SAN FRANCISCO PREVENTIVE MEDICAL GROUP

PATIENT INFORMATION FORM

DATE: _____

PATIENT'S NAME: _____ MR. ____ MRS. ____ MS. ____ AGE: _____
(LAST) (FIRST)

HOME ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

DATE OF BIRTH: _____ HOME PHONE #: ( ) _____

EMPLOYER: _____ WORK PHONE #: ( ) _____

EMPLOYER'S ADDRESS: _____

OCCUPATION: _____ SOCIAL SECURITY #: _____ - _____ - _____

SPOUSE'S EMPLOYER: _____ WORK PHONE #: ( ) _____

SPOUSE'S EMPLOYER'S ADDRESS: _____

PATIENT'S NEAREST RELATIVE: _____ PHONE #: ( ) _____

PHYSICIAN: _____ DATE OF LAST PHYSICAL: _____

DENTIST: _____ DATE OF LAST VISIT: _____

YOUR REFERRAL: _____ PHONE #: ( ) _____

NAME OF MEDICAL INSURANCE: _____

IF PATIENT IS A MINOR, WHO IS FINANCIALLY RESPONSIBLE? _____

WHOM TO CONTACT IN CASE OF EMERGENCY? _____

ACKNOWLEDGEMENT:

I acknowledge full responsibility for the payment of services and agree to pay for them, in full, at the time of service unless other arrangements have been made with the office in writing. A valid credit card number will be required at the time of scheduling in order to secure an appointment. I understand that a $100.00 fee will be charged if my initial appointment is not cancelled 48 hours in advance, as well as a $25.00 service fee for any returned checks.

_____ _____

PARENT OR GUARDIAN'S SIGNITURE PATIENT'S SIGNATURE

DUE TO OUR BUSY SCHEDULE, WE WOULD APPRECIATE YOUR CALLING-IN TO CANCEL OR RE-SCHEDULE YOUR APPOINTMENT TO GIVE THE TIME SET ASIDE FOR YOU TO PATIENTS WHO ARE WAITING TO SEE THE DOCTOR. THANK YOU.

SAN FRANCISCO PREVENTIVE MEDICAL GROUP
380 WEST PORTAL AVE. STE C
SAN FRANCISCO, CALIFORNIA 94127
TELEPHONE (415) 566-1000

NAME _____ DATE _____

Lifestyle Questionaire

A. Diet

1. What ratio of whole grains to refined grains do you eat?

2. How many times per week do you eat food prepared commercially (not in home)?

3. How much (refined or unrefined) sugar do you consume each day?
   1/2 tsp, 1 tsp, 1 tbsp, 1/4 cup, etc.

4. How many cups of coffee or black tea per day do you drink? Is it decaffeinated? What process of decaffeination is used?

5. How many total times per day do you eat any of the following: meat, fish, fowl, eggs, or cheese?

6. Do you drink alcohol? What kind? How often? How much?

7. do you smoke? How many packs? For how long?

B. Exercise

1. Is time set aside in your life for physical exercise? How much time per week?

C. Environment

1. How many years of your life, if any, have you lived in an environment of substantial air pollution?

2. Rate the air in whaich you now spend most of your time. Poor, fair, good, or excellent.

3. Do you have access to foods grown organically?

4. What is the source of your drinking water?

D. Medication

1. Do you take medications regularly? Please list them and the dosages.

E. Modern Stress

1. Are any of these true of you?	Yes	No
a. Frequently short of time?	_____	_____
b. Restless at night, can't sleep?	_____	_____
c. Feel frustrated or stymied by present circumstances in work or personal circumstances?	_____	_____

F. Do you see any relationship between your present disease and any aspect of your lifestyle? Please make note of them briefly so they can be discussed in the clinic.

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NAME _____ DATE _____

Check off each one of the symptoms in one of the columns to indicate the degree of severity which best applies to you. A check in Column 1 means MILD, 2 means MODERATE, column 3 means SEVERE. Please use the designated space on the bottom of the page if you have any other problems not listed or if you want to expand on your answer.

0	1	2	3	
__	__	__	__	Abnormal craving for sweets
__	__	__	__	Afternoon headaches
__	__	__	__	Allergies
__	__	__	__	Awaken after a few hours sleep, can't return easily
__	__	__	__	Aware of breathing heavily
__	__	__	__	Bad dreams
__	__	__	__	Backache
__	__	__	__	Blurred vision
__	__	__	__	Brown spots / bronzing of skin
__	__	__	__	Bruise easily
__	__	__	__	Can't decide easily
__	__	__	__	Can't get started in morning
__	__	__	__	Chills
__	__	__	__	Chronic fatigue
__	__	__	__	Cold hands and feet
__	__	__	__	Chest pain (where _____)
__	__	__	__	Chronic nervous exhaustion
__	__	__	__	Decreased vision clarity
__	__	__	__	Decreased hearing
__	__	__	__	Decreased sex drive
__	__	__	__	Dizziness or light-headedness
__	__	__	__	Dry skin
__	__	__	__	Dry hair
__	__	__	__	Dry or brittle nails
__	__	__	__	Earaches
__	__	__	__	Forgetfull
__	__	__	__	Get "shakey" if hungry
__	__	__	__	Hand/s tremble
__	__	__	__	Head pain

0	1	2	3	
__	__	__	__	Heart palpitations (fast beats)
__	__	__	__	Heart pain
__	__	__	__	Highly emotional
__	__	__	__	Indigestion
__	__	__	__	Insomnia
__	__	__	__	Joint pain (where _____)
__	__	__	__	Lack of energy
__	__	__	__	Leg pain when walking
__	__	__	__	Leg pain when resting
__	__	__	__	Low or high blood pressure
__	__	__	__	"Pins and Needle sensations" (where _____)
__	__	__	__	Poor memory / ability to concentrate
__	__	__	__	Phlebitis
__	__	__	__	Pain when rotating your neck or hips
__	__	__	__	Reduced initiative
__	__	__	__	Ringing in ears
__	__	__	__	Sleepy after meals
__	__	__	__	Sleepy during the day
__	__	__	__	Shortness of breath
__	__	__	__	Swelling in ankles
__	__	__	__	Swishing sounds in ears
__	__	__	__	Tired too often
__	__	__	__	Urinary problems (please explain _____ _____
__	__	__	__	Varicose veins
__	__	__	__	Weakness
__	__	__	__	Forgetfull
__	__	__	__	Worry or feel insecure

Use space below to add or describe any complaints or problems you may have.

_____

_____

_____

_____

San Francisco Preventive Medical Group
380 West Portal Ave. Ste. C San Francisco, CA 94127 (415) 566 1000 Fax: (415) 665 6732

Lifestyle Questions Form

Name: _____ **Date:** _____

		TIME	FOODS EATEN	ENERGY LEVEL (low/good)
BREAKFAST		_____	_____	_____
			_____	
			_____	
LUNCH		_____	_____	_____
			_____	
			_____	
DINNER		_____	_____	_____
			_____	
			_____	
SNACKS	**AM**		_____	_____
	PM		_____	_____

BED TIME _____

NUMBER OF HOURS OF SLEEP _____

TYPE OF SLEEP: DEEP____ **LIGHT** ____ **OTHER**_____

DREAMED ABOUT?

_____
_____
_____
_____
_____
_____
_____
_____

WAKEUP TIME _____

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INFORMED CONSENT FORM

I am seeking medical health care services at SFPMG. I understand that this medical practice uses some diagnostic and treatment methods that are variously known as complementary, alternative, holistic, or nutritionally oriented. Some of these methods have not been accepted by consensus mainstream medicine.

Some of the characteristics qualities of complementary medicine that are used in this practice include the following:

1. A person's lifestyle including his or her diet, exercise patterns, sleep habits, stresses and interpersonal relationships are believed to be directly related to the development and main tenance of illness. Complementary medicine evaluates these factors and seeks to help the patient give up negative life style patterns and establish more positive ones regardless of age or type of medical problem.

2. Although prescription and over-the-counter medications are used when the physician believes it is necessary, an attempt is also made to use products that are natural to the body. These include nutritional supplements such as vitamins, minerals, glandulars, enzymes, amino acids, essential fatty acids, homeopathic medicines and herbs.

3. In addition to recommending that a patient take nutritional supplements by mouth, we frequently recommend that a patient receive a series of injections either intravenously or by intramuscular injection, (intravenous vitamin therapy is an example). Some of the reasons for recommending this procedure include the assurance that the particular substance gets into the body (which may not happen when the supplement is taken orally and the patient has absorbtion problems) and achieving high concentration of the substances in the bloodstream, which may be difficult if the substance is taken only by mouth.

4. Because we look for imbalances in the body and for trends that may result in illness if not addressed, we sometimes order tests that may be considered by consensus mainstream medicine to be either unnecessary or of no value. These tests may include tests for nutritional status, such as blood levels for functional vitamin or mineral tests, ormoneal levels, test for allergies, saliva tests, and urine tests for excreted substances.

5. We very much believe in a person being involved in his own health care and encourage questions, exploration and participation in decisions surrounding diagnostic and treatment procedures. We encourage consultations with consensus mainstream medicine practitioners and use of any other means that a person feels he needs to help him decide about health issues.

6. We believe in the mind-body-spirit connection in bringing about wellness and preventing and dealing with illness. Consequently, part of our program may involve recommendations for counseling, meditation, psychotherapy or hypnotherapy.

7. Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Graded exercise, both aerobic and stretching, is encouraged for most patients.

8. We sometimes use medications that are approved by the FDA to treat one condition to treat another condition for which the FDA has not approved the medication. It should be noted that this is common practice throughout all medical felds, not only in complementary medicine. Perhaps the best example we have is our use of EDTA chelation therapy to treat all forms of atheroscerotic cardiovasculart disease and other degenerative diseases.

The above represents some of the ways that our practice may differ from other physician's offices that you have visited. You should also be aware of the following points:

1. WE MAKE NO REPRESENTATIONS, CLAIM OR GUARANTEES THAT YOU WILL BE HELPED WITH YOUR MEDICAL PROBLEMS OR CONDITIONS BY UNDERGOING TREATMENT HERE. However, we will do our best to help you to accomplish your health care and wellness goals.

2. In our office, we make available nutritional supplements and other recommended products. Generally, we believe the prices are competitive with outside sources. (Please let us know if you find this not to be the case.) Mail order service is also available from our office. YOU ARE IN NO WAY

OBLIGATED TO PURCHASE THESE PRODUCTS FROM THIS OFFICE. YOU ARE FREE TO PURCHASE THESE PRODUCTS FROM ANY SOURCE THAT YOU MAY CHOOSE AS LONG AS THEY ARE EXACTLY THE SAME.

3. Most health insurance plans today have clauses, which limit coverage to "usual and customary services". Because many of the treatments used in complementary medicine are not recognized by consensus mainstream medicine, we cannot garantee the amount of availability of coverage of our services and treatments under your health insurance policy. You are responsible for the payment of all non-covered services. You are entitled to know the cost of all services and procedures in advance. Please ask if they are not told to you.

I have read, understand and agree to the foregoing. I agree that if I ever have any claim with respect to the services and treatment given to me at SFPMG, its employees and/or staff, that they shall be judged by the standards and principles of complementary, alternative, environmental, holistic, and nutritionally-oriented medicine and not by the standards and principles of consensus mainstream medicine. I understand that I have the right to review this Consent with a lawyer I choose before accepting any medical services at SFPMG. I have executed this Consent freely and willingly and understand its provisions. I recognize that SFPMG will rely upon my execution of this document in rendering all services provided. I acknowledge receipt of a copy of this Consent.

Date: _____

Signature: _____

Printed Name: _____

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Information on Protecting Privacy of Patient Records - Maintenance of Confidentiality

At the office of San Francisco Preventive Medical Group, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, by issuing this notice to all patients and following the terms and conditions described. This notice describes how your health information may be used/disclosed, and how you can access this information. Please review the following carefully:

- For ALL medical record release requests, we will not disclose your health information without your prior written authorization and approval from one of the medical practitioners.
- We are permitted to release your medical records to all who participate in your treatment (ie. referred specialist, hospitals).
- We are permitted to release your medical records by request from non-medical facilities/sources such as insurance companies, law offices, etc., and have the right to charge a nominal fee for the medical records given.
- You have the right to request personal copies of some/all of your medical records, and have the right to transfer your medical file to another physician/practice. This information may only be mailed to the appropriate address, or picked up in person by you or a designated representative.
- We may use your information to contact you: For example, we may send newsletters or other information. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers our call.
- As we will contact you from time to time, we will use whatever address or telephone number you prefer. Please keep us updated with your current contact information (as well as current insurance information) with each follow up visit to the office.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- You have the right to know if any disclosures we make with your medical records beyond the above normal uses.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- Your medical information will remain on file in the San Francisco Preventive Medical Group for as long as you are an active patient. We have the right to remove patient records that are inactive for five years or more. The records removed will be placed into storage and subsequently destroyed if they continue to remain inactive for one year after their initial removal from the office.
- You have a right to receive a copy of this notice. If we change any details in this document, we will issue a new agreement, and distribute it to you for a reassessment and patient signature.
- This privacy notice goes into effect as of April 14, 2003.

Acknowledgement

I have read and am in agreement with the above mentioned notification of privacy practices for the office of San Francisco Preventive Medical Group. I also have the right to request a copy for my personal records.

Signed: _____ Date: _____

Print Name: _____

E-mail: _____

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ADVANCED BENEFICIARY NOTICE

I, _____ _____
(patients name) (social security #)

hereby acknowledge by this statement that I have been fully informed that some and perhaps all of the medical services provided by at the San Francisco Preventive Medical Group on or after this date by Dr. Paul Lynn and his associates may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. I realize that in case my insurance coverage including Medicare will not pay for such non-covered services, I will be personally responsible for payment.

MEDICARE WILL NEVER PAY FOR VITAMINS, MINERALS AND NUTRITIONAL SUPPLEMENTS IN ANY FORM INCLUDING CHELATION

Signature _____ Date _____

Witness _____