SHELTER ISLAND MEDICAL GROUP

ADULT MEDICAL HISTORY FORM

Your answers on this form will help your physician better understand your medical concerns. Please provide best estimates if you cannot provide exact dates. Please be sure to complete all pages of this form.

Present Medical/Health Concerns:

_____
_____
_____

MEDICATIONS: (Prescription and Non-Prescriptions Medications)

Medication	Dose	Times per Day	Medication	Dose	Times per day

ALLERGIES OR REACTIONS TO MEDICATIONS:

Medication	Reaction or Side Effect

PAST MEDICAL HISTORY: Please check if you have any of the following common medical conditions

□ Abnormal Pap Smear	□ Diabetes Type 2	□ Migraines	□ Thyroid Problems
□ Alcoholism	□ Heart Attack	□ Obesity	□ Tuberculosis
□ Arthritis	□ GERD/Heartburn	□ Rheumatoid Arthritis	**OTHERS: Please list below**
□ Asthma	□ High Blood Pressure	□ Osteoporosis	
□ Cancer:_____	□ High Cholesterol	□ Enlarged Prostate	
□ Heart Failure	□ Glaucoma	□ Prostate Cancer	
□ Depression	□ Hearing Problems	□ Skin Cancers	
□ Diabetes Type 1	□ Joint Pain	□ Stroke	

FAMILY HISTORY: Please list any pertinent medical problems that run in the family

Family Member	Medical Problem
Mother:	
Father:	
Siblings:	
Grandparents:	

PAST SURGICAL HISTORY: Please provide a list of all surgeries. If you cannot recall the exact date, please provide a reasonable estimate.

Date	Surgery	Date	Surgery
	1)		6)
	2)		7)
	3)		8)
	4)		9)
	5)		10)

HOSPITALIZATIONS: Please provide a list of al hospitalizations within the past 3 years. If you cannot recall the exact date, please provide a reasonable estimate.

Date	Hospitalization Reason	Date	Hospitalization Reason
	1)		6)
	2)		7)
	3)		8)
	4)		9)
	5)		10)

REVIEW OF SYSTEMS: PLEASE PLACE A CHECK IN THE BOX OF ANY SYMPTOMS YOU ARE HAVING NOW OR HAVE HAD RECENTLY.

□ Headache	□ Sore Throat	□ Abdominal pain	□ Chest Pain	□ Depression
□ Dizziness	□ Sinus Congestion	□ Nausea/Vomiting	□ Chest Tightness	□ Anxiety
□ "Passing Out"	□ Runny Nose	□ Diarrhea	□ Palpitations	□ Suicidal Thoughts
□ Weakness	□ Cough	□ Blood in Stool	□ Swelling of legs	□ Numbness
□ Vision loss	□ Wheezing	□ Constipation	□ Blood Clots	□ Memory Loss
□ Hearing loss	□ Shortness of breath	□ Hernia	□ Trouble breathing	□ Insomnia
□ Nose bleeds	□ Fever/Chills	□ Poor Appetite	□ Joint Pain	□ Urinary Problems
□ Fatigue	□ Exposure to TB	□ Weight loss	□ Back Pain	□ Rashes/Moles
□ Bleeding/Bruising	□ Anemia	□ Dental Problems	□ Injuries	□ Bug Bites

SOCIAL HISTORY: Please provide an accurate history. All answers are confidential.

TOBACCO USE	ALCOHOL USE
Do you smoke? Y N If Yes, packs per day:	Do you Drink? Y N If Yes, Drinks per week:
Number of years:	Do you feel you need to cut down on your drinking?
Are you interested in quitting? Y N	Do you get annoyed when people talk to you about your drinking?

IMMUNIZATIONS: Please mark if you have received any of the following immunizations.

□ Hep A Date:	□ MMR Date:
□ Hep B Date:	□ Pneumovax (Pneumonia) Date:
□ Tetanus (Td) Date:	□ Varicella (Chicken Pox) Date:

SHELTER ISLAND MEDICAL GROUP

Andrew Saleh, M.D. / Ned H. Chambers, M.D.
1370 Rosecrans St. San Diego, Ca 92106
Phone: (619) 223-2668 Fax: (619) 223-2698

FINANCIAL POLICY

1) COPAYMENTS: Copays are due at the time of check in for your appointment. Our office accepts cash, credit, and debit.

2) MISSED APPOINTMENT: Cancellations must be done at least 24 hours prior to your appointment. If we are not notified within that period or you fail to show up for your appointment, you maybe subject to a $75 fee.

3) INSURANCE DEDUCTABLES: If you have not met your deductible for your plan year, you are required to pay at the time of your appointment. It is your responsibility to verify with your insurance whether you have met your deductible or not.

4) INSURANCE CARDS: Your insurance card and complete insurance information is required at the time of each visit. New patients MAY NOT be seen without insurance verification.

5) INSURANCE POLICIES: As a courtesy, we will bill your primary and secondary insurance policies, if applicable. However, you are ultimately responsible for payment of services that are not covered by your insurance plan. It is your responsibility to call your insurance and find out which services are covered.

6) RETROACTIVE POLICY CHANGES: Should your eligibility and/or benefits change due to retractive policy changes, you will be responsible for the cost of all services provided at the time of your visit.

7) OUT-OF-NETWORK COVERAGE: Payment is due in full at the of service if we are not contracted with your insurance provider. As a courtesy to you, we will bill your insurance and they will remit payment to you directly.

By signing below, you agree that you understand and will abide by the above described financial policy. Thank you.

Print Name:_____ Signature:_____ Date: _____

SHELTER ISLAND MEDICAL GROUP

Patient Registration Form (Please print clearly)

LAST NAME:_____ FIRST NAME:_____ MI:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____

EMAIL:_____S.S. #:_____-_____-_____DOB:_____/_____/_____

GENDER: □ MALE □ FEMALE □ OTHER:_____ MARITAL STATUS: □ MARRIED □ SINGLE □ DIVORCED □ WIDOWED

DO YO HAVE ANY ALLERGIES TO MEDICATION? □ YES □ NO IF YES, PLEASE LIST:_____

EMPLOYER:_____ PHONE #:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE #:_____

INSURANCE SUBSCRIBER INFORMATION

(IF DIFFERENT FROM ABOVE)

INSURANCE NAME:_____INSURANCE ID#:_____

SUBSCRIBER NAME:_____PHONE #:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

EMAIL:_____S.S. #:_____-_____-_____DOB:_____/_____/_____

IMPORTANT BILLING INFORMATION

I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF ALL INSURANCE BENEFITS TO BE DIRECTLY MADE TO SHELTER ISLAND MEDICAL GROUP. I HEREBY AUTHORIZE SHELTER ISLAND MEDICAL GROUP TO RELEASE ALL INFORMATION NECESARRY TO SECURE THE PAYMENT OF INSURANCE BENEFITS. I UNDERSTAND AND AGREE THAT I AM FINANCIALLY LIABLE FOR ALL CHARGES WHEN THEY ARE NOT COVERED BY INSURANCE. NOTE: BALANCES THAT ARE PATIENT RESPONSIBILITY AND DO NOT HAVE ANY ACTIVITY FOR 60 CONSECUTIVE DAYS ARE SUBJECT TO A 10% LATE FEE.

PATIENT OR GUARDIAN SIGNATURE:_____ DATE:_____

VOICEMAIL/EMAIL AUTHORIZATION

I HEREBY GIVE MY PERMISSION TO ANY STAFF MEMBER OF SHELTER ISLAND MEDICAL GROUP TO LEAVE A VOICEMAIL MESSAGE AND/OR EMAIL PERTAINING TO ANY LAB RESULTS, REFERRALS, APPOINTMENT, AND ANY OTHER MEDICAL CONCERN.

PATIENT OR GUARDIAN SIGNATURE:_____ DATE:_____

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PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I HAVE RECEIVED THE NOTICE Of PRIVACY PRACTICES AND HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT

PATIENT OR GUARDIAN NAME:_____DOB:_____/_____/_____

SIGNATURE:_____DATE:_____