)

| | |
|--------------|--------------------------|
| Measles | Diabetes |
| Mumps | Cancer |
| Chicken Pox | Rheumatic Heart Disease |
| Tuberculosis | Congenital Abnormalities |

PAST SURGERIES AND YEAR OF SURGERY:

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|--|
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| |
| |
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| |

CURRENT MEDICATIONS

| |
|------------------------|
| NAME /DOSE/ HOW OFTEN: |
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| |

ALLERGIES TO MEDICATIONS

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|--|
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| |

SOCIAL HISTORY

Marital Status: _____ Number of Children _____

Current/Prior Occupation: _____ Is Sex Life satisfactory? _____

Do you have dependents at home?: _____ More than one sexual partner? _____

What is your sexual orientation? Heterosexual Homosexual

Tobacco Use: Never or _____ Packs a day since what age? _____

Alcoholic Beverage Use: How many drinks per week? _____

FAMILY HISTORY

| <u>Family</u> | <u>Alive at Age or</u> | <u>Deceased at Age</u> | <u>Health Problems</u> |
|---------------|------------------------|------------------------|------------------------|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| Children | | | |
| Other Family | | | |

Circle the diseases below if any blood relative has had:

| | | | | |
|--------|--------------|-------------------|---------------|---------------------|
| Cancer | Tuberculosis | Diabetes | Heart Trouble | High blood pressure |
| | Stroke | Bleeding Tendency | Insanity | |

SYSTEMIC REVIEW: (Please circle any of the following that relate to you)

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><u>General:</u></p> <ul style="list-style-type: none"> • Recent weight change • Insomnia <p><u>Head/Eye/Ears/</u></p> <p><u>Nose/Throat:</u></p> <ul style="list-style-type: none"> • Headaches • Dry Eyes • Wear Glasses • Bloody Nose • Ringing in Ears • Poor Hearing • Sinus Trouble • Runny Nose • Sore Throat | <p><u>Skin:</u></p> <ul style="list-style-type: none"> • Eczema • Rash/Abnormal lesion • Yellowing of skin <p><u>Neck:</u></p> <ul style="list-style-type: none"> • Thyroid Trouble • Mass or Nodule in neck • Stiffness | <p><u>Respiratory:</u></p> <ul style="list-style-type: none"> • Cold symptoms • Shortness of breath • Asthma • Wheezing • Cough <p><u>Musculoskeletal:</u></p> <ul style="list-style-type: none"> • Back pain • Varicose Veins • Pain in legs with walking | <p><u>Cardiovascular:</u></p> <ul style="list-style-type: none"> • Palpitations • Chest Pain • Shortness of breath with exertion • Shortness of breath when lying flat • Heart Murmur • Swelling in hands or feet |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Hillcrest Internal Medicine
4060 Fourth Avenue, Suite 505
San Diego, CA 92103
619 298-1318

Gastrointestinal:

- Diarrhea
- Constipation
- Acid Relfux/Heart Burn
- Bloody or black stools
- Abdominal Cramping
- Hemorrhoids

Hematologic:

- Bleed easily
- Anemia
- Phlebitis
- Bruise easily

Genitourinary:

- Frequent urination
- Night time urination
- Burning/painful urination
- Discolored urine
- Urine Incontinence (Loss of control)
- Kidney Stone

Neurological:

- Paralysis
- Convulsions/Seizures
- Psychiatric Illness

Endocrine

- Thyroid Disease
- Hormone Therapy
- Hair growth changes
- You get colder easily

Gynecologic:

(FEMALES):
Age menses (period) began _____
How many days does it last? _____
How many days apart are they? _____

Number of pregnancies _____
Number of miscarriages _____
Number of live births _____
Last Pap Smear _____
Last Menstrual Period _____
Last Mammo _____

Health

Maintenance:
Last Colonoscopy:
Bone Density:
Tetanus:

Your Height _____
Your Weight _____

Source of Information, if other than the patient: _____

Signature of person acquiring this information X _____

Doctor Signature X _____

Signature of Patient X _____

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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 _____

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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: _____

HILLCREST INTERNAL MEDICINE

PRESCRIPTION REFILLS:

Please contact your pharmacy to request additional refills. If you do not have any refills available the pharmacy will request them for you.

If your pharmacy says they will process the request, DO NOT call office, unless your refill has not been processed within a few days.

You can also request your refills through the patient portal, please make sure you let us know what pharmacy you wish to use.

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

PATIENT RESPONSIBILITY:

It is the patient's responsibility to make sure we accept their insurance. If you have an HMO it must be through Mercy Physicians Medical Group with the name of the doctor in this practice. It is also the patient's responsibility to make sure we have all your updated information, current address, phone number insurance information, etc.

To be on time for your scheduled appointment, you are required to sign in 15 minutes before your scheduled appt. If you are late for your appt you may have to reschedule.

If you do not hear from us after two weeks of completing lab or diagnostic testing it is the patient's responsibility to contact your practitioner for results.

Co-pays are due the day of your appt., before you see the doctor.

It is your responsibility to pay for any charges that your insurance does not cover, some tests or services recommended by your doctor may not be covered by your insurance.

There is a \$25.00 fee for missed or cancelled appointments without a 24-hour notice.

AFTER HOURS:

Controlled substances will not be refilled after office hours.

Please do not call the doctor on call to request routine refills either after hours or on weekends. They can be requested over the patient portal, but will most likely not be refilled until normal business hours.

PATIENT PORTAL:

The patient portal is NOT to be used for emergencies, there is a doctor on call for emergencies after hours and weekends. The patient portal is normally not accessed after hours, weekends or holidays. If you have not heard from the office within 48 business hours, please call the office.

PHONE CALLS:

All urgent phone calls will be returned as promptly as possible. Most calls will be returned by end of day or possibly the next day. Any non-urgent calls after 4:00 will be handled the next business day. A medical assistant will only call you for urgent prescription request, such as antibiotics- **Please check with your pharmacy for all your refill request.**

TREATMENT:

If you need an appointment, you may have to be seen by one of our Nurse Practitioners or accept the 1st available appointment with your doctor. For all medical issues that require a doctor's advice you may be asked to come in.

HILLCREST INTERNAL MEDICINE COMPANY POLICY

I understand as a patient that if I decline or fail to do diagnostic test the practitioner cannot be responsible for the consequences. I understand that if I do not hear about test results after two weeks, it is my responsibility to contact my practitioner for results. I understand that I am responsible for all charges that my insurance does not cover.

I have read and understand the policies of Hillcrest Internal Medicine

Print name _____ **Date of Birth** _____

Signature _____ **Date:** _____

