New Patient Information

Name (Last, First)	
Sex (M/F)	
Date of Birth (m/d/y)	
Mailing Street Address	
City, State, Zip Code	
Mobile Phone	
Email	
Emergency Contact Name:	Relationship
Phone #	

Insurance Details

POLICY HOLDER NAME		DOB		Relationship	
Primary Insurance					
Member ID		Group ID			
Secondary Insurance					
Member ID		Group ID			

Confidential Health History Questionnaire

Family History

Family Member	Deceased/Living?	Age (current/death)	Diagnosis
Father			
Mother			
Brother(s)			
Sister(s)			

Children	Number	Any Illnesses
# of Sons		
# of Daughters		

Social History

Occupation: Retired? (Y/N) :

Marital Status: Last Physical Examination:

Confidential Health History Questionnaire (cont)

Medications

Name of Medication	Dosage (mg)	How many times per day?

Preffered Pharmacy:

Address:

Phone Number:

Drug Allergies:
if none, write NKDA

Vaccination History: please date with most current vaccination

- TDAP / current tetanus:
- pneumococcal:
- shingles:
- varicella:
- flu:

For Women Only:

- Last pap smear:
- Last menstrual period:

DEL MAR INTEGRATIVE MEDICINE
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Confidential Health History Questionnaire (cont)

Medical Illnesses & Symptom Review

Recent Fever	High Blood Pressure	Urination Problems
Recent Weight Gain	High Cholesterol	Kidney Stones
Excess Fatigue	Heart Disease	Kidney / Bladder Infection
Diabetes	Previous Heart Attack Date:	STD
Thyroid/hormonal problems	Previous Heart Murmur	Serious sexual dysfunction
Cancer	Recurrent Chest Pain	Previous prostate problem
Anemia/blood disorder	Irregular Pulse	Recent menstrual problem
Previous blood transfusion	Leg cramps	Breast problems
Skin Rash/ Mole	Blood Clots	Arthritis/joint pain
Glaucoma / Eye problems	Recent Abdominal Pain	Back Pain
Sinusitis /Hay Fever	Nausea / Vomiting	Mobility Issues
Exposure to Toxic Chemicals	Changes in bowel movements	Dizziness
Asthma/ Lung Diesases	Blood in stool	Fainting
Cough	Heartburn	Previous stroke Date:
Shortness of breath	Ulcer	Seizure/tremor
Swelling in ankle/feet	Colitis	Headache
Hepatitis / Liver Disease	Polyp of Colon	Depression
Stress / Anxiety	Other:	Other:

Surgery History

Type of Surgery Month/Year Type of Surgery Month/Year

1.
2.
3.
4.
5.
6.

Habits

Dietary restrictions or special diet:
Amount of caffeine per day:
Do you use tobacco? *in the past?*
packs per day *total years of smoking*
Do you drink alcohol? *#of drinks per day?* *type?*
Have you used intravenous drugs (will remain confidential)
Amount of exercise per day? type of exercise?

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1349 Camino Del Mar, Ste B
Del Mar, CA 92014
P: (858) 925-8233 F: (858) 935-8218

Authorization to Release Healthcare Information

Patient's Name: **Date of Birth:**

Previous Name (if applicable):

I request and authorize ________________________________ to release healthcare information of the patient named above to Del Mar Integrative Medicine located on 1349 Camino Del Mar, Ste B, Del Mar CA 92014.

This request and authorization applies to:

- **Healthcare information relating to the following treatment, condition, or dates:** ______________________

____

- **All healthcare information**
- **Other:** ____

Defintion: Sexually Transmitted Illnesses (STI) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex human papilloma virus, genital wart, condyloma, Chlamydia, non-specific urethritis, syphillis, VDRL, chancroid, lymphogranuolma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my health records

Yes No I authorize the release of any records regarding general health treatment to the person(s) listed above

Patient Signature: **Date Signed:**

______________________________ ______________

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Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) to Del Mar Integrative Medicine or medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Del Mar Integrative Medicine to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Del Mar Integrative Medicine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred int he course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

________________________________ ________________________
Patient/Responsible Party Signature Date

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Acknowledgment of Receipt of Notice

Office Manager & Privacy Officer

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No I would like to receive a copy of any amended Notice of Privacy Practices emailed to:

Signature: Date:

______________________________ ______________

Print Name:

Telephone:

If not signed by the patient, please indicate relationship to the patient:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient:

For Office Use Only:

- Signed form received by: ____________________
- Acknowledgement refused:

Efforts to obtain:

____

Reasons for Refusal:

____