PATIENT INFORMATION

Name: _____
(Last name) (First Name) (Middle Name) (Maiden)

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Social Security#: _____-____-_____ Driver's License State: _____ Driver's License#: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Physical Home Address: _____

City, State, Zip: _____

Is your physical address different than your mailing address? ☐ No ☐Yes (if yes, enter mailing address below)

Mailing Address: _____

City, State, Zip: _____

Would you like to provide your email address? ☐ No ☐ Yes (enter below)

E-mail address: _____

Home Phone# _____-_____-_____ Mobile Phone# _____-_____-_____

Are you currently (check one): ☐ Employed ☐ Not employed ☐Disabled ☐Retired

Employers Name: _____

Employers Phone#: _____-_____-_____ Occupation: _____

Do you have an emergency contact? ☐Yes ☐ No

Emergency Contact: _____

Relationship: _____ Phone#: _____-_____-_____

Additional contact information (provide here): _____

How did you hear about us? _____

I authorize payment of medical benefits to Eva J. Lopez, MD, PA or Stormy Valdespino, FNP-C to obtain and or release any medical condition/treatment documentation necessary for processing my claims. I understand and agree that for any reason my insurance carrier(s) denies payment to Eva J. Lopez, MD, PA or Stormy Valdespino, FNP-C that I will be responsible for paying balances not covered by my insurance.

_____ _____

(Signature of Patient) (Today's date)

Payment Method: ☐ Private Pay ☐ Insurance

Do you have more than one health insurance plan? ☐ Yes ☐No

Do you have Medicare or a Medicare Replacement Insurance? ☐ Yes ☐ No

If you have a Medicare Replacement Insurance, do you qualify for Dual Eligibility with Medicaid? ☐ Yes ☐ No

Primary Insurance Information

Name of Insurance: _____

Insurance Subscriber (Primary Payor): _____

Relationship to subscriber: _____

Are you covered under the primary insurance? ☐ Yes ☐ No

Social security number of the person the insurance belongs to: _____-_____-_____

Date of birth of insurance subscriber: _____/_____/_____

Name of insurance subscriber employer: _____

Secondary Insurance Information

Name of Insurance: _____

Insurance Subscriber (Primary Payor): _____

Relationship to subscriber: _____

Are you covered under the primary insurance? ☐ Yes ☐ No

Social security number of the person the insurance belongs to: _____-_____-_____

Date of birth of insurance subscriber: _____/_____/_____

Name of insurance subscriber employer: _____

When was the start date/onset for the reason of your visit today: _____
(Month and/or Year)

Are you diabetic? ☐ Yes ☐ No

Have you ever enrolled in a diet program? ☐Yes ☐No If yes, when? _____

What type(s) of diet programs: ☐ Weight Watchers ☐ Jenny Craig ☐ NutriSystem ☐ Other: _____

Do you smoke? ☐ Yes ☐ No If yes, how many per day: _____ ☐ Cigarettes ☐ Cigarette Packs

Do you drink? ☐ Yes ☐ No If yes, what type of alcohol? _____

How often? _____ How many drinks? _____

Please List All Medication Allergies:

_____

_____

_____

Have you been diagnosed with any of the following:

☐ Cirrhosis
☐ Hypertension (High Blood Pressure)
☐ Diabetes
☐ Congestive Health Failure
☐ Renal (Kidney) Disease
☐ Renal Dialysis
☐ Protein in urine
☐ Asthma
☐ Emphysema
☐ Anemia
☐ Thyroid Disease
☐ Arthritis
☐ Myocardial Infarction (Heart Attack)
☐ Coronary Disease
☐ Cancer (specify which type): _____
☐ I have **not** had any of the above

What surgeries have you had?

☐ Appendix ☐ Tonsils ☐ Gall Bladder
☐ Hysterectomy (check one) ____ Partial ____ Total ☐ Breast Biopsy
☐ Coronary Artery Bypass ☐ Colon Surgery ☐ Gastric Bypass
☐ Prostate
☐ Cancer Surgery (location) _____
☐ Other: _____
☐ I have **not** had any surgery(ies)

Immediate Family History (check off any diseases family member have/had)

Diabetes: ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Son ☐ Daughter
Heart Disease: ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Son ☐ Daughter
Cancer: ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Son ☐ Daughter
Stroke: ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Son ☐ Daughter
Hypertension: ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Son ☐ Daughter

☐ **No one** in my immediate family has had any of the above

How did you learn about Be Well 365 diet program? _____

Are you pregnant? ☐ Yes ☐ No

Are you currently attempting to conceive? ☐ Yes ☐ No

Are you currently on birth control? ☐ Yes ☐ No If yes, what form of birth control? _____

Primary Care Physician

Physician Name: _____

Physician Address: _____

Physician Phone #: _____-_____-_____ Physician Fax #: _____-_____-_____

Pharmacy Information

Pharmacy Name (1): _____

Pharmacy Address: _____

Pharmacy Phone #: _____-_____-_____

Pharmacy Fax #: _____-_____-_____

Pharmacy Name (2): _____

Pharmacy Address: _____

Pharmacy Phone #: _____-_____-_____

Pharmacy Fax #: _____-_____-_____

Emergency Contact Information

Contact's Name: _____

Relationship of contact: _____

Phone Number: _____ Alternate: _____

Medication Chart

Please list ALL prescriptions or over the counter medications you are taking to include vitamins/supplements:

Name of Medication	Dosage Prescribed	Frequency Prescribed	Frequency Taken
Example: Medico	**Example: 300mg**	**Example: 30 days**	**Example: 1x day**

For Diet/Weight Management Program

Beverage Intake: Fill in the number of servings per day

Water: _____ Tea: ☐ Sweetened ☐ Unsweetened

Alcohol: _____ Coffee: ☐ Caffeinated ☐ Decaffeinated

100% Juice: _____ Milk: ☐ Whole ☐ 2% ☐ 1% ☐ Skim ☐ Non-Dairy

Other Fruit Drinks: _____ Soda: ☐ Regular ☐ Diet

Meal Replacement Drinks: _____

Protein Intake: Fill in the number of servings per week

Chicken: _____ Turkey: _____

Beef: _____ Pork: _____

Fish: _____ Seafood: _____

Eggs: _____ Nuts: _____

Tofu: _____ Soy: _____

Dairy Intake: Fill in the number of servings per week

Yogurt: _____ Cheese: _____

Fruit/Vegetable Intake: Fill in the number of servings per week

Fruits: _____ Vegetables: _____

Carbohydrate Intake: Fill in the number of servings per week

Bread: ☐ White ☐ Wheat ☐ Rye ☐ Other: _____ Serving: _____(#)

Pasta: _____ Cereal: _____ Potatoes: _____

Rice: ☐ White ☐ Brown ☐ Other: _____ Serving: _____ (#)

Tortillas: ☐ Flour ☐ Corn

Fat/Sweets Intake: Fill in the number of servings per week

Crackers: _____ Pretzels: _____

Popcorn: _____ Chips: _____

Candy: _____ Pastries (baked goods): _____

Cooking methods: Fill in the number of servings per week

Fried foods: _____ Fast Food: _____

Restaurants: _____ Artificial sweeteners: _____

Behavioral Methods:

Binge Eat: ☐ Yes ☐ No Emotional Eater: ☐ Yes ☐ No

Purge (make yourself vomit): ☐ Yes ☐ No Midnight Snack: ☐ Yes ☐ No

Supplement Intake:

Multi-Vitamin: ☐ Yes ☐ No Minerals: ☐ Yes ☐ No

Food Allergies: ☐ No ☐ Yes If yes, please list:

_____

Food Intolerance: ☐ No ☐ Yes If yes, please list:

_____

Previous Weight Loss Attempts (check all that apply)

Commercial Diets: Weight Watchers ☐ Jenny Craig ☐ NutriSystem ☐ TOPS ☐ LA Weight Loss

☐ Other: _____

Liquid diets: ☐ OptiFast ☐ SlimFast ☐ Medifast

☐ Other: _____

Fad diets: ☐ Atkins ☐ South Beach ☐ Cabbage Soup

☐ Other: _____

Prescription Drugs: ☐ Redux ☐ Pondimin ☐ Fen/Phen ☐ Meridia ☐ Xenical ☐ Adipex

☐ Other: _____

OTC pills: ☐ Dexatrim ☐ Herbal Life ☐ Metabolife ☐ Hydroxycut ☐ Trim Spa ☐ Alli ☐ Quick Slim ☐ Other:

Which program was the most successful? _____

What was the most weight lost during this program? _____

Why do you feel this program was the most successful? _____

Perceived reasons for weight gain/regain/unsuccessful diet attempts:

☐ Cost ☐ Program hard to maintain ☐ Frustration/Lack of motivation

☐ Slow weight loss ☐ Weight loss plateau ☐Too restrictive

☐ Caused uncomfortable feelings (i.e. headaches, heart palpitations, etc.)

☐ Other: _____

Describe your health goals

☐ Change body composition ☐ Learn to eat healthier ☐Reduce/Eliminate medications

☐ Increase mobility/exercise ☐ Increased energy ☐ Increased life span

☐ Reduce/Eliminate/Prevent Health Conditions ☐ Other: _____

Your Weight Goal: Goal weight _____ lbs.

Was significant weight gaining apparent at a certain age or specific event (i.e. surgery, pregnancy, medical diagnosis) of your life? ☐ No ☐ Yes (if yes, explain below)

_____

_____

_____

_____

_____

Were weight issues also apparent as a child? ☐ Yes ☐ No

At what age, did you begin dieting? _____ (years old)

Current Exercise Program

Do you exercise? ☐ Yes ☐ No

If yes, how many times per week? _____ (#)

What type(s) of exercise:

_____

☐ Walking ☐ Jogging ☐ Biking ☐ Swimming ☐ Aerobics ☐ Stretching ☐ Yoga ☐ Pilates

☐Weight Lifting/Strength Training ☐Gym Membership ☐ Other:

_____

Cardio Activity: _____ (# of days/week)

Duration of cardio activity? ☐ < 15 minutes ☐ 15-30 minutes ☐ 30 minutes- 1 hour ☐ 1 or more hour(s)

Strength Activity: _____ (# of days/week)

Duration of strength activity? ☐ < 15 minutes ☐ 15-30 minutes ☐ 30 minutes- 1 hour ☐ 1 or more hour(s)

BE WELL 365

Policies and Procedures

Welcome to Be Well 365. The following information contains policies and procedures for this practice that we feel are necessary for you to read and fully understand.

Making Appointments:
During our business hours of operation, our staff will gladly schedule appointments.

- *We do not accept "WALK-INS" to see the doctor at this office.*
- *You must make an appointment to see the doctor.*

Emergency:
If you are having a medical emergency, please dial 9-1-1 and/or go to your nearest medical facility (emergency room, urgent care). Schedule an appointment to see the doctor after your visit and bring any reports (lab results, physician notes, etc.) from the visit

Missed Appointments:
If you are unable to keep your appointment, we ask that you kindly provide us with at least **24 business hours** notice prior to your scheduled appointment. This courtesy on your part will make it possible to provide other patients with care at the particular time of service.

- *If you are a "No Call/No Show" for your appointment, you will be billed a **$35.00** fee.*
- *If you miss **two** scheduled appointments, without the courtesy of a cancellation within the 24 business hours period, you may be dismissed from our practice.*

Return Phone Calls:
Any requests for a return phone call from the physician must be explained to the office staff prior to receiving a return call. Any confidential information that you do not want to discuss with our staff, will require a scheduled appointment with the physician. If your message is NOT of an urgent nature, leave a message and it will be handled accordingly.

Medication Refills:
It is **your** responsibility to make sure that you do not run out of you medication. If you are taking long-term medications, refills will be handled at the time of your office visit. Please check your bottles prior to your appointment. If you need a refill, prior to a scheduled appointment, and you have seen the doctor within an acceptable amount of time, your script may be refilled at the discretion of the physician. If you have missed your appointment it will be filled at the discretion of the physician. Many medications require close monitoring of labs therefore; you may need to be seen in order to get a refill. This is for your own safety. If you do require a refill of your prescription, please contact your pharmacy. The pharmacy will submit the refill request to our office. Our staff will process the prescription request within 48 business hours after receiving request.

Referrals:
Some insurance companies require referrals to see a physician. If you do not have a referral at the time of your visit you may not be covered and you will be responsible for the charges.

- *It is your responsibility to obtain a referral from your primary care physician*
- *If a referral is required and is not present at time of service, you will be rescheduled.*

Patient acknowledgement _____ Date _____

Witness _____ Date _____

BE WELL 365

New Patient Information for the Use and Disclosure of Health Information

Regarding Treatment, Payment and Healthcare Operations

I, _____, understand that as part of my health care, Be Well 365, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means of communication among the many health professionals who contribute to my care.
3. Sources by which a third party payer can verify that services billed were actually provided.
4. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have seen the Notice of Information Privacy Practices that provides a more complete description for information uses and disclosures. I understand that I have the following rights and privileges:

1. The right to review the notice prior to signing this consent.
2. The right to request restrictions as to how my health information may be disclosed to carry out treatment, payment or health care operations.

I understand that Be Well 365 is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as a permitted by Section §164.506 of the Code of Federal Regulations.

I further understand that Be Well 365 reserves the right to change their notice and practices prior to implementation, in accordance with Section §164.520 of the Code of Federal Regulations.

I wish to have my Private Health Care Information given to:

_____

I wish to have the following people restricted from my Private Health Care Information:

_____

I understand that as part of this organization's treatment, payment or health care operations it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I further understand that as part of this organization's treatment, payment or health care operations, it may become necessary to request protected health information from another entity and I consent to such disclosure for these permitted uses, including via fax.

I fully understand and accept/decline the terms of this consent.

Patient Signature:	Date of Birth:
SS#:	Today's Date:

BEWELL365

Advance Practice Nurse Consent for Treatment

This facility has on staff an advance practice nurse to assist in the delivery of medical care.

An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, monitor, and prescribe for all acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advance practice nurse for my health care needs.

I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

Signature: _____ Date: _____

Be Well 365: Acknowledgement of Receipt of Notice of Privacy Practices

Your Name: _____

DOB: _____

SSN: _____

I acknowledge that I was provided with a copy of the Notice of Privacy Practices for this facility.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature: _____

Date: _____

BEWELL365

Consent Form for Use of Language Interpreter

English

I hereby give my permission for _____ and Dr. Eva Lopez to use a language interpreter for the purposes of communicating medical information. I understand that the interpreter will have access to my medical information, only through the interpretation of this information. I understand that the interpreter will NOT have access to my written medical records.

Language Interpretation required: _____ (e.g. French; Chinese; Sign Language)

Permission granted by: _____
(Signature of Patient and/or Guardian)

Date of Signature: _____

Witnessed by: _____
(Staff member)

Spanish

Yo, doy mi consentimiento a _____ y el Doctor Eva Lopez par obtener un interprete para la intencion de communicando information medico. Yo entiende y estoy en acuerdo que el interprete tience acceso a mi informacion medico, solamente para interpreter esta informacion. Yo entiende que el interprete NO tiene aceso a mi datos medicos.

Consentimiento de: _____
(Firma del paciente o guardian)

Fecha de firma: _____

Testigo: _____