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

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

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

EMERGENCY ROOM

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

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Office Policies

Dear Valued Patient,

To best accommodate our patients, we have implemented the following policies:

- We do not provide medical care over the phone. If you have a medical need, please call our office to make an in-office appointment or a video appointment with one of our providers.
- In case of urgency, our providers will address your issues over the phone on an as needed basis.
- Changes in current medications or request for new medications, including antibiotics, will need a provider's assessment and therefore require a visit with one of our providers.
- If you are having medication side effects, we will gladly see you immediately. Please call to schedule an appointment.
- Lab results may be reviewed on your patient portal, sent to you via email or fax, or a nurse can occasionally give results over the phone. However, our nurses do not provide 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 one of our providers.
- We *do not fill* controlled medications over the phone. Controlled medications are highly regulated by the DEA and therefore require a visit with one of our providers to ensure proper care is given.
- No-show fee: Visits canceled with less than 24-hours' notice or missed visits will incur a $25 no-show fee.
- We are committed to reducing wait times for all of our patients. Therefore, if you arrive greater than 30 minutes late for your appointment, we may need to reschedule you for a different time.
- Our front desk is open Monday through Friday from 9 am to 5 pm to assist you in any way that we can. Our answering service is available after-hours to help you with any urgent after-hour needs.

We greatly value you as a patient and our goal is to give you the best care possible. Your signature below indicates that you have reviewed and understand the above policies. Thank you and we look forward to participating in your medical care.

_____ _____

Printed Name Date

_____

Signature

HIPAA / Notice of Privacy Practices

BERNARD A. MICHLIN, M.D.
6367 Alvarado Court, Ste 200 San Diego, CA 92120 Ph) 619-583-1954 Fax) 619-583-5499

I hereby acknowledge that the office of Bernard Michlin, MD has provided me with an explanation of its Notice of Privacy Practices in compliance with the HIPAA Patient Privacy Act.

I understand my rights regarding the handling of my Protected Health Information as a patient of the office of Bernard Michlin, MD.

Patient Acknowledgement

_____

Patient Name

_____ _____

Patient Signature Date

Informed Consent for Telemedicine Services

Bernard A. Michlin, MD
6367 Alvarado Court, Ste 200
San Diego, CA 92120
Tel) 619-583-1954 Fax) 619-583-5499

1. PURPOSE. The purpose of this form is to obtain your consent for engaging in telemedicine services with a physician or other health care provider.

2. NATURE OF TELEMEDICINE SERVICES. Telemedicine involves the use of audio, video, or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. A physical examination of you may take place and video, audio, and/or photo recordings may be taken. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

3. RISKS, BENEFITS AND ALTERNATIVES. The benefits of telemedicine include having access to medical care and additional medical information and education without having to travel outside of home or community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.

4. **MEDICAL INFORMATION AND RECORDS**. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.

5. CONFIDENTIALITY. All existing confidentiality protections under federal and California law apply to information used or disclosed during your telemedicine consultation. You are responsible to ensure privacy at your location. You are also responsible for the information security on your device, including but not limited to, computer, tablet, or phone.

6. RIGHTS. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

7. FEES. The same fee rates apply for telehealth as apply for in-person treatment. Some insurers may have different rates or waive co-pays in specific instances. It is your responsibility to contact your insurer before engaging in telehealth to determine if there are applicable co-pays or fees for which you are responsible.

I have read and understand the information provided above regarding telemedicine. I have had an opportunity to ask questions about this information and all of my questions have been answered. I hereby give my informed consent for the use of telemedicine services in my medical care.

_____

Patient Name

_____ _____

Signature of Patient or Patient's Representative Date

Michlin, MD
6367 Alvarado Court, Ste 200
San Diego, CA 92120
619-583-1954

The Sunshine Act and Open Payments

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

This data is published annually in a database known as Open Payments. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I hereby acknowledge that I have been offered a copy of Dr. Michlin's notice of Open Payments. I have been advised that a copy of the notice is posted in the reception area and a copy of this acknowledgement will be placed in my chart.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

_____
PATIENT NAME (please print)

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:		
Patient Address:		
Medical Record Number:	Last four digits of Social Security Number:	Date of Birth: / /

I hereby authorize (physician stated below)

Physician name:	
Address:	
Phone:	Fax:

To release the following information: (Please be specific and check those that apply)

	History and Physical		Clinical and laboratory results
	Radiology		Cardio-pulmonary testing
	Inpatient/Outpatient hospital records		Physician progress notes
	Alcohol/drug abuse treatment		Mental health records
	Other (please specify):		

To:

Bernard A. Michlin, MD
6367 Alvarado Court, Ste 200
San Diego, CA 92120
Ph) 619-583-1954
Fax) 619-583-5499

This Private Health Information is being used or disclosed for carrying out treatment, evaluation, disability evaluation, payment, and/or:

_____.

TO BE READ AND SIGNED BY THE PATIENT

I understand the following:

1. This medical information may be used by the person I authorize to receive this information for medical treatment, consultation, billing or claims payment, or other purposes as I may direct.

2. This authorization shall be in force and effect until _____ (date or event) at which time this authorization expires.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligivilty for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient signature:		Date:
Signature of Patient's Representative:	Relationship:	Date:

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San Diego, CA 92120
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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