Del Mar M.E.D.
12395 El Camino Real, Ste. 200
San Diego, CA 92130
PH: 858-755-6647 F: 858-755-5947
www.delmarmed.com

Dina Massry, M.D.
Jeff Eaton, M.D.
Jennifer Eastlack, M.D.
Jenna Borok, M.D.

SUMMARY OF MEDICAL HISTORY

PATIENT NAME: **DOB:**

1. **Please indicate if you have a personal history of any of the following**

	YES	NO		YES	NO		YES	NO
EAR, NOSE, THROAT:			**EYES:**			**PSYCHIATRIC:**		
Vertigo			Cataracts			Anxiety		
Sinusitis			Glaucoma			Depression		
Allergies			Other:_____			Drug Abuse		
Other:_____			**RESPIRATORY:**			Other:_____		
CARDIOVASCULAR:			Asthma			**NEUROLOGIC:**		
Heart Defect			Bronchitis			Seizures		
Palpitations			Emphysema			Migraines		
Heart Disease			Other:_____			Stroke		
Heart Attack			**GASTROINTESTINAL:**			Other:_____		
Hypertension			Heartburn/Reflux			**OTHER:**		
Other:_____			Stomach Ulcers			Cancer:_____		
SKIN:			Liver Disease/Hepatitis			Osteoporosis		
Melanoma			Other:_____			Kidney Disease		
Skin Cancer (BCC/SCC)			**ENDOCRINE/IMMUNE:**			Other:_____		
Rash (eczema/psoriasis)			Autoimmune					
Other:_____			Diabetes					
			Thyroid Disease					
			Other:_____					

2. **Please list any known drug allergies and their corresponding interactions:**

3. **Please list any operations or surgeries and include dates:**

4. **Please list any medications or supplements (name only) or attach separate sheet if necessary**

_____ _____
_____ _____
_____ _____
_____ _____

5. **Are you pregnant?** Yes No **Breastfeeding?** Yes No

To the best of my knowledge, I attest that the information provided above is correct.

Print Name of Patient or Parent/Guardian_____
Signature of Patient or Parent/Guardian_____ **Date**_____

PLEASE FILL OUT THE FOLLOWING PAGES ⇨

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NO SHOW / MISSED APPOINTMENT POLICY

We, at Del Mar M.E.D., understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice for a routine appointment and 48-hours for a surgical appointment). You can cancel appointments by calling the following numbers: 858-481-3376 or 858-755-6647.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to arrive to their visit on time. As a courtesy, an appointment reminder text to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to make a record of their scheduled appointment and to arrive promptly for them.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your routine office visit/appointment with a notice of at least one full business day. Canceling or failing to show up to your visit with less than one full business days' notice will result in a $50 fee. In addition, a credit card will be held on file to schedule any subsequent appointments.
2. Please cancel your surgical appointment with a notice of at least **TWO FULL BUSINESS DAYS**. There is a surgical waiting list to see the surgeon at Del Mar M.E.D.—whenever possible, we fill canceled spaces to shorten the waiting period for our patients. Canceling or failing to show up to your surgery with less than two full business days' notice will result in a **$250 fee**. In addition, a credit card will be held on file to schedule any subsequent appointments.
3. If a patient presents to the office late for a scheduled appointment with our providers, the patient may be asked to reschedule their appointment. When a patient arrives late, the time spent with the patient is minimized and does not allow for a full assessment. It also disrupts the schedules of our providers and other patients.

I have read and understand Del Mar M.E.D. No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Del Mar M.E.D appropriately if I have difficulty keeping my scheduled appointments.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN:_____Date:_____

Patient's Name (please print): _____

PLEASE SIGN THE FOLLOWING PAGE ⇨

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CONSENT FOR ADDITIONAL OFFICE PROCEDURES AND PATIENT RESPONSIBILITY

There are a number of procedures performed in our office which are necessary as either part of your diagnostic work-up and/or as treatment. On your bill, you may see separate charges in addition to your office visit charge. Often these have billing codes that are listed as "surgery' and may seem confusing on the bill. All the charges are submitted to your insurance, but not all may be covered equally. These procedures will only be done if it is determined to be necessary for the treatment and/or evaluation of your condition. Prior to doing any of these procedures your doctor will make you aware. These procedures are as follows, but not limited to:

Nasal Endoscopy
Fiberoptic Laryngoscopy
Biopsy of mass/lesion
Cerumen (wax) impaction removal
Liquid Nitrogen
Injections

Additionally, due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, coinsurances, or copayments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out-of-pocket maximum, and we do not collect that fee, your out-of-pocket maximum has not been correctly calculated.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we are bound by all provisions of insurance policy and federal law. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Please sign and print name, that you have read and understand this explanation

SIGNATURE OF PATIENT OR PARENT/GUARDIAN:_____Date:_____

Patient's Name (please print): _____