PACIFIC GROVE FAMILY MEDICINE

Name______________________________ DOB______________
Last Name First Name Middle Initial

Sex: Male/Female Social Sec #______________ Married ___Single___Widowed___Divorced___Minor___

Street Address______________________City______________State____Zip__________

Home Phone #______________ Cell Phone #______________Work #______________

Email : ______________________Preferred Language (If not English)______________

Mailing Address (if different) ______________________________

Parent's Name (if minor)______________ Social Sec # ______________ DOB______________

Emergency Contact______________________ Relationship to Patient ______________

Primary Phone # ______________________ Alt. Phone # ______________________

Race:African-Amer___Asian___Caucasian___Hispan___Native-Amer.___Pacif Islan.___Other___Decline___

Primary Insurance

Person responsible for account (Primary Insured/Sponsor) ______________________________
Last Name First Name Middle Initial

Relation to patient______________Birthdate______________Social Security #______________

Address (If different from patient's)______________________ Phone #______________

City ______________ State______________ Zip__________ Work #______________

Insurance Company/Branch of Service______________________________

Subscriber ID #______________________ Group # ______________

Additional Insurance

Person responsible for account ______________________________
Last Name First Name Middle Initial

Relation to patient______________Birthdate______________Social Security #______________

Address (If different from patient's)______________________ Phone #______________

City ______________ State______________ Zip__________ Work #______________

Insurance Company______________________________

Subscriber ID #______________________ Group # ______________

Assignment and Release

I hereby consent for treatment and give authorization for payment of insurance benefits to be made directly to Pacific Grove Family Medicine, Inc. for services rendered. The above information I have provided is current and accurate to the best of my knowledge. I understand that I am financially responsible for all charges should my insurance company deny my claim. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I authorize the use of my signature on all of my insurance claim forms. I agree that certain samples or specimens may be sent out for further testing and I may receive a separate bill for these services. I am aware that there is a $50.00 fee if 24 hour notice is not given for cancellation of appointments.

Signature ______________________Relationship to patient ______________Date______________

Pacific Grove Family Medicine, Inc.
621 Forest Avenue
Pacific Grove, CA 93950
Tel : 831-649-1011 Fax : 831-920-4506

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: ______________________________

I, ______________________ (print name) hereby acknowledge that a copy of the Notice of Privacy Practices (HIPAA) is available upon request.

Signed: ______________________ Date: ____________

If not signed by the patient, please indicate signer's relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary of personal representative of deceased patient

- -

Authorization to Discuss Health Information

I, ______________________ (print name) authorize the office of Pacific Grove Family Medicine to discuss my health information with the following person(s):

______________________ ______________________
Name Relationship

______________________ ______________________
Name Relationship

I do _____ / do not _____ authorize the physicians & staff of Pacific Grove Family Medicine to leave voicemail messages containing health information at the following phone numbers:

______________________ ______________________
Cell Home

____
Signature Date

Pacific Grove Family Medicine

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OFFICE & FINANCIAL POLICIES

Cancelled Appointments: Should you not be able to keep your scheduled appointment, kindly give our office a **24-hour notice**. Any appointment that is rescheduled, cancelled or "no showed" within 24 hours of the scheduled appointment will result in a **$50.00** fee.

Insurance & Cash Payments: Please bring your insurance card with you to your appointment. Co-payments are due upon check-in. If you do not have health insurance coverage, you are responsible for paying for services rendered at the time of the appointment, for which we will extend a discount of 20%.

Prescriptions: Please allow 3 business days to refill your medication. As the patient, you are responsible for contacting your pharmacy and requesting that a refill authorization be faxed to our office.

Medical Records: Medical Records are available after signing our Medical Records release form. Please allow 7-10 business days for us to complete your request. The first set of records are at no charge. Should you need an additional set, there will be a fee of $15.00.

Perfumes & Lotions: We please ask that you be courteous to our physicians, medical staff, and fellow patients by not wearing any perfumes or scented lotions while in our office.

Cell Phones: You are welcome to use your cell phone (on silent/vibrate mode). If you need to take a call, please excuse yourself outside. Unless making a call, please turn your cell phone off.

I was offered and ***accepted*** *a copy of the Office & Financial Policies.* ________

I was offered and ***declined*** *a copy of the Office & Financial Policies.* ________

By signing below I agree to comply with the Office & Financial Policies of Pacific Grove Family Medicine.

____

Signature of Patient or Guardian Date

____

Printed Name of Patient or Guardian

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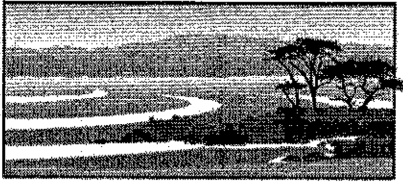
THANK YOU



PACIFIC GROVE
FAMILY MEDICINE

ADULT HEALTH HISTORY

Today's Date: ____________________

Name: ____ Date of Birth: ______________________

Email: ____

Pharmacy: ____

Please check if you have or have had any of the following:

☐ High Blood Pressure	☐ Pneumonia	☐ Colon Polyps
☐ Heart Attack	☐ Asthma	☐ Diverticulitis
☐ Heart Murmur	☐ Emphysema / COPD	☐ Hepatitis
☐ Heart Failure	☐ Gallstones	☐ Anemia
☐ Diabetes	☐ Stomach Ulcer	☐ Thyroid Disorder
☐ High Cholesterol	☐ Hiatal Hernia	☐ Kidney Stone
☐ Cancer: if yes; type __________	☐ Stroke	☐ Convulsion
☐ Depression	☐ Anxiety	☐ Arthritis
☐ Convulsion	☐ Arthritis	☐ Sexually Transmitted Dz

Past Medical History (not listed above): ____

____

Medications: ____

____

Allergies (medications and reactions): ____

____

Food allergies and reaction: ____

____

List serious illnesses / injuries / surgeries and year (Not to include Normal Pregnancies and Deliveries)

Year Illness, Injury, Surgery

__________ ____

__________ ____

__________ ____

__________ ____

__________ ____

__________ ____

Obstetrical: # of pregnancies ______ # of abortion ______ # of miscarriages ______

# of living children ______ #C-section________ # vaginal deliveries____

Immunizations: Tetanus ______ Pneumonia ______ Shingles ______

FAMILY MEDICAL HISTORY

	Mother	Father	Sibling	Grandparent	Aunt / Uncle	Child
High Blood Pressure						
Heart Attack						
High Cholesterol						
Diabetes						
Stroke						
Cancer (type)						
Tuberculosis						
Bleeding Disorder						
Alcoholism						

Mother living? ☐ Yes ☐ No Cause of death? ____________________

Father living? ☐ Yes ☐ No Cause of death? ____________________

Sexual Identity: ☐ Heterosexual ☐ G/L ☐ Bisexual ☐ Transgender

SOCIAL HISTORY

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Significant Other / Partner

Number of Children: ________ Sons: ________ Daughters: ________

Occupation: ____

Who lives with you? ____

Do you have a living will? ☐ Yes ☐ No

Health Care Power of Attorney? ☐ Yes ☐ No

HABITS

Have you ever smoked? ☐ Yes ☐ No

If yes; how many packs per day? ________ How many years? ________

Do you smoke now? ☐ Yes ☐ No; Quit ________ years ago

Any other tobacco use? ______________

Do you drink coffee / caffeinated drinks? ☐ Yes ☐ No

If yes; how many cups of coffee / caffeinated drinks per day? ________

Do you drink alcohol? ☐ Yes ☐ No

What type? (circle any that apply) beer wine liquor

How much? ____________ How often? ____________

Do you exercise? ☐ Yes ☐ No How often? ________ What type? _______

Do you follow a special diet? ☐ Yes ☐ No What type? ________

Do you wear seatbelts? ☐ Yes ☐ No

Do you self Exam? (breast or testicular) ☐ Yes ☐ No

Do you have a history of substance abuse? ☐ Yes ☐ No What type? ________________

Time in sobriety / recovery? ______________________

PATIENT HEALTH QUESTIONNAIRE

NAME:____ **DATE:___________________**

Over the past 2 weeks how often have you been bothered by any of the following problems?

(Use **X** to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let your family down	0	1	2	3
7. Trouble concentrating on things such as reading the paper or watching television	0	1	2	3
8. Moving or speaking so slowly that others could have noticed. Or the opposite-being more fidgety or restless than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself	0	1	2	3
Add columns	+	+	+	

Total _____________

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				