GRIMALDI CENTER FOR WELLNESS & AESTHETICS
John A. Grimaldi, D.O. INC
450 4th Avenue, Suite 312
Chula Vista, CA 91910
Telephone: (619) 420-0201
Facsimile: (619) 425-7795

MANDATORY INFORMATION

Patient Name: _____ **DOB**: _____ **SSN**: _____-_____-_____

Sex: M / F **Marital status:** _____ **Address**: _____

City: _____ **State**: _____ **Zip**:_____ **Email Address:** _____

Phone:(_____) _____-_____ **Cell**: (_____)_____-_____

Employer: _____ **Work Phone**: (_____) _____-_____

Work Address: _____ **City**: _____ **State**: _____ **Zip**: _____

In case of emergency, please contact:
Name: _____ **Relationship**: _____ **Phone**: (_____)-_____-_____

Name of Primary Care Physician: _____

Language Circle Preference: English Y/N Spanish Y/N Other Y/N

MEDICAL INSURANCE:
Primary Insurance Provider: _____Guarantor: _____
ID#_____Group#_____
Secondary Insurance Provider: _____ Guarantor: _____
ID#_____ Group#_____

Pharmacy Name: _____ Phone number (_____) _____-_____
Pharmacy Address: _____ City: _____ State: _____ Zip: _____

What is the reason for your visit? _____
_____

I hereby consent to any necessary medical treatment/physical exam required by myself of the minor named above for whom I am legally responsible. I permit payment directly to Dr. Grimaldi's office any benefits due for the services rendered. I understand that I am financially responsible for all charges, whether or not covered by my insurance company. I grant authorization for release of any information required to process an insurance claim. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We can't accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Signature_____ **Date** _____

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PERSONAL MEDICAL HISTORY

Have you had any visits to the Hospital or Emergency Room visits within the past year? Yes / No

If so, briefly describe the location and reason for the visit below.

1. Where?

_____

2. Why?

_____

CURRENT MEDICATIONS:

Medication/Dose/Frequency/Route	Reason
Example: Tylenol/ 250mg/Twice daily/Orally (By mouth)	*For back pain*

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

Have you traveled internationally (including Mexico) within the past 21 days? Y / N
If so please describe where?

_____

Have you received the Seasonal Flu / Tuberculosis / Shingles / Hepatitis C / Pneumonia vaccine? Y / N
Date and type of vaccination(s):

_____

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Have you ever had an allergic reaction to the following?

__ Iodine __ Penicillin __Aspirin __Sulfa __ Eggs __ Shellfish __Nuts __ Soy __Gluten

Other:_____

Please describe the reaction:
_____

Whom may we confirm your future appointments with?
Name: _____ Phone # (_____) _____-_____ Relationship:

Spouse's name:_____
DOB:_____ SSN:_____-_____-_____
Address:_____ City:_____ State:_____ Zip:_____

Phone Number: (_____) _____-_____ Cell:(_____)_____-_____
Email Address:_____

Do you have a current power of attorney and/or an advance healthcare directive? Y / N
If yes, please provide it.
_____

If not, would you like us to provide you with information on an advance healthcare directive? Y / N

ENGLISH
May we have your permission to access your medication list from your pharmacy /pharmacies on file? Yes / No

SPANISH
The Grimaldi Center for Wellness and Aesthetics tiene su permiso para acceder a su lista de medicamentos de su farmacia / farmacias archivo? Sí/No

Patient Name: _____ **Date:** _____

Patient Signature: _____