Patient History Sheet

Your Name: _____

Prior Surgeries	Dates	Medical Illness	Onset
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

Prior Hospital Visits	Dates	Allergies	Reaction
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____

Current Meds and Dosages

_____
_____

_____

_____

Family History

Alive or Year Died/Age/Cause of Death

Mother_____ _____

Father_____ _____

Brother_____ _____
_____ _____

Sister _____ _____
_____ _____

Habits (Amount and Duration)

	Current	Prior
Smoking	_____	_____
Alcohol	_____	_____
Coffee	_____	_____
Other	_____	_____

Children _____ _____
_____ _____
_____ _____

Social History

Education _____
Marital Status_____
Occupation_____
Recent Travel_____
Religious Preference_____
Other_____

Family Members with:	Relationship
Diabetes	_____
Heart Disease	_____
Hypertension	_____
Gastrointestinal	_____
Liver Disease	_____
Lung Disease	_____
Kidney Disease	_____
Cancer	_____
Other	_____

Immunizations	Yes	No	Dates:
Last Tetanus Booster	___	___	___/___/___
Hepatitis B Vaccine	___	___	___/___/___
Pneumonia Vaccine	___	___	___/___/___
Childhood Vaccines	___	___	___/___/___

Transfusion History:

Any History of Prior Transfusion_____

If yes, When?_____

Dr. Jill Cottel M.D.
Poway Integrative Medicine Center

Patient Acknowledgment
Of
Financial Responsibility

Date: _____

Your Name: _____
(Please Print)

I, the Patient or legal guardian understands that it is my responsibility to provide a copy of my health insurance card to the Medical Group to facilitate claim processing. If I am unable to provide this information, I understand that my appointment will be my financial responsibility until such information is provided.

If an insurance card is given, I acknowledge that if the patient is determined as "not eligible" under my insurance member provisions and/or any specific procedures are not covered. Financial responsibility for services rendered is mine.

I agree to pay in full for all services rendered within 30 days of receiving a bill from the above noted physician or any healthcare provider from this Medical Group if insurance information is not provided or covered under my plan.

I also understand that it is my responsibility to know if my provider is a contracted provider under my health plan and agree to pay for any charge incurred as a result of care received if my provider is not a contracted provider under my specific health plan.

_____ _____
Signature of Patient or Legal Guardian Date

Patient Information

Name: _____
Last First Middle

Email Address: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____

Social Security # _____ Drivers License: _____
State Number

Marital Status (Circle one): Married Single Divorced Widower Minor

Home Address: _____
Street City State Zip

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Mobile Phone: _____-_____-_____

Employed By: _____ Occupation: _____

Work Address: _____
Street City State Zip

Person to Contact in Case of Emergency

Name: _____
Last First Middle

Home Address: _____
Street City State Zip

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Mobile Phone: _____-_____-_____

Relationship: Spouse Parent Child Sibling Other: _____

Personal Representative

Your personal representative has your permission to access any of your medical records.

Name: _____
Last First Middle

Home Address: _____
Street City State Zip

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Mobile Phone: _____-_____-_____

Relationship: Spouse Parent Child Sibling Other: _____

I the undersigned hereby assign directly to the physician Jill S. Cottel MD surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Signature X _____ Date: _____

*Please notify us if any of the above information changes during the course of your treatment

Poway Integrative Medicine Center

Receipt of Notice of Privacy Practices Written Acknowledgment Form

Please check one of the boxes below:

☐ I, _____, have received a copy of Poway
(Please print your name)
Integrative Medicine Center's Notice of Privacy Practice. (This form is available to view at the front desk or online at www.pimchealth.com)

☐ I, _____, do not need a copy of the Notice of Privacy Practices.
(Please print your name)

_____ _____
Signature of Patient Date