DR BERNARD A. MICHLIN, MD
6367 ALVARADO COURT SUITE 200
SAN DIEGO, CA 92120
619-583-1954

REGISTRATION FORM

PATIENT INFORMATION

Today's Date:

Patients last name: First: Middle:	❑ Mr ❑ Mrs	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes | ❑ No	If not, what is your legal name?	(Former Name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Race ❑ Caucasian ❑ African-American ❑ American-Indian ❑ Asian ❑ Hispanic ❑ Other: _____	Ethnicity:	Language Preference:
	Social Security No.:	Driver's License: State _____ Number _____

Street Address:	Home Phone No.: ( ) -	Cell Phone No.: ( ) -

P.O. BOX:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Patient Email Address**:

** Email addresses will not be used for marketing purposes. We do not distribute email addresses to third party corporations. We do not provide names or email addresses to anyone, including publishers, and/or advertising companies. Emails are used solely to provide patients with online access to their medical records. If you have any questions or concerns, please feel free to ask the front desk regarding this. An email will be sent out to provide you with a temporary password and log in information to access medical records.

Referred to clinic by (please check one or more boxes):

❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend

❑ Close to home/work ❑ Other: _____

INSURANCE INFORMATION

(please provide insurance card to receptionist so we may make a copy for our records)

Responsible party name:	Birth date:	Address (if different than above)	Home phone no.:

Is responsible party a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer Address:	Employer phone no.:

Please indicate primary insurance:

❑ Anthem BCBS ❑ Aetna ❑ Medicare ❑ Medical ❑ United HealthCare ❑ Blue Shield

❑ Private Pay ❑ Healthnet ❑ Tricare

❑ Sharp Community Medical Group (please provide name of insurance on line provided) _____

❑ Other: _____

Subscriber's name:	Subscribers ID no.:	Birth Date:	Group No.:	Co-Payment : $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑Child ❑ Other: _____				
Name of secondary insurance (if applicable)	Subscriber's name:	Subscribers ID no.:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑Child ❑ Other: _____				

EMERGENCY CONTACT

Name of contact (not living at same address as patient):	Relationship to patient:	Home phone no.:	Work phone no.:

ASSIGNMENT AND RELEASE

I hereby authorize that the above information is true to the best of my knowledge. I hereby authorize medical provider, Dr. Bernard Aron Michlin, MD, to release information which is normally required in the course of my treatment for the sole purpose of processing health information. I hereby authorize payment directly to this medical provider for the medical benefits, if any, that would be otherwise payable to me for services rendered. I understand that I am financially responsible for the charges not covered by insurance.

_____

Patient/Guardian printed name

_____ _____

Patient/guardian signature *Date*

Name: _____ Date: _____

□ **Check here if you are not experiencing any of the symptoms listed below**

GENERAL:
- Unexplained Weight changes
- Fatigue
- Fever
- Difficulty falling asleep
- Difficulty
- Sleeping chills
- Night Sweats
- Abnormal bleeding or bruising
- Lightheaded

EYES:
- Changes in vision
- Eye discharge

HEAD & NECK:
- Abnormal Lumps or masses
- Changes in hearing
- Ear pain or discharge
- Difficulty swallowing
- voice changes
- Painful swallowing
- Tooth pain or other problems
- Non-healing ulcers or sores in mouth

LUNGS:
- Shortness of breath
- Dry Cough
- Productive cough
- Wheezing
- Snoring

HEART:
- Chest pain
- Leg swelling
- Leg cramps

STOMACH:
- Abdominal pain
- Bloating
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Blood in Stool
- Black Tarry Stool
- Yellow skin

URINARY:
- Blood in urine
- Pain with urination
- Urinary urgency
- Urinary frequency
- Frequent urination at night
- Unintentionally wet yourself
- Incomplete emptying of bladder
- Decreased force of urine stream
- Sensation to urinate but have trouble starting to go

OB/GYN (Women):
- Vaginal discharge
- Unusual vaginal odor
- Irregular menstrual cycles
- Breast masses or lumps
- Spotting
- Abnormal nipple discharge

NEUROLOGICAL:
- Seizure activity
- Numbness
- Weakness
- Dizziness
- Balance problems
- Headaches

MUSCULOSKELETAL:
- Joint pain or swelling
- Muscle aches
- Back pain
- Pain with motion
- Locking, clicking or popping of joint

SKIN:
- Skin rashes
- Skin growths
- Itching
- Sores that grow or don't heal
- Any areas/ lesions that have changed in color, shape and/or size

Name: _____ Date: _____

Please list the surgeries you've had and what year they were performed.
1._____ 2._____
3._____ 4. _____

Please list any hospitalizations
1._____ 2._____
3._____ 4. _____

Do you drink alcohol? _____
If so, how often? _____ And how many drinks per episode? _____

Were you ever a smoker? _____
Do you Smoke? _____ If so how much? _____ For how many years? _____

Do you have any allergies? _____

Do you exercise? _____ If so, how often?_____

Any medical problems in your family: (heart disease, strokes, diabetes)
Mother: _____ Father: _____
Siblings:_____
_____

Do you work? _____ if so what is your occupation? _____
What is your marital status? _____
Are you sexually active? _____ If so How many partners do you have? _____

Women:
Have you ever been pregnant? _____
Have you had any abortions? _____If so how many? _____
Have you had any miscarriages? _____ If so how many? _____
Do you have any Children? _____ If so how many?_____