PACIFICA WELLNESS

Integrated Physical Medicine Through
Therapy, Fitness, and Nutrition

- Dr. Tim Ramirez Wellness Master -

The person you trust. The information you need.

New Patient Packet
PLEASE BRING COMPLETED FORMS TO YOUR FIRST APPOINTMENT

(Please Print Clearly)
Today's Date___/___/___CDL. #_______________ SS#_________-_________-________

Name: ____
(First, Middle Initial and Last)

Primary Reason for Visit: ____

Secondary Reason: ____

Sex: _________ Birth Date: _____/_____/_____ Age: ________

Mailing Address: ____

City: ______________________________ State: ____________ Zip: _____________

E-mail Address:____

Primary Telephone No. (______) _______-_________ . home . cell

Secondary Telephone No. (______) _______-_________ . home . cell . work

Occupation:______________________Employer:______________________________

Employer Telephone (______) _______-_________ # of hours worked per week___________

Spouse/Partner Name: _____________________________Spouse/Partner Birth Date: _____/_____/_____

Payment must be made at the time of service.
We do not accept medical insurance for visits with our Doctor.

Who may we contact in the case of an emergency?

Name: ____

Tel: _________________________

If you are a minor (under 18) or dependent, please provide us with your guardian information:

Name of Guardian: ___________________________________

Tel: ___________________________

Mailing Address:____

City: _______________________________ State: __________ Zip: ___________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify the information above is true and correct to the best of my knowledge. I will notify Pacifica Wellness of any changes in the status of the above information.

Signature: ____

Date: _________________________

Parent Signature (if minor): _____________________________

Date: _________________________

____

Patient name (Last, First)

150 Paularino, Suite # B140 Costa Mesa, CA 92626
Tel:(949) 677-7763
www.PacificaWellness.com

Referral Information

How did you hear about us? Please choose the referral type and fill in the information below.

Healthcare practitioner (name)____

Friend or Family (name)____
.
Website (name) ____

Print Media (name)____

Other (please specify)____

Notice of Privacy Practices

Pacifica Wellness is required by law to follow the privacy practices
established by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In addition we will not sell, distribute or otherwise share your personal contact information with any third party for marketing and promotional purposes.

Patient Contact Information

Staff at Pacifica Wellness may contact you by mail, e-mail or telephone to relay important information about your health such as appointment reminders, laboratory results, doctor recommendations and prescription information.

Office Policy

We recognize and appreciate that health care can involve a major financial commitment. We aim to provide you with effective services and treatments. As a patient of Pacifica Wellness, you are responsible for the total charges incurred for each visit . All patients are required to sign a copy of the standard arbitration form included in this packet before they may see a doctor or receive any services.

We accept Visa, MasterCard, American Express , personal checks and cash as forms of payment. There will be a $35.00 dollar charge for all returned checks. If you have a private insurance our office staff can provide you with the necessary paperwork (super-bill, procedure and diagnosis codes) you will need to submit for reimbursement to your insurance. Please remember that you have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. We are unable to submit a bill for you if we are not a contracted provider for your insurance. Doctor's appointments not canceled with AT LEAST 24 HOURS NOTICE will be charged a session fee. This charge is directly payable by you and cannot be submitted to your insurance. We make every effort to see all scheduled appointments. However, we reserve the right to reschedule your appointment if you arrive more than 15 minutes after your scheduled appointment time. You have the right to refuse any service recommended by our staff. Mail order supplements are sent via UPS. Payment must be received before any items can be shipped to you. I have read, understand and agree to the above stated policies of Pacifica Wellness.

Signature:____Date:_________________

Printed Name:____

For all the following sections:
Y = a condition you have now
N = have never had
P = a condition you have had in the past

Childhood Illnesses

Scarlet fever Y N
Diphtheria Y N
Rheumatic fever Y N
Mumps Y N
Measles Y N
German measles Y N

Hospitalization and Surgery

What hospitalizations or surgeries have you had?
year: year:
year: year:
X-Rays and Special Studies
X-rays, CAT scans, or other studies you have had:

____
____
____

Immunizations

Polio Y N
Tetanus shot Y N
Measles/Mumps/Rubella Y N
Pertussis Y N
Diphtheria Y N
Any reactions to vaccinations? Y N

Allergies

Are you hypersensitive or allergic to...
Any drugs? ____
Any foods? ____
Any environmental?
____

Current Medications

Please list any prescription or over-the-counter medications you are taking, with dosages.
1) ________________________________ 4) ________________________________
2) ________________________________ 5) ________________________________
3) ________________________________ 6) ________________________________

Please list any vitamins or other supplements you are taking, with dosages.
1) ________________________________ 4) ________________________________
2) ________________________________ 5) ________________________________
3) ________________________________ 6) ________________________________

HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Are you currently receiving healthcare? Y N
If yes, where and from whom?____
If no, when and where did you last receive medical or health care?
____
What was the reason? ____
What are your most important health problems? List as many as you can in order of importance.
1)____
2) ____
3) ____
4) ____
5) ____
6) ____
Do you have any known contagious diseases at this time? Y N If yes, what?___________

FAMILY HISTORY

	Dad	Mom	Kid	Spouse	Sister	Brother
Age (if living)						
Health (G=good P=poor)						
Age at death (if deceased)						
Check (v) those applicable						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Cause of Death						

Weight: lbs._______ Weight 1 year ago: lbs. _______

Maximum Weight: ____________ When? __________Height: _________

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety?	Y P N
Memory problems?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Seasonal depression?	Y P N

ENDOCRINE

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue? Y P N			

IMMUNE

Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

NEUROLOGIC

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Loss of balance?	Y P N
Vertigo or dizziness? Y P N			

SKIN

Rashes?	Y P N	Eczema, Hives?	Y P N
Acne, Boils?	Y P N	Itching?	Y P N
Color Change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps? Y P N			

HEAD

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

EYES

Spots in Eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double Vision?	Y P N	Glaucoma?	Y P N

EARS

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

NOSE AND SINUSES

Frequent colds?	Y P N	Nose Bleeds?	Y P N
Stuffiness?	Y P N	Hayfever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

MOUTH AND THROAT

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N

Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter (enlarged thyroid)?	Y P N	Pain or stiffness?	Y P N

RESPIRATORY

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing?	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Tuberculosis?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath (SOB)?	Y P N
Shortness of breath at night (SOB)?	Y P N	SOB lying down?	Y P N

CARDIOVASCULAR

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic Fever?	Y P N	Chest pain?	Y P N
Swelling in ankles? Y P N			

GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bowel Movements: How often?	_____
Blood in stool?	Y P N	Is this a change?	_____
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

URINARY

Pain on urination?	Y P N	Increased frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent infections?	Y P N	Kidney stones?	Y P N

MALE REPRODUCTION

Hernias?	Y P N	Testicular masses?	Y P N
Testicular pain?	Y P N	Prostate disease?	Y P N
Discharge or sores?	Y P N	Sexually transmitted infections?	Y P N
Are you sexually active?	Y N	Birth control? Type?_______________	
Impotence?	Y P N	Genital warts?	Y P N
Premature ejaculation?	Y P N	Herpes?	Y P N

FEMALE REPRODUCTION / BREASTS

Age of first menses?____________________

First day of last menses?________________

# of days in between menses?_________ days		Are cycles regular?	Y N
# of days your menses lasts?_________ days		Bleeding between cycles?	Y P N
Painful menses?	Y P N	Clotting?	Y P N
Heavy or excessive flow?	Y P N	Discharge?	Y P N
Are you sexually active?	Y N	Sexual difficulties?	Y P N
Pain during intercourse?	Y P N	Birth control?	Y P N
PMS?	Y P N	What type?______________________	

If yes, what are your symptoms?____

Difficulty conceiving? Y P N

Number of pregnancies___________________

Number of live births ___________________

Endometriosis?	Y P N	Ovarian cysts?	Y P N
Menopausal symptoms?	Y P N	Abnormal PAP?	Y P N
Sexually transmitted infection?	Y P N	Genital warts?	Y P N
Herpes? Y P N			
Do you do breast self exams?	Y P N	Breast lumps?	Y P N
Breast pain/tenderness?	Y P N	Nipple discharge?	Y P N

MUSCULOSKELETAL

Joint pain or stiffness?	Y P N	Arthritis?	Y P N
Broken bones?	Y P N	Weakness?	Y P N
Muscle spasms or cramps?	Y P N	Sciatica?	Y P N
Balance Problems	Y P N		

BLOOD / PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y P N	Anemia?	Y P N
Deep leg pain?	Y P N	Cold hands/feet?	Y P N
Varicose veins?	Y P N		

DIETARY

Typical Food Intake

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

Do you drink black or green tea? Y N

Do you drink cola or other sodas? Y N

Do you eat refined sugar? Y N

Do you add salt? Y N

Do you go on diets often? Y N

Do you eat three meals a day? Y N

Do you drink coffee? Y N

Do you eat out often? Y N

Servings per **week** / **Dislikes / Allergies**

Fish________/____ ______________________________________

Red meat_____/____

Chicken______/____

Alcohol___/______________________NA______________________NA___________________

Servings per **day** / **Dislikes / Allergies**

Vegetables___/____

Fruit_____/____

Caffeine_________

Water___________

GENERAL

When during the day is your energy the best? worst?

Main interests and hobbies?______________________________________

Do you exercise? Y N

If yes, what kind?_______________________________

How often? _______________

Average 6-8 hrs. sleep? Y N

Sleep well? Y N

Awaken rested? Y N

Spend time outdoors? Y N

Do you use tobacco? Y N

Smoked previously? Y N

**how many years*? _______ *how many packs per day*? _______

Please write any additional information regarding your health, nutrition and exercise history as well as all goals:

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well. Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient. Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with California law. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:__________________________
Physician (Date)
Authorized Representative Signature

By: _________________________
Patient's Signature (Date)

____
Print Patient's Name

By __________________________
Print or Stamp Name of Physician: Dr Tim Ramirez
Pacifica Wellness