MICHLIN | MD

6367 Alvarado Court suite 200
San Diego, CA 92120

REGISTRATION FORM

PATIENT INFORMATION

Today's Date:

Patients last name: First: Middle:	❑ Mr ❑ Mrs	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes | ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Sex: ❑ M ❑ F

Race ❑ Caucasian ❑ African-American ❑ American-Indian ❑ Asian ❑ Hispanic ❑ Other: _____	Ethnicity:	Language Preference:
	Social Security No.:	Driver's License: State _____ Number _____

Street Address:	Home Phone No.: ( ) -	Cell Phone No.: ( ) -

P.O. BOX *if applicable*:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Patient Email Address**:

** Email addresses will not be used for marketing purposes. We do not distribute email addresses to third party corporations. We do not provide names or email addresses to anyone, including publishers, and/or advertising companies. Emails are used solely to provide patients with online access to their medical records. If you have any questions or concerns, please feel free to ask the front desk regarding this. An email will be sent out to provide you with a temporary password and log in information to access medical records.

Referred to clinic by (please check one or more boxes):

❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend

❑ Close to home/work ❑ Other: _____

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INSURANCE INFORMATION

(please provide insurance card to receptionist so we may make a copy for our records)

[ ] Please check here if you are CASH PAY

Please indicate primary insurance:

❑ Anthem BCBS ❑ Aetna ❑ Medicare ❑ Medical ❑ United HealthCare ❑ Blue Shield

❑ Private Pay ❑ Healthnet ❑ Tricare

❑ Sharp Community Medical Group (please provide name of insurance on line provided) _____

❑ Other: _____

Subscriber's name:	Subscribers ID no.:	Group No.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑Child ❑ Other: _____

Name of secondary insurance (if applicable)	Subscriber's name:	Subscribers ID no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑Child ❑ Other: _____

EMERGENCY CONTACTS

Emergency Contact #1:

Name: _____ Relationship to patient: _____

Primary Number: _____ Secondary number: _____

Emergency Contact #2:

Name: _____ Relationship to patient: _____

Primary Number: _____ Secondary number: _____

Emergency Contact #3:

Name: _____ Relationship to patient: _____

Primary Number: _____ Secondary number: _____

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ASSIGNMENT AND RELEASE

I hereby authorize that the above information is true to the best of my knowledge. I hereby authorize medical provider, Dr. Bernard Aron Michlin, MD, to release information which is normally required in the course of my treatment for the sole purpose of processing health information. I hereby authorize payment directly to this medical provider for the medical benefits, if any, that would be otherwise payable to me for services rendered. I understand that I am financially responsible for the charges not covered by insurance.

_____

Patient/Guardian printed name

_____ _____

Patient/guardian signature *Date*

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PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ | Sex: M / F | DOB: _____ /_____ /_____ | Date:_____

List all prescriptions and over-the-counter medications, supplements, and vitamins you take (including the dose and strength)

_____ _____

_____ _____

_____ _____

_____ _____

Please list any allergies you may have: _____

Do you have a latex allergy: [ ] Yes [ ] No

PAST MEDICAL HISTORY

Do you have now or have you ever had any of the following?

Unexplained weight gain	Yes	No	Hyperthyroid	Yes	No
Heart Disease	Yes	No	Kidney stones	Yes	No
Heart Attack	Yes	No	Kidney disease	Yes	No
Heart Arrhythmia	Yes	No	Stroke	Yes	No
Atrial Fibrillation	Yes	No	Gallbladder disease	Yes	No
Congestive Heart Failure	Yes	No	Anemia	Yes	No
Hypertension	Yes	No	Chronic back pain	Yes	No
Vascular Disease	Yes	No	Rheumatoid arthritis	Yes	No
Diabetes	Yes	No	Lyme disease	Yes	No
*Insulin Dependent	Yes	No	Psoriasis	Yes	No
*Non-insulin dependent	Yes	No	Depression	Yes	No
High cholesterol	Yes	No	Osteoporosis	Yes	No
Lung Disease	Yes	No	Neuropathy	Yes	No
Asthma	Yes	No	Hypothyroidism	Yes	No
Reflux Disease (GERD)	Yes	No	Fibromyalgia	Yes	No
Ulcers	Yes	No	Colitis	Yes	No
Cancer (location)_____	Yes	No			
Blood Clots (DVT or PE)	Yes	No			

Other:_____

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PAST SURGICAL HISTORY

Please list any operations you may have had. Please include date and physician who performed the surgery if possible:

_____

_____

_____

_____

_____

_____

FAMILY/SOCIAL HISTORY

Occupation: _____

Marital Status: Single Married Widowed Divorced

Please answer the following in regards to your personal habits:

Do you:

Exercise regularly	Yes	No
Smoke or use tobacco	Yes	No
*If yes, how many per day: _____		
*If yes, for how many years: _____		
Used tobacco in the past	Yes	No
Drink alcohol	Yes	No
*If yes, how often: _____		
*If yes, how many per week: _____		
Are you sexually active:	Yes	No
Have you had a colonoscopy:	Yes	No
*If yes, when was your last one: _____		

Do you have a family history of:

			Relationship
Heart Disease	Yes	No	_____
High blood pressure	Yes	No	_____
Diabetes	Yes	No	_____
Stroke	Yes	No	_____
Cancer	Yes	No	_____
Thyroid Disease	Yes	No	_____
Depression	Yes	No	_____
Blood Clots	Yes	No	_____

How would you describe your diet? _____

Have you received the shingles or pneumonia vaccination recently? Yes No

*If yes, please record the date: / /

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WOMEN'S MEDICAL HISTORY

Have you ever been pregnant: Yes No

Have you ever had any abortions: Yes No
*If yes, how many: _____

Have you had any miscarriages: Yes No
*If yes, how many: _____

Do you have any children: Yes No
*If yes, how many: _____

Have you had a mammogram: Yes No
*If yes, when was your last one: _____

Have you had a pap smear: Yes No
*If yes, when was your last one: _____
*If yes, have you had a history of an abnormal pap smear? _____

REVIEW OF SYSTEMS

Have you recently been troubled with any of the following symptoms:

Backache	Yes	No	Bloody sputum	Yes	No
Leg pain	Yes	No	Indigestion	Yes	No
Painful joints	Yes	No	Abdominal pain	Yes	No
Headaches	Yes	No	Diarrhea	Yes	No
Double vision	Yes	No	Constipation	Yes	No
Difficulty swallowing	Yes	No	Change in bowel habits	Yes	No
Hoarseness	Yes	No	Slow urine stream	Yes	No
Nosebleeds	Yes	No	Abnormal bleeding	Yes	No
Shortness of breath	Yes	No	Blood in stole	Yes	No
Dizziness	Yes	No	Pus in urine	Yes	No
Chest pain/pressure	Yes	No	Yellow jaundice	Yes	No
Irregular heartbeat	Yes	No	Depression/anxiety	Yes	No
Swelling of feet	Yes	No	Weight gain	Yes	No
Cough	Yes	No	Weight loss	Yes	No
Wheezing	Yes	No	Vaginal discharge	Yes	No
Vomited blood	Yes	No			

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TELEPHONE POLICY

Dear Valued Patients,

Please read over the following telephone policies that we have put in place to ensure that you get the best care available to you.

- *We do not provide medical care over the phone*. If you have a medical need, please call our office to make an appointment with one of our physicians.
- In the case of urgency, our physicians will address your issues over the phone on an as need basis.
- Changes in current medications or requests for new medications, including antibiotics, will need to be done in person and do require an office visit.
- If you are having medication side effects, we will gladly see you immediately.
- Lab results may be sent to you via email, fax, or a nurse can occasionally give results over the phone. However, our nurses are only simply giving you lab values not interpretations. If your lab values are out of range, or you would like to discuss the results in length, we can accommodate you by making an appointment with our physicians.
- We *do not* fill controlled medications over the phone under any circumstances. Controlled medications are highly regulated by the DEA and therefore require a doctor's visit to ensure proper care is given.

Our office values you as a patient and our goal is to give you the best care available. To do this we must discuss medical concerns in person. Our office is directly available Monday through Friday 9am to 5pm. If calling after hours, our answering services will be available to help with your needs.

Thank you for your cooperation,

Dr. Michlin's Office

_____ _____

Patients printed name Patients signature

_____

Date

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6367 Alvarado Court suite 200
San Diego, CA 92120
(619) 583-1954

We listen to you

Your feedback is essential for our success

Dear Valued Patients,

We are working hard to ensure you receive excellent care and a positive patient experience when you step into our office! You may receive a survey asking about how we are doing and we hope that you will take the time out of your busy schedule to share your feedback with us so that we can continue to improve. Our goal is to exceed expectations and keep our patients happy and satisfied.

Furthermore, if for any reason(s) we have failed to meet your expectations or if you have any questions or comments regarding your patient experience, please feel free to contact us now, or at any time, so that we can rectify the situation.

Thank you for the privilege of caring for you,

Dr. Michlin’s and Staff

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IMPORTANT NUMBERS TO KNOW

OUR OFFICE

Address: 6367 Alvarado Court Suite:200
San Diego, CA 92120
Hours: 9am to 5pm, Monday - Friday
Phone number: (619) 583-1954
Fax number(s): (619) 583-5499
(619) 583-2875

OUR PREFERRED PHARMACY

Alvarado Community Pharmacy
Address: 6367 Alvarado Ct # 109
San Diego, CA 92120
Hours: 9am to 5:30pm, Monday - Friday
Phone number: (619) 287-7697

URGENT CARE

Partners Urgent Care - Grossmont
Address: 6136 Lake Murray Blvd
La Mesa, CA 91942

Hours: 8am to 8pm, everyday
Phone number: (619) 303-5500
Fax number: (619) 303-5595

Partners Urgent Care – Eastlake
Address: 2315 Otay Lakes Road, Ste. 306
Chula Vista, CA 91914

Hours: 8am to 8pm, everyday
Phone number: (619) 946-4700
Fax number: (619) 946-4701

Partners Urgent Care – UTC
Address: 4085 Governor Drive
San Diego, CA 92122

Hours: 8am to 8pm, everyday
Phone number: (858) 888-7800
Fax number: (858) 888-7801

EMERGENCY ROOM

Grossmont Hospital ER
Address: 5555 Grossmont Ctr Dr
La Mesa, CA 91942
Phone number: (619) 740-6000

Alvarado Hospital ER
Address: 6655 Alvarado Rd
San Diego, CA 92120
Phone number: (619) 287-3270