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 1tablet 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

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

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
Tubercolosis	Congenital Abnormalities

PAST SURGERIES AND YEAR OF SURGERY:

CURRENT MEDICATIONS

NAME /DOSE/ HOW OFTEN:

ALLERGIES TO MEDICATIONS

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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

Family	**Alive at Age or**	**Deceased at Age**	**Health Problems**
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)

General:
- Recent weight change
- Insomnia

Head/Eye/Ears/ Nose/Throat:
- Headaches
- Dry Eyes
- Wear Glasses
- Bloody Nose
- Ringing in Ears
- Poor Hearing
- Sinus Trouble
- Runny Nose
- Sore Throat

Skin:
- Eczema
- Rash/Abnormal lesion
- Yellowing of skin

Neck:
- Thyroid Trouble
- Mass or Nodule in neck
- Stiffness

Respiratory:
- Cold symptoms
- Shortness of breath
- Asthma
- Wheezing
- Cough

Musculoskeletal:
- Back pain
- Varicose Veins
- Pain in legs with walking

Cardiovascular:
- Palpitations
- Chest Pain
- Shortness of breath with exertion
- Shortness of breath when lying flat
- Heart Murmur
- Swelling in hands or feet

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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_____

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 _____

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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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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 nutricial 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: _____