La Jolla Personal Physicians Medical Group, Inc.
9834 Genesee Ave, Suite 400 • La Jolla, California 92037
(858) 622-9076 • Fax: (858) 587-4785

Seth D. Bulow, M.D.
Obstetrics, Gynecology & Infertility

PATIENT INFORMATION

Last Name:______________________ First Name:______________________ MI:______

Date of Birth: ______/______/______ Social Security# ______________________

Address: ______________________ City:______________ State:______ Zip:______

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other ☐ ______________

Home Phone # (   )__________ Cell Phone # (   )__________ Work Phone # (   )__________

Email: ______________________ @ ______________ . ______

May we leave a detailed message? Yes ☐ No ☐ If yes, which phone number Home ☐ Cell ☐ Work ☐

Employer Name:______________________ Occupation:______________________

EMERGENCY CONTACT

Last Name:______________ First Name:______________ Phone # (   )__________

INSURANCE SUBSCRIBER (Complete if you are not the policy holder or patient is a minor)

Last Name:______________________ First Name:______________________

Relationship to Patient:______________________ Date of Birth______/______/______

PREFERRED PHARMACY

Pharmacy Name:______________ Address:______________________ Phone #: (   )__________

REFERRAL

Referred By: ____

Assignment of Benefits and Release of Information: I hereby authorize my insurance benefits to be paid directly to La Jolla Personal Physicians Medical Group, Inc. I understand that I am financially responsible for all non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

Signature of Patient or Guardian: ______________________ Date:______/______/______

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Financial Policy of La Jolla Personal Physicians Medical Group, Inc.

Please be aware that it is your responsibility to know your insurance plan and to verify coverage for referrals to other doctors, recommended tests, and laboratories. We make every effort to refer you to providers, labs, and x-ray facilities that are members of most plans, but it is not possible for us to know the details of every plan. If you are in doubt about what is covered, please call your plan's member services department and check.

This office cannot be responsible for out-of-pocket expenses incurred from utilizing the wrong provider or facility, or for undergoing non-covered tests or procedures.

You are responsible for and we will collect any co-payments required by your insurance company.

Lab Tests and other charges:

You will receive separate billing from the lab and other companies who perform the processing and evaluation of those tests. Financial questions should be directed to the telephone number on the lab invoice.

I have read, and I agree to, the Financial Policy of La Jolla Personal Physicians Medical Group, Inc.

I understand I am responsible for making payments for my medical care according to these policies.

Patient name:____

Name of responsible party (print)

____

Responsible party's signature____________________________________

(Date)_______________________________________

PERSONAL HISTORY
(TO BE COMPLETED BY THE PATIENT)

NAME______________________ AGE__________ DATE OF BIRTH______________

MARITAL STATUS__________ SPOUSE'S NAME______________________ AGE__________

OCCUPATION______________________ SPOUSE'S OCCUPATION______________________

GYNECOLOGICAL AND OBSTETRICAL HISTORY

PREGNANCIES: List in order (include miscarriages and abortions)

No.	YR.	DURATION OF GESTATION	LENGTH OF LABOR	TYPE OF DELIVERY	SEX	WT.	LOCATION	COMPLICATIONS
1								
2								
3								
4								
5								
6								

Blood type (If known)__________

Date of last menstrual period______________ Was it Normal? YES / NO ______________
Date of last pap?______________ Date of last mammogram?______________ Where?______________
Abnormal Pap smear? Yes / No If Yes When?______________ What was done?______________
Birth control you are now using? None Pill IUD Other______________
Age at onset of period?__________ Number of days of flow?__________ How often do you menstruate?__________

ARE YOU CURRENTLY EXPERIENCING:	YES	NO	COMMENTS
Irregular Periods?			
Painful Periods?			
Tension or headaches with period?			
Heavy Periods?			
Bleeding between Periods?			
Bleeding during or after sex?			
Pain with sex?			
Abnormal discharge?			
Sexually transmitted diseases & Herpes?			
Pelvic infection?			
"Change of Life" (Menopause)?			
If Yes: Hot flashes?			
Hormones?			
If "Yes" What are they?			
Any breast lumps or discharge from the nipples?			
Loss of urine when you cough or sneeze?			

PAST HISTORY

Previous serious illness and/or other hospitalizations:

____

____

Operations? (When, What, Where?)

____

____

____

____

Drug Allergies?______________________

____

Blood Transfusions?______________________

____

Current Medications?______________________

____

____

____

SIGNATURE______________________ DATE______________

FAMILY HISTORY

Has anyone in your family had:

	YES	NO	If yes, Who?		YES	NO	If yes, Who?
Breast Cancer?				Twins?			
Ovarian Cancer?				High Blood Pressure?			
Uterine Cancer?				Bleeding Tendency?			
Colon Cancer?				Mental Illness?			
Other Cancers?				Blood Clots (in legs, lungs, or eyes)?			
Birth Defects?				HIV Infection (AIDS)?			
Tuberculosis?				Heart Disease?			
Diabetes?				Stroke?			

PERSONAL HISTORY

	YES	NO	
Do you smoke?			How much?
Do you drink?			How much?
Do you use any street drugs?			If yes, what?
Are you presently taking any type of medication?			If so, what?

SKIN:	YES	NO	CHEST (cont'd):	YES	NO
Bruise easily?			Chronic cough?		
Prolonged bleeding from cuts?			Cough up blood?		
Sore that doesn't heal?			Ankle swelling?		
Blood clots? (in legs, lungs, or eyes)			Heart often skip a beat or race?		
Moles or lesions that have grown or changed in size or color?			Chest pain?		
			Rheumatic fever?		

EYES:	YES	NO	GASTROINTESTINAL:	YES	NO
Wear glasses?			Recent change in appetite?		
Blurred vision?			Chronic constipation or diarrhea?		
See double?			Recent change in bowel habits?		
See spots or halos around light?			Bloody or tarry stools?		

EARS:	YES	NO	URINARY TRACT:	YES	NO
Difficulty hearing?			Kidney infection?		
Ringing in ears?			Pain, urgency or burning with urination?		
Frequent dizzy spells?			Blood in urine?		
Frequent headaches?			Sugar in your urine?		
			More than two urinary tract infections in the past year?		

NOSE, MOUTH THROAT:	YES	NO	NEUROMUSCULAR:	YES	NO
Frequent nose bleeds?			Convulsions?		
Dentures?			Swollen, red or stiff joints?		
Sore, sensitive, or bleeding gums?			Paralysis or deformity?		
Frequent sore throats?					
Hay fever or allergies?					

CHEST:	YES	NO	ENDOCRINE:	YES	NO
Asthma?			Unduly sensitive to heat or cold?		
High blood pressure?			Thyroid trouble?		
Heart trouble or murmur?			Diabetes?		
Shortness of breath?			Has you weight varied over 10 lbs in the last year?		

COMMENTS

____

____

SIGNATURE______________________ DATE______________

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Cancellation Policy/No Show Policy For Doctor Appointments and Surgery

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $50 fee; this will not be covered by your insurance company.

2. *Cancellation/ No Show Policy for Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a $250 fee; this is will not be covered by your insurance company.

3. *Account balances*

We require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

______________________	______________________	_____/_____/_____
Print Name	**Signature Patient/Guardian**	**Date**

Acknowledgement of Receipt of Notice of Privacy Practices

Seth D. Bulow, M.D.
9834 Genesee Avenue, Suite 400
La Jolla, CA 92037

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

______________________________@____________________.

Signed: ________________________ Date: ____________________

Print Name: ______________________ Telephone: __________________

If not signed by the patient, please indicate:

Relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

Name of Patient: __________________________

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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient:____
(First Name) *(Middle Initial)* *(Last Name)*

Former Name (if any)____________________ **Date of Birth:**___/___/___

Daytime Telephone Number: (   )____________________

I hereby authorize and request you to release:

- ☐ The complete medical records in your possession concerning my illness and/or treatment.
- ☐ Only the records indicated:______________________________

Release From:

____
Name

____
Address City State Zip

Phone # (____)____________________ Fax # (____)____________________

Release To:

Seth D. Bulow, M.D.
9834 Genesee Avenue
Suite 400
La Jolla, CA 92037
Telephone (858) 622-9076 Fax (858) 587-4785

I have an appointment with this office on: ______/______/______

This Authorization expires on _____/_____/_____ (optional) If no expiration date is given, then this authorization shall remain in effect.

I understand that I have the right to revoke this authorization, in writing, at any time.
I acknowledge I have fully reviewed and understand the contents of this authorization form . My signature below indicates that I hereby agree and authorize to release of patient health information to the above names person or organization.

______________________ ______________________ ____________
Patient or Guardian Signature Relationship to Patient Date