Patient Registration Information

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

HOW DID YOU HEAR ABOUT US? ☐ NEWSPAPER ☐ SOCIAL MEDIA/WEB SEARCH ☐ INSURANCE REFERRAL ☐ FAMILY/FRIEND

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐ M ☐ F
	N/A				

BILLING ADDRESS	CITY	STATE	ZIP

PHYSICAL ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL (example@test.com)

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email ☐Text	MARITAL STATUS	RACE	ETHNICITY

EMERGENCY CONTACT NAME	EMERGENCY PHONE XXX-XXX-XXXX

ADDRESS	PHONE#	OCCUPATION

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If applicable)
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP

WORK PHONE	OCCUPATION	WORK PHONE	OCCUPATION

POLICY HOLDER/GUARANTOR (If different than patient)

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐M ☐F

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email ☐Text	MARITAL STATUS	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF POLICY HOLDER	BIRTH DATE	GROUP #	
RELATIONSHIP TO PATIENT		COPAY AMT. PCP $	SPECIALIST
ADDRESS OF INSURANCE COMPANY		DEDUCTIBLE AMT. SELF	DEDUCTIBLE AMT. FAMILY
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF POLICY HOLDER	BIRTH DATE	GROUP #	
RELATIONSHIP TO PATIENT		COPAY AMOUNT $	
ADDRESS OF INSURANCE COMPANY		DEDUCTIBLE AMOUNT	
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

REFERRAL INFORMATION

NAME OF REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Palomar Health Medical Group to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Palomar Health Medical Group.

Patient / Guardian Signature _____ Date _____ Relationship to Patient _____

Patient Diversity Form

PALOMAR HEALTH MEDICAL GROUP®
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PATIENT INFORMATION

Dear Palomar Health Medical Group Patient:

The Federal Government requests the following questions be asked of every patient. Please select the preference that fits you the best and return this to the front office person. *** See below for race and ethnicity descriptions*

I identify my race as: (Please check one)

- ☐ I decline to self identify.
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black, African American
- ☐ Native Hawaiian or other Pacific
- ☐ Islander Other Pacific Islander
- ☐ Other Race- _____
- ☐ White

I identify my ethnicity as: (Please check one)

- ☐ I decline to self identify.
- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino / Spanish
- ☐ Latin / American / Latin, Latino Mexican
- ☐ Not Hispanic / Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard

My Language Preference is: (Please check one)

- ☐ English
- ☐ Spanish
- ☐ Tagalog
- ☐ Russian
- ☐ Persian / Farsi
- ☐ Other (Please specify) _____

***Race is defined as a "person's self-identification with one or more social group".*

***Ethnicity is defined as a "person's self-identification based on nationality, language, culture and religion, geography or family's origin."*

DO NOT FILE IN NG

Health History

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NAME (LAST, FIRST, M.I.)	DATE OF BIRTH	SEX: ☐M ☐F	TODAY'S DATE
ADDRESS	PHONE		EMAIL

PHARMACY

PHARMACY	ADDRESS	PHONE #
PHARMACY	ADDRESS	PHONE #

MEDICATIONS, OVER THE COUNTER MEDICATIONS & VITAMINS

DRUG NAME, STRENGTH, FREQUENCY	DRUG NAME, STRENGTH, FREQUENCY

ADULT ALLERGIES

NOTE: ALLERGIES ENTERED HERE WILL NOT BE CHECKED AGAINST THE CURRENT MEDICATION LIST.

☐ ACCUPRIL (QUINAPRIL)	☐ DEMEROL	☐ LATEX	☐ PREVACID
☐ ACETAMINOPHEN	☐ DEPAKOTE	☐ LEVOFLOXACIN	☐ PRILOSEC
☐ ACYCLOVIR	☐ DIABETA (GLYBURIDE)	☐ LIDOCANE	☐ PRINIVIL
☐ ADVIL (IBUPROFEN)	☐ DIAMOX	☐ LIPITOR	☐ QUINOLONES
☐ ALTACE (RAMIPRIL)	☐ DICLOXACILLIN	☐ LODINE	☐ RANITIDINE
☐ AMPICILLIN	☐ DOXYCYCLINE	☐ LOPRESSOR (METOPROLOL)	☐ SEPTRA (SULFAMETHOXAZOLE)
☐ AMARYL (GLIMEPIRIDE)	☐ EGG	☐ MICRONASE (GLYBURIDE)	☐ SULFA
☐ AUGMENTIN (AMOXICILLIN)	☐ ERYTHROMYCIN	☐ MINOCIN (MINOCYCLINE)	☐ TAGAMET (CIMETIDINE)
☐ ASPIRIN	☐ FAMOTIDINE	☐ MORPHINE	☐ TEGRETOL (CARBAMAZEPINE)
☐ BACTRIM (SULFAMETHOXAZOLE)	☐ FLAGYL	☐ MOTRIN (IBUPROFEN)	☐ TENORMIN (ATENOLOL)
☐ BIAXIN	☐ FLOXIN	☐ NAPROSYN (NAPROXEN)	☐ TETANUS TOXOID
☐ CARAFATE (SUCRALFATE)	☐ GLUCETROL (GLIPIZIDE)	☐ NEPTAZANE	☐ TETRACYCLINE
☐ CECLOR (CEFACLOR)	☐ HEPARIN	☐ NIACIN	☐ TICLID
☐ CELEBREX	☐ IBUPROFEN	☐ OXYCODONE	☐ VALIUM (DIAZEPAM)
☐ CEPHALOSPORINS	☐ INDERAL (PROPRANOLOL)	☐ PEANUT	☐ VANCOMYCIN
☐ CIPRO (CIPROFLOXACIN)	☐ INDOCIN (INDOMETHACIN)	☐ PENICILLIN	☐ VASOTEC
☐ CLINORIL (SULINDAC)	☐ INSULIN (ANIMAL)	☐ PERCOCET (OXYCODONE)	☐ ZESTRIL
☐ CONTRAST MEDIA (IOVERSOL)	☐ IODINE OR SHELLFISH	☐ PERSANTINE	☐ ZITHROMAX
☐ CODEINE	☐ KEFLEX (CEPHALEXIN)	☐ PLAVIX	☐ ZOCOR
☐ COUMADINE	☐ KLONOPIN	☐ PHENYTOIN	☐ ZYLOPRIM (ALLOPURINOL
☐ DARVON	☐ LASIX (FUROSEMIDE)	☐ PRAVOCHOL	

Health History

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FOOD ALLERGIES / OTHER ALLERGIES

MEDICAL HISTORY

☐ ALLERGIES	ONSET DATE	☐ GALLBLADDER DISEASE	ONSET DATE
☐ ANEMIA	ONSET DATE	☐ GERD	ONSET DATE
☐ ANGINA	ONSET DATE 12/6/17	☐ HEADACHE, MIGRAINE	ONSET DATE
☐ ANXIETY	ONSET DATE	☐ HEART DISEASE	ONSET DATE
☐ ARTHRITIS	ONSET DATE	☐ HEART VALVE DISORDER	ONSET DATE
☐ ASTHMA	ONSET DATE	☐ HEPATITIS / LIVER DISEASE	ONSET DATE
☐ ATRIAL FIBRILLATION	ONSET DATE	☐ HYPERTENSION	ONSET DATE
☐ BLOOD CLOTS	ONSET DATE	☐ IRRITABLE BOWEL DISEASE	ONSET DATE
☐ CANCER	ONSET DATE	☐ MYOCARDIAL INFARCTION	ONSET DATE
☐ CARDIAC ARRYTHMIA	ONSET DATE	☐ OSTEOPOROSIS	ONSET DATE
☐ COPD	ONSET DATE	☐ RENAL DISEASE	ONSET DATE
☐ CORONARY ARTERY DISEASE	ONSET DATE	☐ SEIZURE DISORDER	ONSET DATE
☐ DEPRESSION	ONSET DATE	☐ STROKE	ONSET DATE
☐ DIABETES	ONSET DATE	☐ THYROID DISEASE	ONSET DATE
☐ ELEVATED LIPIDS	ONSET DATE	☐ OTHER	ONSET DATE

SURGICAL HISTORY

☐ ANGIOPLASTY	DATE	☐ CATARACT EXTRACTION	DATE	☐ LASIK	DATE
☐ APPENDECTOMY	DATE	☐ CHOLECYSTECTOMY	DATE	☐ MASTECTOMY	DATE
☐ ARTHROSCOPY	DATE	☐ COLECTOMY	DATE	☐ MYOMECTOMY	DATE
☐ BACK SURGERY	DATE	☐ COLOSTOMY	DATE	☐ ORIF	DATE
☐ BILATERAL TUBAL LITIGATION	DATE	☐ D&C	DATE	☐ THYROIDECTOMY	DATE
☐ BLOOD TRANSFUSION	DATE	☐ GASTRIC BYPASS	DATE	☐ TONSILLECTOMY	DATE
☐ BREAST AUGMENTATION	DATE	☐ HERNIA REPAIR	DATE	☐ OTHER	DATE
☐ CABG	DATE	☐ HIP REPLACEMENT	DATE		
☐ CARDIAC PACEMAKER	DATE	☐ HYSTERECTOMY	DATE		
☐ CARPAL TUNNEL RELEASE	DATE	☐ KNEE REPLACEMENT	DATE		

Health History

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FAMILY HISTORY ☐ None

RELATIONSHIP	☐ ALIVE AND WELL
FAMILY MEMBER NAME	☐ DECEASED
☐ ADD / ADHD ONSET AGE	☐ CAUSE OF DEATH
☐ ALCOHOLISM ONSET AGE	☐ CAUSE OF DEATH
☐ ALLERGIES ONSET AGE	☐ CAUSE OF DEATH
☐ ALZHEIMER'S DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ ARTHRITIS ONSET AGE	☐ CAUSE OF DEATH
☐ ASTHMA ONSET AGE	☐ CAUSE OF DEATH
☐ BLOOD DISORDER ONSET AGE	☐ CAUSE OF DEATH
☐ CANCER ONSET AGE	☐ CAUSE OF DEATH
☐ CARDIOVASCULAR DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ CORONARY ARTERY DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ CORONARY ARTERY DISEASE (PRE) ONSET AGE	☐ CAUSE OF DEATH
☐ DEPRESSION ONSET AGE	☐ CAUSE OF DEATH
☐ DEVELOPMENTAL DELAY ONSET AGE	☐ CAUSE OF DEATH
☐ DIABETES ONSET AGE	☐ CAUSE OF DEATH
☐ ECZEMA ONSET AGE	☐ CAUSE OF DEATH
☐ ELEVATED LIPIDS ONSET AGE	☐ CAUSE OF DEATH
☐ GENETIC DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ HEARING DEFICIENCY ONSET AGE	☐ CAUSE OF DEATH
☐ HYPERTENSION ONSET AGE	☐ CAUSE OF DEATH
☐ IRRITABLE BOWEL DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ LEARNING DISABILITY ONSET AGE	☐ CAUSE OF DEATH
☐ MENTAL ILLNESS ONSET AGE	☐ CAUSE OF DEATH
☐ MIGRANES ONSET AGE	☐ CAUSE OF DEATH
☐ OBESITY ONSET AGE	☐ CAUSE OF DEATH
☐ OSTEOPOROSIS ONSET AGE	☐ CAUSE OF DEATH
☐ PERIPHERAL VASCULAR DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ RENAL DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ SEIZURE DISORDER ONSET AGE	☐ CAUSE OF DEATH
☐ STROKE ONSET AGE	☐ CAUSE OF DEATH
☐ THYROID DISORDER ONSET AGE	☐ CAUSE OF DEATH
☐ OTHER ONSET AGE	☐ CAUSE OF DEATH

FAMILY HISTORY – Continued

RELATIONSHIP	☐ ALIVE AND WELL
FAMILY MEMBER NAME	☐ DECEASED
☐ ADD / ADHD ONSET AGE	☐ CAUSE OF DEATH
☐ ALCOHOLISM ONSET AGE	☐ CAUSE OF DEATH
☐ ALLERGIES ONSET AGE	☐ CAUSE OF DEATH
☐ ALZHEIMER'S DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ ARTHRITIS ONSET AGE	☐ CAUSE OF DEATH
☐ ASTHMA ONSET AGE	☐ CAUSE OF DEATH
☐ BLOOD DISORDER ONSET AGE	☐ CAUSE OF DEATH
☐ CANCER ONSET AGE	☐ CAUSE OF DEATH
☐ CARDIOVASCULAR DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ CORONARY ARTERY DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ CORONARY ARTERY DISEASE (PRE) ONSET AGE	☐ CAUSE OF DEATH
☐ DEPRESSION ONSET AGE	☐ CAUSE OF DEATH
☐ DEVELOPMENTAL DELAY ONSET AGE	☐ CAUSE OF DEATH
☐ DIABETES ONSET AGE	☐ CAUSE OF DEATH
☐ ECZEMA ONSET AGE	☐ CAUSE OF DEATH
☐ ELEVATED LIPIDS ONSET AGE	☐ CAUSE OF DEATH
☐ GENETIC DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ HEARING DEFICIENCY ONSET AGE	☐ CAUSE OF DEATH
☐ HYPERTENSION ONSET AGE	☐ CAUSE OF DEATH
☐ IRRITABLE BOWEL DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ LEARNING DISABILITY ONSET AGE	☐ CAUSE OF DEATH
☐ MENTAL ILLNESS ONSET AGE	☐ CAUSE OF DEATH
☐ MIGRANES ONSET AGE	☐ CAUSE OF DEATH
☐ OBESITY ONSET AGE	☐ CAUSE OF DEATH
☐ OSTEOPOROSIS ONSET AGE	☐ CAUSE OF DEATH
☐ PERIPHERAL VASCULAR DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ RENAL DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ SEIZURE DISORDER ONSET AGE	☐ CAUSE OF DEATH
☐ STROKE ONSET AGE	☐ CAUSE OF DEATH
☐ THYROID DISORDER ONSET AGE	☐ CAUSE OF DEATH
☐ OTHER ONSET AGE	☐ CAUSE OF DEATH

Health History

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SOCIAL HISTORY

DATE OF RECENT TRAVEL AND DESTINATION:

GENERAL HEALTH & HABITS (CHECK ALL THAT APPLY)

PRESENT HEALTH STATUS: ☐ EXCELLENT ☐ VERY GOOD ☐ AVERAGE ☐ POOR		WEIGHT: 10 YRS AGO? 5 YRS AGO? WEIGHT NOW?	
REGULAR EXERCISE? ☐ YES ☐ NO	DO YOU SMOKE? ☐ YES ☐ NO	ALCOHOL USE? ☐ YES ☐ NO	CAFFEINE USE? ☐ YES ☐ NO
HOW LONG REGULARLY? (YRS)	☐ CIGARETTES ☐ PIPE ☐ CIGARS	# DRINKS PER DAY/WK	# CUPS OF COFFEE/DAY?
TYPE:	PACKS PER DAY:	STOPPED? ☐ YES ☐ NO	# CUPS OF TEA/DAY?
FREQUENCY (WK/TIME)	YRS SMOKED:	YRS QUIT:	# CANS/GLASSES?

OB GYN HISTORY

LAST PERIOD:	☐ LIGHT BLEEDING	FLOW DURATION	☐ REGULAR CYCLES	LAST PAP SMEAR
PADS USED IN 24HR:	☐ HEAVY BLEEDING	AGE OF FIRST PERIOD	☐ IRREGULAR CYCLES	☐ PAST ABNORMAL PAP
☐ TAMPON USE	PREGNANCIES (GRAVID)	DELIVERIES (PARA):		☐ MENOPAUSE

OB GYN SURGICAL HISTORY (PLEASE CHECK ALL THAT APPLY) ☐ None

☐ BREAST AUGMENTATION	☐ BREAST LUMPECTOMY	☐ HYSTERECTOMY (TOTAL ABD)	☐ MYOMECTOMY	☐ SALPINGO OOPHORECTOMY
☐ BILATERAL TUBAL LIGATION	☐ CESAREAN SECTION	☐ MASTECTOMY	☐ REDUCTION MAMMOPLASTY	☐ VAGINA HYSTERECTOMY
☐ BREAST BIOPSY	☐ D AND C	☐ OTHER:		

VACCINATIONS

☐ FLU	☐ PNEUMOCOCCAL	☐ HEP B	☐ MENINGOCOCCAL	☐ TETANUS
☐ PPD (TUBERCULOSIS TEST)		☐ OTHER:		

ADVANCE DIRECTIVE

Do you have an Advance Directive? ☐ Yes ☐ No

Would you like to discuss Advance Directives? ☐ Yes ☐ No