Advanced Metabolic Care + Research

3927 Waring Road, Suite C
Oceanside, CA 92056
Phone (760) 941-9850
Fax (760) 941-9845

Dear Patient,

We are pleased to welcome you to our office! Please fill out this questionnaire at your convenience *prior* to your appointment and bring it with you the *day of* the appointment. Should you have any difficulty with any of the questions, answer to the best of your ability. Try not to leave any answer blank.

Enclosed you will find a map to locate our office. At the end of this packet, we have enclosed a Record Release Form for additional records that you feel would be important. If there are any recent Labs, Scans, and/or X-rays that you think may be important, please try to have these made available to us at the time of your appointment. ***Send the form enclosed on page 8 to your Referring doctor.*** If the Records are difficult to obtain, we can usually work without them.

If you need to cancel or reschedule your appointment for any reason, please give us at least 24 hours' notice. It is our policy to charge $75.00 for appointments that are missed, or those cancelled less than 24 hours in advance. Unfortunately, insurance does not cover these charges.

All Co-pays are due upon check-in. Checks, Cash, or Credit Cards (Visa MasterCard or Discover) are accepted and we will give you a Receipt.

For prescription refills or renewals, please contact your Pharmacy at least 48 hours in advance, so they can fax us their forms.

Lastly, we look forward to meeting you and helping serve your Endocrinology-related needs. Our goal is to build a partnership with you. If you do not understand a treatment, medications, or any other aspect of your healthcare, please let us know. We want you to be completely satisfied with the care you receive in our office. Please let us know if you have any additional concerns you would like us to address. If at any time you need any additional clarification about our office policies, please do not hesitate to contact our office directly.

Sincerely,

Chris K. Guerin, M.D., Alan B. Douglass, M.D., Margot J. Aiken, M.D. and Staff

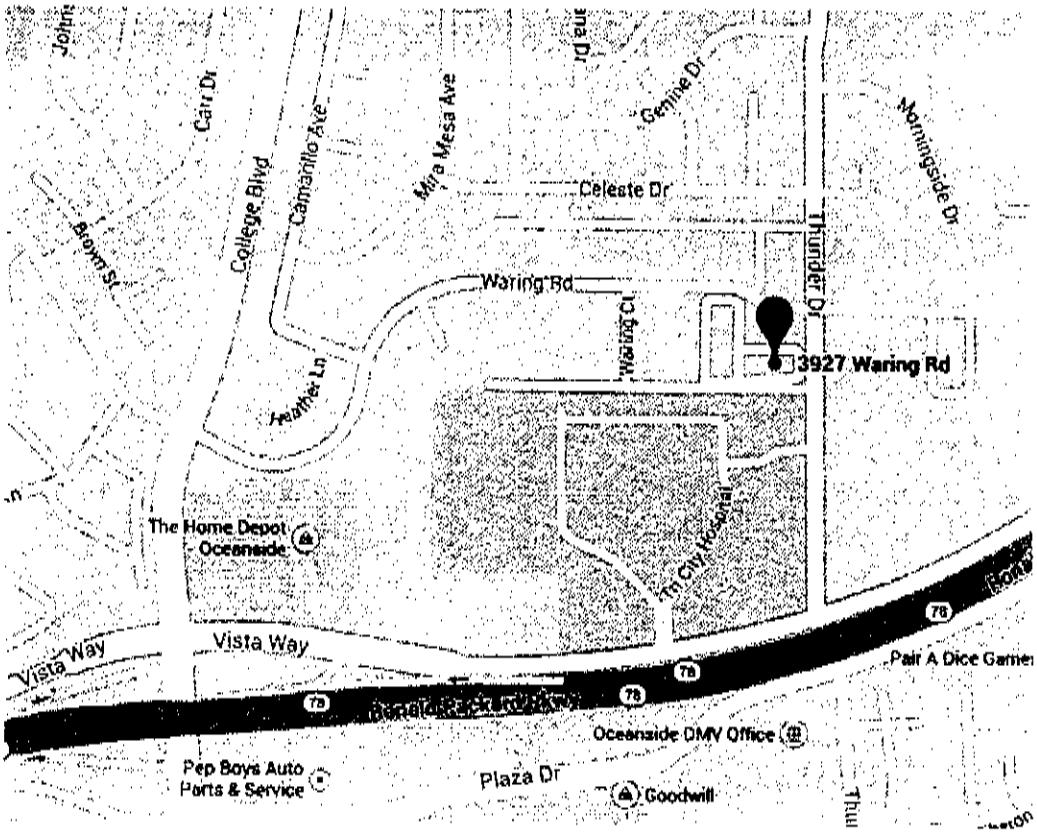
Chris K. Guerin, M.D., F.A.C.E. Alan B. Douglass, M.D., F.A.C.E. Margot J. Aiken, M.D., F.A.C.E.

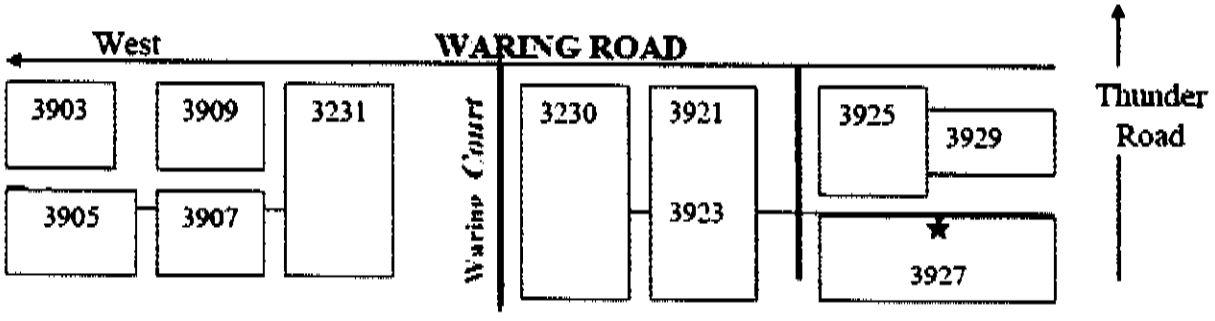
I have read the above and agree to the office policies

Patient Signature_____ Date_____

Revised 5/30/17

Map to Office





Written Directions

We are on the corner of Waring Rd and Thunder Dr. The easiest way to get to the office is from I-78 and College Blvd. Head north and take a right on Waring Road not Waring CT (behind the Circle K, and Home Depot). Go approximately 3/4 mile through a Residential area until you get to the last group of offices on the Right hand side of the street. Turn Right into the last *driveway,* before Thunder. The Office is located in the building marked 3927 Suite C, located in the back.

Record Release

The last page of this packet contains a form if you think any records will be helpful for **us to have. You can mail, bring, or fax this form** ***to your referring or previous doctor, so that we can have these records at the time of your appointment.*** If you are unable to get records, we can usually work without them.

NAME: _____ **Age:** _____ **Gender: Male** _____ **Female** _____

Primary Doctor _____ Referred by _____

CHIEF COMPLAINT:

List the main problems that you have and the approximate onset of each:

	Date
1. _____	_____
2. _____	_____
3. _____	_____

MEDICATIONS:

List all the medications you are currently taking, including hormones, vitamins, herbals, and over-the-counter medications. List the name of each, how much you are taking (the strength of each dose and how often you take it) and how long you have been taking it. ***Continue the list on the back of this page if necessary.***

Name of Medicine	**Strength**	**How Often Taken**	**How Long Taken**

MEDICAL HISTORY:

Check if you ever had the following (if answer is "Yes," indicate age of onset):

✓	Age		✓	Age		✓	Age	
		Diabetes			Kidney Disease			Asthma
		High Blood Pressure			Protein in Urine			Emphysema
		High Cholesterol			Kidney Stones			Eczema
		Thyroid Disease			Pancreatitis			Psoriasis
		Leg or Foot Ulcers			Liver Disease			Glaucoma
		Heart Trouble			Hepatitis			Cancer
		Heart Failure			Peptic Ulcers			Osteoporosis
		Gout			Gallbladder Disease			Depression
		Anemia			Prostate Disease			Anxiety

DRUG ALLERGIES:

List all drugs to which you are allergic and note your reaction to the medicine:

1. _____ Reaction _____
2. _____ Reaction _____

SURGICAL HISTORY:

List all the surgical operations you have had indicating the year and hospital in which each one was done.

Year	**Operation**	**Hospital & City**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS:

List all hospital admissions, ***other than the surgical operations or delivery of children***..

Year	**Reason for Hospitalization**	**Hospital & City**
_____	_____	_____
_____	_____	_____

FAMILY HISTORY:

Please give the following information about your family (check conditions if present):

	Living? (Y/N)	Year Born	Age	✓Diabetes	✓Hypertension	✓Heart Disease	✓Stroke	✓Cancer	✓Hypothyroidism	Other Conditions (please list)
Father										
Mother										
Brother										
Brother										
Brother										
Sister										
Sister										
Sister										
Spouse										

Children? ☐Yes ☐No How many boys? _____ How many girls? _____

Please list any other diseases that run in your family:

PERSONAL HISTORY

TOBACCO:

Are you a: ☐ Current smoker ☐ Former smoker ☐ Non-smoker	If you are a smoker: How often do you smoke? ☐ Every day ☐ Some days, but not every day	If you are a smoker: How many cigarettes a day? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more	If you are a smoker: How soon after you wake up do you smoke your 1st cigarette? ☐ Within 5 minutes ☐ 6-30 minutes ☐ 31-60 minutes ☐ after 60 minutes	If you are a smoker: Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit
If you are a former smoker, when did you quit? _____				

ALCOHOL:

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No	If "yes," how often did you have a drink containing alcohol in the past year? ☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times a week ☐ 4 or more times a week	If "yes," how many drinks did you have on a typical day when you were drinking in the past year? ☐ 1 or 2 drinks ☐ 3 or 4 drinks ☐ 5 or 6 drinks ☐ 7 to 9 drinks ☐ 10 or more drinks	If "yes," how often did you have 6 or more drinks on one occasion in the past year? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

MISCELLANEOUS:

Where were you born? (City, State or Country) _____ Date _____

Do you exercise? ☐ Yes ☐ No
If yes, what exercise do you do and how often? _____

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

What is your current occupation? _____

List past occupations: 1. _____ 2. _____

Have you been out of the U.S. in the last 6 months? (If so, list the date and place)

_____

Have you ever contracted any illness while outside the U.S.? (If so, what, when, & where)

_____

Please check Yes or No regarding whether or not you have any of the following symptoms:

Y	N	GENERAL/CONSTITUTIONAL
		Fevers
		Chills
		Unusual fatigue
		Lightheadedness
		Abnormal weight gain
		Abnormal weight loss
		Insomnia
Y	N	OPHTHALMOLOGIC
		Blurred vision
		Double vision
		Eye pain
		Bulging of the eyes
		Difficulty closing your eyes
		Gritty feeling in your eyes
		Pain with eye movement
		Loss of peripheral vision
Y	N	EAR/NOSE/THROAT
		Decreased hearing
		Feeling of pressure in neck
		Hoarse voice
		Food sticking in throat
		Lump in neck
Y	N	ENDOCRINE
		Excessive thirst
		Frequent urination
		Dry mouth
		Increase in body odor
		Excessive sweating
		Recent change in shoe size
		Recent change in ring size
		Deepening of your voice
		Cold intolerance
		Heat intolerance
Y	N	RESPIRATORY
		Shortness of breath at rest
		Shortness of breath with exertion
		Cough
		Wheezing

Y	N	CARDIOVASCULAR
		Heart palpitations
		Irregular heartbeat
		Rapid heartbeat
		Swelling in your legs
		Chest pain at rest
		Chest pain with exertion
Y	N	GASTROINTESTINAL
		Abdominal pain
		Abdominal cramps
		Nausea
		Vomiting
		Constipation
		Diarrhea
		Decreased appetite
		Difficulty swallowing
		Change in bowel habits
		Heartburn
Y	N	GENITOURINARY
		Difficulty urinating
		Urinary incontinence
		Painful urination
		Blood in urine
		Get up at night to urinate
Y	N	MUSCULOSKELETAL
		Leg cramps
		Calf pain when walking
		Chronic back pain
		Sciatica
		Swollen joints
		Joint stiffness
		Painful joints
Y	N	SKIN
		Dry skin
		Brittle nails
		Rash
		Acne
		Stretch marks
		Loss of hair
		Itching
		Vitiligo

Y	N	NEUROLOGIC
		Headaches
		Tremors
		Fainting
		Dizziness
		Numbness in feet
		Tingling in feet
		Burning in feet
		Loss of strength
Y	N	PSYCHIATRIC
		Severe mood swings
		Mental fatigue
		Unusual anxiety
		Depressed mood
		Thoughts of suicide
		Panic attacks
		Spells of anxiety, headaches and sweats
Y	N	**WOMEN ONLY**
		Missed periods
		Irregular periods
		Bleeding between periods
		Heavy menstrual bleeding
		Hot flashes
		Hair growth on face
		Hair growth on chest
		Hair growth on abdomen
Y	N	**MEN ONLY**
		Lack of energy
		Decrease in strength, endurance, or both
		Lost height
		Decreased enjoyment of life
		Sad, grumpy, or both
		Deterioration in ability to play sports
		Falling asleep after dinner
		Deterioration in work performance
		Decreased sex drive
		Erections less strong
		Trouble initiating urination
		Incomplete bladder emptying

FOR DIABETIC PATIENTS ONLY

How long have you had Diabetes? _____ yrs. _____ mos.

How was it diagnosed? (e.g. routine lab test, symptoms): _____

Have you ever been hospitalized due to Diabetes and/or complications?

Explain _____

Medications for Diabetes:

Oral Agents (Type and Dose) _____

Insulin Pens or Vials _____

Type of Insulin and Dose _____

Where do you give your injections? _____

Any bruises or problems with injections? _____

Do you do Self Blood Glucose Monitoring? Yes _____ No _____

If so, what type of machine? _____

How often do you test? _____ times per week; at what times? _____

Results before meals: _____ Results after meals (2 hours): _____

Do you follow a Diabetes Diet? Yes _____ No _____

Would you like to attend Classes on Diabetes taught by a Certified Diabetes Nurse Educator and Certified Diabetes Dietitian? Yes _____ No _____

If known, most recent HbA1C result: _____ mg/dl When done? _____

Have you had any ***Low blood sugar*** reactions in the past 6 months?

Explain (what caused and how they were treated): _____

Do you usually have ***High blood sugar*** readings at any particular time of day?

Explain (what caused and how they were treated): _____

Complications Related to Diabetes:

Eyes: Last exam by Ophthalmologist, or Optometrist: Date:_____ Findings: _____

Heart: Any heart condition (i.e. CABG, angina, MI, none) _____

Kidney: Last check for microalbuminuria: Date: _____ Results: _____

History of foot infection? Yes _____ No _____

Pain or loss of sensation? Yes _____ No _____

Advanced Metabolic Care + Research

Dr. Chris Guerin **Dr. Alan Douglass** **Dr. Margot Aiken**

Authorization for Release of Medical Information

RE: _____
(Your Name)

Date of Birth: _____

I hereby authorize and request _____
(Primary or Referring Doctor's Name)

_____
(Address)

_____

to furnish the following information concerning my medical history and condition:

- ❑ History and Physical Examination
- ❑ Recent Laboratory Reports, such as HbA1C, Lipid values, and Thyroid Function tests, if done within last year
- ❑ Ultrasound Reports, Scans, and/or X-rays
- ❑ Operative and Pathology Reports

My appointment is on _____ (Date)

Please *mail or fax* promptly to:

Advanced Metabolic Care + Research
3927 Waring Road, Suite C
Oceanside, CA 92056
Phone: 760-941-9850
Fax: 760-941-9845

Or *give to patient to hand carry in.*

DATE: _____ SIGNED: _____ (Your Name)

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form. If you have any questions, we'll be glad to help you.

Last Name _____ First _____ M.I. ____ AGE ____ SEX _____
Address _____ City _____ State _____ ZIP _____
Date of Birth _____ Marital Status _____ Cell Phone (_____) _____
Home Phone (_____) _____ Work Phone (_____) _____

Social Security No. _____ **E-Mail Address** _____
Occupation _____ Employed by _____
Name of Spouse _____ Occupation _____
Spouse Employed by _____ Spouse Work Phone _____

Name and Phone of closest Relative/Friend (in emergency) Name _____
Phone _____

Name of party responsible for bill _____
Relationship to patient _____ Phone _____
Address _____ City _____ State _____ ZIP _____

Referred by or Primary Care Provider: _____

PLEASE PRESENT ALL INSURANCE CARDS AT THE FRONT DESK

Name of *Primary* insurance company _____
Policy no. _____ Group no. _____
Deductible: $_____ Co-payment: $_____
Name of *Secondary* insurance company _____
Policy no. _____ Group no. _____
Deductible: $_____ Co-payment: $_____

MEDICARE: This Office will file all Medicare Claims and accepts Medicare assignment. We will bill Medicare and one secondary Insurance. The patient is responsible for all deductibles and any co-payments not covered by their supplemental insurance.

INSURANCES: Most HMO's and some PPO's require pre-authorization for services. If pre-authorization is not obtained and/or the HMO/PPO refuses to cover within 60 days, the patient is responsible for services rendered. If unsure of coverage, contact your HMO/PPO.

LABORATORY: Laboratory work charges are billed by the Lab and are separate from our Services. It is always a good idea to check with your Insurance Company to be sure the Lab studies are covered and that the lab has a current contract to provide services.

I have read and understood all of the above and give my consent for medical treatment. We follow HIPAA Guidelines (copy available upon request). I hereby authorize Chris K. Guerin M.D., F.A.C.E. Alan B. Douglass, M.D., F.A.C.E. and/or Margot J. Aiken, M.D., F.A.C.E. to release any medical and/or billing information to my insurance company and/or my Referring or Consulting Health Care Providers.

***Patient Signature** _____ **Date** _____

Advanced Metabolic Care + Research

Dr. Chris Guerin Dr. Alan Douglass Dr. Margot Aiken
3927 Waring Road, Suite C
Oceanside, CA 92056
(760) 941-9850

PERMISSION TO FURNISH MEDICAL INFORMATION

Please list people to whom we may furnish medical information about you (example: blood test results, other test results, doctor instructions, etc.) in the event you are not immediately available. Unless otherwise indicated, we will leave a message on your answering machine or voice mail with any routine results or instructions when you are not immediately available.

THIS AUTHORIZATION WILL BE IN EFFECT UNTIL REVOKED IN WRITING

Approved Person(s):	**Relationship to you:**
_____	_____
_____	_____
_____	_____

_____ **Initial here if you wish us to furnish information ONLY to you. In this instance, we will leave a message for you to call our office if you are not immediately available.**

_____ _____
Name (please print) **Date of Birth**

_____ _____
Signature **Date**

ADVANCED
METABOLIC
CARE +
RESEARCH

PATIENT FINANCIAL AGREEMENT

Deductible/Co-Insurance: All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill. We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover). For any questions regarding billing, please call (760) 466-1548 or email billing@amcrclinic.com.

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived.

Payment Options: If you do not have insurance: payment is expected on the day treatment is rendered. If you do have insurance: you are responsible for any deductibles, coinsurance, and any out of pocket portions on the day that treatment is rendered.

Checks: Returned checks may be subject to a $30.00 fee.

Missed Appointments: Please note a $75.00 fee may be charged for a missed appointment or failure to cancel an appointment within 24 hours prior to scheduled appointment time. This fee will be billed directly to you.

Claims Submission: As a courtesy, Advanced Metabolic Care + Research will bill your insurance and one other insurance. A quote of benefits is not a guarantee of payment. We will submit your claim and assist you until the claim is resolved. Payment from your insurance company is expected within 30 days. After 30 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance card(s) for all applicable health plans. All outstanding balances will be subject to a statement fee of $10.00. Additional statement fees will accrue for each subsequent thirty (30) day period of nonpayment. Accounts that are 90 days past due may be referred to a collection agency. Should the account be referred to an outside agency for collection or to an attorney, the undersigned shall pay reasonable collection expenses.

Form Fees: Any forms that require a physician to review your chart and require an MD signature will have an applicable form fee charge.

Prescription Refills: In general, if you have not been seen within the last 6 months, a follow up appointment will need to be scheduled to ensure proper treatment. Some patients require a shorter or longer follow up time frame and their refill requests will be approved on a case-by-case basis. Please contact your pharmacy for prescription refills.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to Advanced Metabolic Care + Research for all services rendered.

I have read and understand the above statements.

I agree to comply with the financial policies of Advanced Metabolic Care + Research and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

Patient Name (please print): _____ Date of Birth: _____

Patient or Guardian Signature: _____ Date: _____