Stephen B. Lewis, M.D., F.A.C.P., C.D.E.

Endocrinology/Metabolism/Diabetes & Obesity

Welcome!

We are delighted to welcome you to our practice and are pleased that you chose us to serve your healthcare needs. I have put together this packet to help make the transition easier.

Please arrive to your appointment 15 minutes prior to your scheduled appointment time. You will need to bring your current insurance cards; you will not be seen without them. You will be required to take a photo on your first visit for identification purposes. Copays are due at each appointment; they will be collected before any service is provided. Please bring ALL medications you are taking along with any previous labs or other pertinent medical information. I have included a release of medical records form that you may send to any previous providers, if needed.

You may fax or email this packet prior to your appointment. If fax and email are unavailable please bring this completed packet with you to your first appointment.

We are looking forward to a long partnership with you. I realize this is a lot of paperwork and it may be overwhelming if you should have any questions please don't hesitate to call.

Sincerely,

Stephen B. Lewis MD

2425 East St. Suite 15
Concord, CA 94520
(925)682-9232
Fax: (925)676-2198
Ashlie@docstephenlewis.com

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Name(last, first):	Marital status (circle one): Single Married Divorced Widowed

Is this your legal name? Yes No	If not, what is your legal name?	Former/ Maiden name:	Birth date:	Age:	Sex:

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Work phone no.:

Chose clinic because/referred to clinic by :

Other family members seen here: [Other patients]

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:

Subscriber's name:	Subscriber's Date of Birth:	Subscriber #	Group Name:	Group #

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber #	Group #

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Person to contact in an emergency:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Stephen B. Lewis MD Inc. or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Patient Financial Responsibility

As a courtesy we will bill your insurance for all medical fees. However you are responsible to pay for any amount not covered by your insurance provider. It is important to remember that your insurance is a contract between you and your insurer.

As a patient, it is in your best interest to know if Dr. Stephen Lewis is considered an in-network physician with your insurance plan, and to understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Your insurance company's customer service representative can help verify your benefits and out-of-pocket costs.

Policies and coverage determination vary from year to year and with some insurance companies it may even vary month to month.

If Dr. Stephen Lewis is listed as an out of network provider with your insurance plan, we are still happy to provide you services. If your policy has out-of-network benefits, your insurance plan may still cover the service provided to you. However, you may be responsible to pay a higher out-of-pocket amount.

If Dr. Stephen Lewis is not contracted with your insurance plan we will be happy to see you as a Self Pay patient. In this circumstance we will not bill your insurance company at all. We will charge you a flat rate price for service provided in our office.

Non Cancellation Policy

If you do not call us BEFORE your scheduled appointment time you will be charged a $25 fee that is not covered by your insurance. This fee must be paid before your next appointment.

I have read and understand all the above information and agree to the policy as listed above.

_____

Print Name

_____

Signature Date

Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Is sex entirely satisfactory?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

CONSENT FOR USE OF PROTECTED HEALTH INFORMATION FOR IN-OFFICE TREATMENT, PAYMENT, AND OPERATIONS

I consent to the use of my Protected Health Information for treatment, payment for treatment, and Dr. Lewis's health care operations for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Stephen B. Lewis MD Inc. will share patient protected health information according to the federal and state law for treatment, payment, and operations, as well as in accordance with its Notice of Privacy Practices.

I understand that I am responsible for all charges incurred, regardless of my insurance status. I agree that I must pay for services as I incur the charges. I authorize Stephen B. Lewis MD Inc. to provide necessary information to my insurance carrier or other payer for payment purposes, and I authorize my insurance company/payer to pay Stephen B. Lewis MD Inc. for services filed on my behalf. This assignment remains effective until I revoke it in writing.

Signature of Patient:_____ Date: _____

Printed Name of Patient: _____ DOB: _____

*Signature of Legal Representative: _____

Printed Name of Legal Representative: _____

*May be requested to show proof of representative status.

Request for Release of Medical Records

Physician Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

I hereby authorize and request that my medical records be release to:

Stephen B. Lewis MD

2425 East St #13

Concord, CA 94520

(925)682-9232 Fax: (925)676-2198

Patient Name:_____

Date of Birth:_____

_____

Patient Signature Date