FAMILY & INDUSTRIAL MEDICAL CENTER

47 Santa Rosa St., San Luis Obispo, CA 93405

Welcome To Our Office!

Patient Information (please print)			
Last Name:	First Name:	Middle Initial:	Sex: M ☐ F ☐
Mailing Address:		City:	State: Zip:
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Drivers License #:	Social Security Number:	
Race:	Ethnicity:	Language:	
Marital Status: Circle One:	Married ☐	Single ☐	Divorced ☐ Widowed ☐
E-mail Address:			
Please Let us know if you are interested in having access to our web based portal:	YES ☐	NO ☐	
Preferred Pharmacy?			
If patient is a minor, please provide parent/guardian information			
Name of parent/guardian:			
Provide address if different than patient:			
Parent/Guardian Date of Birth:			
Parent/Guardian Social Security Number:			
Parent/Guardian email:			
Insurance Information			
Please present your insurance card and photo ID to receptionist to be scanned into electronic chart.			
Name of PRIMARY Insurance Plan:			
Claims Address:			
ID Number:			
Group Number:			
Name of SUBSCRIBER:			
Birth date of SUBSCRIBER:			
Name of SECONDARY Insurance Plan:			
Claims Address:			
ID Number:			
Group Number:			
Name of SUBSCRIBER:			
Birth date of SUBSCRIBER:			
Emergency Contact Information:			
Emergency Contact Name & Relationship:			
Emergency Contact Phone Number			
Emergency Contact Address:			
Advanced Directive			
Do you have an Advanced Directive? (Circle one):	YES ☐	NO ☐	

Authorization to release protected health information to family and friends

By my signature, I authorize the practice to discuss my appointment dates, time location, medical history, diagnosis, treatment, prognosis, financial and insurance and billing information with those listed below. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.
I understand that except in limited circumstances, a family member or friend seeking information about me must be on the following list.

My personal health information may be released to the following individuals:

1. _____ and/or 2._____

The Practice staff have permission to leave messages concerning my treatment (I.E. Lab results, Radiology results) on my (Please check all boxes that apply)

☐ Home _____ ☐Cell_____ ☐Work_____ ☐E-mail_____

☐No Information: I do not authorize release of any verbal information (other than appointment reminders to the number(s) I have provided concerning my treatment. I understand that includes lab results and billing information.

_____ _____
Print Name of Patient Print Name of Authorized Representative

_____ _____
Patient or Authorized Representative Signature Date Signed

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Office & Financial Policy

Appointments

If you are more than 10 minutes late to your appointment, you may be asked to reschedule. Appointments have priority over Walk In's and Walk In's are seen on a first come first serve basis unless considered emergent by way of triage.

Prescription Refills

We require a 72 hour notice for prescription refills and if not given you may be subject to additional charges. Requests made on Thursday or Friday's may not be ready until the following week. To expedite your request we ask that you contact your pharmacy and have them contact us rather than contacting our office first.

Lab Results

Please allow up to a week for standard lab test call back's. For some specialty labs, it may take up to 2 weeks to receive a call back. All lab results considered essentially normal will not receive a call back unless requested by the patient.

Office Fees are as follows:

$50.00 No show Fee (without prior notice)

$25.00 Cancellation Fee(within 24 hours of appointment)

$25.00 Prescription Fee(less than 24 hour notice given)

$15.00 Prescription Transfer Fee

$25.00 Form Fee (forms up to 4 pages)

$40.00 Form Fee(forms more than 4 pages)

$25.00 Letter/Note Fee (work notes, school notes, jury duty and other's requested outside an office visit)

Service Charges/Late Fees/Collections

Any balances carried to the next billing cycle will be subject to a service charge: 1% per 30 days beginning on the 60th day. If it is necessary to assign your account to a collection agency and /or attorney, you will be responsible for all of our fees and costs involved with that process.

These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

_____ _____ _____

Print Patient Name Patient Signature Date

FAMILY & INDUSTRIAL MEDICAL CENTER

Acknowledgment of Receipt of Notice of Privacy Policy

I hereby acknowledge that I received a copy of this medical practic's Notice of Privacy Policies. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____

Print Name of Patient Print Name of Authorized Representative

_____ _____

Patient or Authorized Representative Signature Date Signed

Authorized Representative's authority to act on the Patient's behalf:

☐ Parent/Legal Guardian ☐ Limited Power of Attorney ☐ General Power of Attorney ☐ Other as described:__

Evidence of Authority must be provided and on file with the practice. If you have any questions regarding your privacy as a patient, please contact our Administrator at 805-542-9596 ext 135.

Notices

1. As mandated by the Business and Professions Code, I understand as a consumer that my healthcare provider is licensed and regulated by the Medical Board of California.

2. In the interest of prompt and efficient patient care, I allow this office to electronically check my external prescription history.

3. I hereby authorize the release of any information necessary to file an insurance claim on my behalf with my insurance carrier or any workers compensation carrier. I assign benefits otherwise payable to me for any service furnished me. I understand that I am personally responsible for all balances not paid by my insurance for any reason and promise to make prompt payment of any outstanding amounts. I also agree to personally pay in full any bill that is unreasonably delayed by litigation.

_____ _____

Print Name of Patient Print Name of Authorized Representative

_____ _____

Patient or Authorized Representative Signature Date Signed

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HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, MI): _____ **Date of Birth:** _____
❒ **Male** ❒ **Female** **Date Form Completed:** _____

Reason for visit/your main concern today: _____
_____
_____

Past/Current Medical History

❒ Alcohol Abuse	❒ Cancer	❒ Heart Disease	❒ Liver Disease	❒ Peripheral Vascular Disease
❒ Alzheimer's	❒ Chronic Pain	❒ Heart Murmur	❒ Lung Disease	❒ Psychiatric Disorder
❒ Anemia	❒ COPD	❒ Heart Surgery	❒ Memory Problems	❒ Seizure Disorder
❒ Arthritis	❒ Depression	❒ Heartburn	❒ Migraines	❒ STDs
❒ Blood Clot	❒ Diabetes	❒ High Cholesterol	❒ Multiple Sclerosis	❒ Skin Problems
❒ Blood Disease	❒ Drug Abuse	❒ Hypertension	❒ Muscle Problems	❒ Stroke
❒ Bowel Disease	❒ Ear Problem	❒ Joint Problems	❒ Parkinson's	❒ Thyroid Disease
	❒ Eye Problem			

Childhood Illnesses:

❒ Measles ❒ Mumps ❒ Rubella ❒ Chickenpox ❒ Rheumatic Fever ❒ Polio

Immunizations and dates:

Flu _____/_____	Meningitis _____/_____	Tetanus _____/_____
Hepatitis A _____/_____	Pneumovax _____/_____	Gardasil _____/_____
Hepatitis B _____/_____	Shingles _____/_____	Other: _____/_____

Health Maintenance: (List month and year of the screening/evaluation):

❒ Bone Density: _____/_____	❒ Colon Ca Screen: _____/_____	❒ Eye Exam _ _____/_____
❒ PAP: _____/_____	❒ Cholesterol: _____/_____	
❒ Mammogram: _____/_____	❒ Dental Exam: _____/_____	

Allergies and Sensitivities:

❒ No Known Drug Allergies, if so proceed to Surgeries	
Medication:	Reaction:
Medication:	Reaction:
Foods:	Reaction:
Other:	Reaction:

Surgeries: Please list any surgeries, date and reason for surgery: ❒ No Surgeries OR Complete ↓

Surgery:	Date:	Reason:
Surgery:	Date:	Reason:
Surgery:	Date:	Reason:
Surgery:	Date:	Reason:

Medication List: Please list all medications including dose (or attached a list)

Please turn the page over to continue.

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HEALTH HISTORY QUESTIONNAIRE

Family Health History: Does your mother, father, grandparents, siblings, aunts, uncles or children have any of the following? If yes, who? If family history is unknown, record "unknown".

❒ Yes	❒ No	Cancer	Relation:	Age Diagnosed:
❒ Yes	❒ No	Diabetes	Relation:	Age Diagnosed:
❒ Yes	❒ No	Drinking Problems	Relation:	Age Diagnosed:
❒ Yes	❒ No	Drug Problems	Relation:	Age Diagnosed:
❒ Yes	❒ No	Heart Problems	Relation:	Age Diagnosed:
❒ Yes	❒ No	High Blood Pressure	Relation:	Age Diagnosed:
❒ Yes	❒ No	Learning Problems	Relation:	Age Diagnosed:
❒ Yes	❒ No	Breathing Problems (Asthma)	Relation:	Age Diagnosed:
❒ Yes	❒ No	Mental Illness (Depression)	Relation:	Age Diagnosed:

SOCIAL HISTORY

Substance Abuse

Cigarette Smoking Current: ❒ Yes ❒ No	**Packs per day:____ # of Years:____**
Cigarette Smoking Past: ❒ Yes ❒ No	**Packs per day:____ # of Years:____ Year Quit_____**
Chewing tobacco ❒ Yes ❒ No	**E-Cigarettes:** ❒ Yes ❒ No
Smoke Exposure: ❒ Yes ❒ No	**Drug Use:**
Alcohol Drinks per week:	❒ Beer ❒ Wine ❒ Spirits

Work/School/Education Level

Occupation:_____	❒ Full Time ❒ Part Time ❒ Retired ❒ Disabled ❒ Unemployed
Highest Educational Level:	❒ Some High School ❒ High School Grad ❒ Some College ❒ College Grad ❒ Post Graduate

Cultural/Religious Beliefs:

Do you have cultural or religious beliefs that we need to be aware of in provider your care?	❒Yes ❒ No If yes, please specify: _____

Exercise/Diet:

Exercise? ❒ Yes ❒ No	**If Yes** _____ **X/Week**	**Type:** _____
Diet?	❒ Regular ❒ Diabetic ❒ Low Fat ❒ Low Salt ❒ Veggie ❒ Vegan ❒ Other: _____	
Hobbies: _____		

Communication Needs:

Do you have hearing loss, wear hearing aids or have deafness?	❒ Yes ❒ No
Do you have visual loss, wear glasses or contacts or have blindness?	❒ Yes ❒ No

Legal Guardian/Health Care Proxy:

Do you have a Legal Guardian or Healthcare Power of Attorney? ❒ Yes ❒ No	_____
Do you have a Living Will or Advanced Directives? ❒ Yes ❒ No	**Provide Copy**
Do you have a DNR (Do Not Resuscitate) Order ❒ Yes ❒ No	**Provide Copy**

How would you rate your overall health: ❒ Good ❒ Fair ❒ Poor

Do you see any specialist: ❒ Yes ❒ No If yes, list the specialists name below

Allergist:	Nephrologist:
Cardiologist:	Neurologist:
Dermatologist:	Pulmonologist:
ENT:	Psychologist:
Endocrinologist	Rheumatologist:
Gastroenterologist:	Urologist:

Preferred Pharmacy:
Local: _____
Mail Order: _____