Pacific Central Coast Health Centers
A Service of Dignity Health

Patient Demographics Today's Date_____

Name_____ AKA_____
Last First Middle

DOB_____ Social Security_____ Sex ☐ Female ☐ Male

Address_____

City_____ State_____ Zip_____

Home Phone ( )_____ Cell Phone ( )_____

Pref. Contact Method_____ Email_____

Primary Care Physician_____ Primary Language _____

Race ☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Island ☐ White ☐ Other ☐ Decline

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Refuse to Report

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact
Name_____ Home Phone ( )_____

Relationship _____ Work Phone ( )_____

Emergency Contact
Name_____ Home Phone ( )_____

Relationship _____ Work Phone ( )_____

Employer/Student Status ☐ Fulltime ☐ Part-time ☐ Unemployed ☐ Retired ☐ Student ☐ Active Military

Employer_____ Work Phone ( )_____

Family and Friends Authorization- Individuals staff can discuss appointment and balance information with.

Name_____ DOB _____

Name_____ DOB _____

Name_____ DOB _____

Responsibility for Care (for minors)

☐ Parent ☐ Guardian's Name _____ DOB_____

Address_____

City_____ State_____ Zip_____

Home Phone ( )_____ Cell Phone ( )_____

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Datos demográficos del/ de la paciente Fecha de hoy_____

Nombre_____Alias_____
Apellido Primer nombre Segundo nombre

Fecha de nacimiento_____N° de Seguro Social_____Sexo: ☐ Femenino ☐ Masculino

Dirección_____

Ciudad_____ Estado____ Código postal_____

Teléfono del domicilio ( )_____ Teléfono celular ( )_____

Método preferido de contacto_____Correo electrónico_____

Médico de atención primaria_____Idioma primario_____

Raza ☐ Afroamericano/a o negro/a ☐ Indio/a americano/a o nativo/a de Alaska ☐ Asiático/a
☐ Nativo/a de Hawái o isla del Pacífico ☐ Blanco/a ☐ Otro ☐ Prefiero no contestar

Etnicidad ☐ Hispano/a o latino/a ☐ Ni hispano/a ni latino/a ☐ Me rehúso a revelarla

Estado civil ☐ Soltero/a ☐Casado/a ☐ Divorciado/a ☐ Viudo/a ☐ Separado/a

Persona para contactar en caso de emergencia

Nombre_____ Teléfono del domicilio ( )_____

Relación_____Teléfono del trabajo ( )_____

Persona para contactar en caso de emergencia

Nombre_____ Teléfono del domicilio ( )_____

Relación_____ Teléfono del trabajo ( )_____

Empleador/ Estudiante Estatus ☐ Tiempo completo ☐ Tiempo parcial ☐ Desempleado ☐ Jubilado
☐ Estudiante ☐ Militar Activo

Empleador_____ Teléfono del trabajo ( )_____

Autorización para familiares y amistades- Podemos discutir la cita y la información de equilibrio con personas.

Nombre_____ Fecha de nacimiento_____

Nombre_____ Fecha de nacimiento_____

Nombre_____ Fecha de nacimiento_____

Responsabilidad de la atención del/ de la paciente (para menores de edad)

☐ Padre/ Madre ☐ Nombre del/ de la tutor(a) _____Fecha de nacimiento_____

Dirección_____

Ciudad_____ Estado____ Código postal_____

Teléfono del domicilio ( )_____ Teléfono celular ( )_____

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Annual Patient Acknowledgement

Today's Date _____

Patient Name _____ **DOB** _____

Insurance Information Primary Coverage

Insurance Name _____ Subscriber ID _____

Subscriber's Name _____ DOB _____ Relationship to Patient _____

Insurance Information Secondary Coverage

Insurance Name _____ Subscriber ID _____

Subscriber's Name _____ DOB _____ Relationship to Patient _____

Advanced Healthcare Directive
Does patient have a current Advanced Healthcare Directive? ☐ Yes ☐ NO
If no, was Advanced Healthcare Directive information offered to the patient? ☐ Yes ☐ NO

Consent/Authorization

I hereby consent to and authorize all examinations including physical exams, x-ray, and laboratory procedures and obtaining medical histories from pharmaceutical databases that may be necessary in the judgment of the practitioner for diagnostic purposes. I authorize the release of medical or other information necessary to process my insurance claim.

Assignment of Insurance Benefits
The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Pacific Central Coast Health Centers (PHC) of any insurance benefits payable to, or on behalf of the patient. It is agreed that payment to PHC, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for the charges not paid pursuant to this agreement.

Financial Policy

- Payment is due for all co-pays, co-insurance, deductibles and non-covered services on the date of service.
- It is your responsibility to know your benefits prior to your visit. Some services and procedures may not be covered by your insurance including preventive care. You are responsible for payment of all non-covered care.
- Amounts due at the time of service are estimates only. Your actual costs may differ.
- Eligibility and benefit confirmation is not a guarantee of payment by your insurance company.
- As a service we will bill all contracted insurance companies for you, however you are responsible for obtaining reimbursement for employer sponsored reimbursement plans.
- Even though you may be covered by medical insurance, you are responsible for the fee. Most insurance companies pay only a portion of the costs.
- For patients who cancel an appointment with less than 24 hours of prior notice or when a patient misses an appointment, a fee of $25.00 may be charged to the patient. This fee is the patient's responsibility to pay, as it is not payable by insurance companies
- I authorize PHC, its assignees, and third party collection agents to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone, employment telephone, and email/text communications. I hereby grant permission and consent to PHC, its assignees, and third party collection agents to place calls to my home telephone, cellular telephone, and employment telephone; leave messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection.

By the signature(s) below, I have read, understand, and agree to the Health Care Directive, Consent/Authorization, Assignment of Insurance Benefits and Financial Policy.

_____ _____
Patient Name (Please Print) Parent/Guardian Name (Please Print)

_____ _____ _____ _____
Patient Signature Date Parent/Guardian Signature Date

Pacific Central Coast Health Centers
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Confirmación anual del/ de la paciente

Fecha de hoy_____

Nombre del/ de la paciente_____ **Fecha de nacimiento** _____

Información del seguro — Cobertura primaria

Nombre del seguro (o aseguranza)_____ Nº de carnet del abonado_____

Nombre del/ de la abonado/a _____Fecha de nacimiento _____Relación con el/ la paciente_____

Información del seguro — Cobertura secundaria

Nombre del seguro (o aseguranza)_____ Nº de carnet del abonado_____

Nombre del/ de la abonado/a _____ Fecha de nacimiento _____Relación con el/ la paciente_____

Instrucciones por anticipado acerca de la atención médica

¿El/ la paciente tiene instrucciones por anticipado actuales acerca de la atención médica? ☐ SÍ ☐ NO

Si respondió que no, ¿se le ofreció información acerca de las instrucciones por anticipado acerca de la atención médica al/ a la paciente?
☐ SÍ ☐ NO

Consentimiento o autorización

Por la presente acepto y autorizo todos los exámenes, incluyendo exámenes físicos, radiografías, y procedimientos de laboratorio y la obtención de historias clínicas de las bases de datos farmacéuticas que sean necesarios para propósitos diagnósticos según el criterio del profesional. Autorizo la divulgación de información médica u otra información necesaria para procesar mi reclamación del seguro.

Asignación de las prestaciones del seguro

El/ la que suscribe autoriza, sea al firmar como representante o como paciente, el pago directo a Pacific Central Coast Health Centers (PHC; Centros de Salud de la Costa Pacífica Central, en español) de cualquier prestación del seguro, pagadero al/ a la paciente o de parte de éste/a. Se dispone que el pago que le haga una compañía aseguradora a PHC, en virtud de esta autorización, eximirá a dicha compañía aseguradora de cualquier obligación bajo una póliza dentro del alcance de tal pago. El/ la que suscribe tiene entendido que él o ella tiene la responsabilidad financiera de los cargos que no se paguen en virtud de este acuerdo.

Normas financieras

- Se deben pagar en la fecha del servicio, todos los copagos, el coseguro, los deducibles y los servicios que no estén cubiertos.
- Usted tiene la responsabilidad de estar al tanto de sus prestaciones antes de la consulta. Es posible que algunos servicios y procedimientos no estén cubiertos por su seguro, incluyendo la atención preventiva. Usted es responsable de pagar toda la atención que no tenga cobertura.
- Las cantidades pagaderas en el momento del servicio son solamente aproximadas. Es posible que sus costos reales sean diferentes.
- Los requisitos y la confirmación de una prestación no constituyen una garantía de pago por parte de su compañía aseguradora.
- Como un servicio, facturaremos por usted a todas las compañías aseguradoras contratadas; sin embargo, usted es responsable de obtener los reembolsos de los planes de reembolso patrocinados por el empleador.
- Aunque puede ser que usted esté cubierto/a por un seguro médico, usted es responsable del cargo. La mayoría de las compañías aseguradoras pagan solamente una porción de los costos.
- Para aquellos/as pacientes que cancelen una cita con menos de 24 horas de anticipación o cuando a un(a) paciente se le pase una cita, puede que se le haga un cargo de $25.00 al/ a la paciente. El/ la paciente es responsable de pagar este cargo, ya que no lo pagan las compañías de seguros.
- Autorizo a PHC, sus cesionarios y agentes de cobranza que sean terceras partes, para utilizar toda la información de contacto que he proporcionado para comunicarse conmigo. Esto incluye, entre otros, el teléfono de mi domicilio, mi teléfono celular, el teléfono de mi empleo y las comunicaciones por correo electrónico y texto. Por la presente le otorgo mi permiso y consentimiento a PHC, sus cesionarios y agentes de cobranza que sean terceras partes, para hacer llamadas al teléfono de mi casa, a mi teléfono celular y al teléfono de mi empleo; para dejar mensajes (ya sea de voz o texto); y en relación con lo mismo, para utilizar mensajes grabados de antemano y con voz artificial y/o dispositivos de marcación automática.

Al firmar a continuación, indico que he leído, entiendo y acepto *las Instrucciones por anticipado acerca de la atención médica*, el *Consentimiento o autorización*, la *Asignación de las prestaciones del seguro*, y las *Normas financieras*.

Nombre del/ de la paciente (en letras de molde o imprenta)		Nombre del padre/ de la madre o tutor(a) (en letras de molde o imprenta)	
Firma del/ de la paciente	Fecha	Firma del padre/ de la madre o tutor(a)	Fecha

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Joint Notice of Privacy Practices for Health Information (NPP) Acknowledgment Form

Effective April 14, 2003, the law requires that Dignity Health give to a patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care.

Patient Name: _____ Medical Record # _____

Acknowledgment Signature: _____ Date: _____

Print Name: _____ Relationship to patient _____
(if signed by someone other than patient)

Conjunto Aviso de Prácticas para Información de Salud (NPP) Forma de Reconocimiento

Efectivo el 14 de abril, 2003, la ley requiere que Dignity Health de al paciente una copia de su Aviso de Prácticas de Privacidad para Información de Salud. Le daremos a usted una copia en la hora de su primer tratamiento y, si cambiamos nuestro aviso, de allí en adelante, en su próxima visita. Firmando más abajo, usted como paciente, representante personal del paciente, representante autorizado, o individuo involucrado en el cuidado médico del paciente, reconoce haberlo recibido.

Nombre del paciente: _____ # de Récord Médico _____

Firma de Recibo: _____ Fecha: _____

Nombre: _____ Relación al paciente: _____
(si ha sido firmado por alguien que no sea el paciente)

For Official Use

Signature of Employee: _____ Date: _____

Print Name: _____ Department: _____

NPP

Pacific Central Coast Health Centers
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide ***all*** information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____ Date of Birth: _____

Other Names Used: _____ Telephone Number: _____

Medical Record or Account#: _____
(Hospital use only)

I AUTHORIZE: _____
(Facility or other provider)

TO DISCLOSE TO: _____
(Persons/organizations authorized to ***receive*** the information)

at the following address: _____
(Street, city, state and zip code)

the following information contained in the records specified below (check box and initial applicable lines below):

_____ Mental health or developmental disability treatment records (excludes "psychotherapy notes").

_____ Substance abused treatment records.

_____ HIV test results (This authorizes disclosure of laboratory test results only.).
Note that your records may include information concerning your HIV status <u>even</u> if you do not initial this line.)

☐ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

○ Billing Record	○ Emergency Room Reports	○ Procedure Report
○ Consultation Reports	○ History and Physical	○ Progress Notes
○ Discharge Summary	○ Laboratory Tests	○ X-ray Reports

○ Date(s): _____

○ Other: _____

☐ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care.
A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

- ☐ At the request of the patient or personal representative; ***OR***
- ☐ Other: Change of Ownership

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____
(insert date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it. My revocation will take effect upon receipt, except to the extent that others have taken action in reliance upon this authorization.
- I have a right to receive a copy of this authorization

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE:_____ Date: _____
(Patient or personal representative)

_____ _____
Print name of personal representative Relationship to patient

Patient/Representative Identification Verified. *Initials:* _____ *Dept:* _____

Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.D.E. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that I have the right to receive a copy of my medical records for my own personal use, for a charge of $25, due payable upon request.
Copy requested: Yes ☒ No ☐

Pacific Central Coast Health Centers
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Weight Loss Surgery Institute
of the Central Coast

Bariatric Patient Health History

Patient name_____ DOB____/____/____ Age____

Primary Care Physician_____
Address_____
Phone_____ Fax_____

Please list any MEDICAL HISTORY:

Problem	Year of Diagnosis	Management/Special Care
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a problem with easy bleeding or blood clots (DVT or PE)? Yes No

Please list any SURGERY procedures:

Procedure	Year	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any problems with Anesthetics or Surgery? Yes No

Please list any MEDICATIONS you are taking:

Name of Drug	Dosage	Doses Per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medications you are ALLERGIC to:

Name of Drug	Reaction
_____	_____
_____	_____

Please list any HOSPITALIZATIONS not already listed above:

Date	Reason
_____	_____
_____	_____
_____	_____

Family History

Father Age___ Living___ Deceased___ Cause of death_____
Mother Age___ Living___ Deceased___ Cause of death_____

Children

Number of children____ Ages_____
Any health problems in your children? Yes No
If so, please explain_____
_____

Siblings

Brothers and sisters (list ages and significant medial problems)
_____
_____

Have any family members ever had?

Cardiac Disease/ Heart Attacks	Yes	No	Anesthetic Complications	Yes	No
Lung Disease	Yes	No	Other Disease	Yes	No
Cancer	Yes	No	Thyroid Disorders	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
High Blood Pressure	Yes	No	Bleeding Disorders	Yes	No

If so, please state whom and at what age_____

Social History

Single___ Married___ Widowed___ Divorced___
Occupation_____

Habits

Tobacco

Do you smoke? Yes No Cigarettes per day_____ How many years?_____
When did you stop smoking?_____

Alcohol

Do you drink alcohol? Yes No Drinks per day?_____

Other Substances

Do you use or have you ever used any recreational drugs (marijuana, methamphetamine, etc)? Yes No
Please explain _____
_____
_____
_____

Review of Systems (common medical problems)

Does your weight cause any of the following complications:
High Blood Pressure Yes No Date diagnosed___/___/___
How do you control your high blood pressure? __ Diet ___Oral medications ___Exercise ___Nothing
What is the highest blood pressure that you can recall?_____

Obstructive Sleep Apnea
Do you snore? Yes No
Do you wake from sleep often? Yes No
Do you feel rested when you wake up in the morning? Yes No
Does your spouse or significant other notice that you seem to have trouble breathing when you lie down? Yes No

Heartburn
When and how often does it occur?_____
How many years? _____
Does it awaken you at night? Yes No How often? _____
Do you ever awakened coughing and choking with regurgitations? Yes No
Do you ever regurgitate solid food? Yes No
Have you ever had an upper GI study or endoscopy? Yes No When? _____

Cholesterol and Lipids
Have you ever been told that your cholesterol or triglycerides were too high?
High cholesterol? Yes No How high?_____ What is it now? _____
High triglycerides? Yes No How high _____ What is it now? _____
How are/were these conditions treated? Diet _____ Medications _____ Not treated _____

Do you have **diabetes**? Yes No

Are you **depressed**? Yes No

Do you have **arthritis**? Yes No

Bariatric History

Are your parents or siblings overweight? Mother ___ Father___ Sisters___ Brothers___
Of those are any morbidly obese, which ones?_____

When did your obesity start? In childhood___ In puberty___ As an adult___ After pregnancy___
After a traumatic event___ Other___

Were you overweight as a teenager? Yes No If so, by how many pounds? ___

My weight as an adult has ranged between ___ pounds and ___ pounds.

I maintained this weight for ___ years or ___ months.

My current weight is ___ pounds.

My realistic goal weight is ___ pounds.

I felt best at a weight of ___ pounds when I was ___years of age.

Eating Patterns (please check all applicable):

Portions Large___ Medium ___ Small___
Type Normal___ Healthy___ Fast Food___ Junk Food___
Taste Preference Sweet___ Salty___ Comfort Foods___ Other___
Number of meals per day ___ Number of snacks per day ___
I eat extra calories due to Stress ___ Boredom___ Sweets craving___ Snacking___
Closet eating___ Binging___

I have participated in the following weight loss programs/ diets/ medications:

___Conventional dieting (limiting calorie intake)___Medifast ___Meridia ___Redux
___ Phen-fen ___Schick Center ___Nutra-System ___Weight Watchers
___ Jenny Craig ___ Slim Fast ___ Diet Center ___ Metabolife
___ Optifast ___ Atkins Diet ___ Lindora ___ Diet Pills
___ Cambridge ___ Sansum Wellness ___ Xenical ___Jaw Wiring
___ Hypnosis ___Acupuncture ___ Protein Diet
___ Medically Supervised Weight Loss Clinics ___ Overeater's Anonymous
___ Other _____

What have you tried for weight loss in the past five years? (i.e. Weight Watchers, Atkins diet, pills, etc.)

Weight Loss Method	Pounds Lost (approximate)	Month/Year (approximate)