Trilogy Medical
CENTERS FOR INTEGRATIVE MEDICINE

ADULT PATIENT REGISTRATION FORM

☐ MALE ☐ FEMALE

Please Print

Name____ Birth Date______________
Last First M

Address____________________________ City______________ State________ Zip__________

Home Phone (___)____________________ Daytime Phone (___)______________________

Cell Phone ____________________ Other ______________________________

Email____

Marital Status ☐ Now Married ☐ Never Married ☐ Divorced ☐ Widowed ☐ Sig Other

Employment____

Work Address____________________________ Occupation______________________

Referred By____

Type of Insurance ☐ Independent ☐ PPO ☐ HMO ☐ Medicare ☐ None

Name of Insurance Co.____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT:

Name________________________________ Relationship______________________

Employed By____

Home Phone__________________ Work__________________ Cell__________________

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name____ Phone____________________

Relationship______________________________________

CANCELLATION/RESCHEDULE POLICY:

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE NOTIFY OUR OFFICE 3

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE NOTIFY OUR OFFICE AT LEAST 3 BUSINESS DAYS PRIOR, OR YOUR ACCOUNT WILL BE CHARGED THE FULL AMOUNT OF YOUR APPOINTMENT.

We require that you or others accompanying you not wear colognes, perfumes, scents, essential oils, or scented lotions to the office. We keep a scent-free office for people with chemical sensitivities.

PLEASE SIGN AND RETURN IN ADVANCE YOUR APPOINTMENT IF POSSIBLE.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT.
I UNDERSTAND THE CANCELLATION POLICY AND PAYMENT POLICY. I HEREBY CONSENT TO MEDICAL AND HOMEOPATHIC TREATMENT BY DR. JEFF LESTER, D.O.

SIGNATURE____ DATE__________________

ADULT HOMEOPATHIC REGISTRATION FORM

Name____Date___________________
Last First MI

CURRENT PROBLEMS Date of Onset

1.______________________________ ______________
2.______________________________ ______________
3.______________________________ ______________
4.______________________________ ______________
5.______________________________ ______________

PAST PROBLEMS Dates

1.______________________________ ______________
2.______________________________ ______________
3.______________________________ ______________
4.______________________________ ______________

FURTHER DESCRIPTIONS OF PROBLEMS

____
____
____
____

SURGERIES Dates

1.______________________________ ______________
2.______________________________ ______________
3.______________________________ ______________
4.______________________________ ______________
5.______________________________ ______________

HOSPITALIZATIONS Dates

1.______________________________ ______________
2.______________________________ ______________
3.______________________________ ______________

Trilogy Medical
CENTERS FOR INTEGRATIVE MEDICINE

Name ____________________

Last First MI

CURRENT MEDICATIONS & DOSAGE	DATE BEGAN	CURRENT HERBS, VITAMINS & DOSAGE

PAST MEDICATIONS &DOSAGE	DATE BEGAN	DATE STOPPED

CURRENT OVER THE COUNTER MEDICATIONS: ____________________

TOPICAL MEDICATIONS: *(ie, cortisone)* ____________________

Any Prior Constitutional Homeopathic Medications:	Prescribed By	Result (+ or -)

ALLERGIES TO MEDICATION:	REACTION

TOBACCO USE: Never or ______ packs per day for ___ years, until ______

COFFEE USE: ____________________

ALCOHOL USE: Present: ____________________ Past: ____________________

LIVING SITUATION Members at Home

	NAME	AGE	RELATIONSHIP
1.			
2.			
3.			
4.			
5.			

FAMILY HISTORY:

PERSON	**AGE** *(alive or age died)*	**MEDICAL PROBLEMS**
FATHER	____________________	______________________________
		______________________________
MOTHER	____________________	______________________________
		______________________________

SIBLINGS: *(Brother or Sister)*

____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

OTHER ILLNESSES THAT RUN IN THE FAMILY LINEAGE: *(List Who and Approximate Age)*

____
____
____
____

ENVIRONMENTAL ALLERGIES:

Substance	Reaction
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________

REVIEW OF SYSTEMS: Give details to be discussed.

MIND: *Describe any difficulties Emotionally or Mentally.*

____
____
____
____
____
____

HEAD, EYES, EARS, NOSE & THROAT:

____

____

____

____

RESPIRATORY:

____

____

____

CARDIOVASCULAR:

____

____

GASTROINTESTINAL: *(Any Colonoscopy or Endoscopy with Dates)*

____

____

RECTAL TROUBLE:*(Constipation, Diarrhea, Anal Itching, Fissures, Hemorrhoids)*

____

____

URINATION:

____

____

SEXUALLY TRANSMITTED DISEASES:	DATE	TREATMENT

BIOLOGICAL CHILDREN OR ADOPTIONS:*(Son or Daughter & Ages))*

____

____

MISCARRIAGES / ABORTIONS: *(Number & Date)*

____

GYNECOLOGY / UROLOGY / PROSTATE / TESTICAL, ETC: *(Any Troubles & Date Last Checked)*

____

____

____

Trilogy Medical
CENTERS FOR INTEGRATIVE MEDICINE

DERMATOLOGICAL: *(Rashes, Sweat, Acne Treatments)*

SPINE & EXTREMITIES: *(Specify Neck or Back Abnormalities - ie, Cramping, Pain, or Numbness)*

BONE DENSITY TESTS: *(Dates)*

SLEEP DIFFICULTY:

DREAMS: *(Recurrent Themes)*

ENERGY: *(When Low & High)*

TEMPERATURE: *(Generally feel warm or chilly)*

TIME OF DAY PROBLEMS OCCUR:

OTHER:

Trilogy Medical
CENTERS FOR INTEGRATIVE MEDICINE

Trilogy Medical, Inc.

4105 Soquel Dr, #A
Soquel, CA 95073
(831) 600-8117 Phone
(831) 600-8811 Fax
staff@trilogymedical.net
www.trilogymedical.net

EMAIL

Email is a way to correspond for general matters, but please
DO NOT SEND EMERGENCY OR URGENT INFORMATION BY EMAIL.

REMEDIES BY MAIL

To have homeopathic remedies sent to you:
1. Call or email with which remedy or remedies are needed (name and dosage).
2. Confirm the address you want it sent to and any special delivery requests.
3. Relay the cc# to be used (security protected) for the items plus shipping cost.

CANCELLATION/RESCHEDULE POLICY

If you need to reschedule or cancel your appointment for any reason, please notify our office at least 3 business days prior, or your account will be charged the full amount of your appointment. We appreciate your cooperation. Payment for initial visits are due in advance, and follow up visits are due at the time of visit.

Credit Card Number (Visa, Mastercard, Discover Accepted)

______________________	______________	______________
Credit Card Number	Expiration Date	Code# (3 digits on back of card)

____
Billing Zip Code

______________________________	______________
I understand & agree with the above policies	Date

Acknowledgement of Receipt of

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our office.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary. By signing below, I certify that I have read and understood the Notice of Privacy Practices.

Patient Name ________________________________

Patient Signature______________________________ Date:_____________