Michael Aguilar, M.D.
GENERAL SURGEON

Office Use Only

PCP Name _____

PCP Fax # _____

Patient Acct # _____

Registration Form

Name _____ Date of Birth _____

Address _____
Street City State Zip Code

Phone _____ Work _____ Cell _____

Marital Status: ☐ S ☐ M ☐ D ☐ W Gender: ☐ M ☐ F Spouse Name _____

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Other _____

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Other _____

Language: _____

Social Security # _____ Driver's License # _____

Occupation _____ Employer _____

Emergency Contact _____ Relationship _____ Phone _____

Primary MD _____ Referring MD _____

PRIMARY INSURANCE

Name _____

Group # _____

ID # _____

Subscriber _____

SECONDARY INSURANCE

Name _____

Group # _____

ID # _____

Subscriber _____

OUR INSURANCE BILLING POLICY:
We will bill your insurance(s) for services rendered by Michael Aguilar, M.D. If your insurance plan requires a referral or authorization, we must have your referral or authorization on file prior to your visit. You are responsible for any balance not covered or authorized by your insurance(s).

I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO:
Michael Aguilar, M.D.

I also authorize the release of any information about me that is necessary to process my insurance claims. A copy of this authorization may be used in place of the original authorization.

We understand that insurance coverage is very confusing to many people, and we are committed to helping you with any questions you may have. Please contact our business office at (916) 923-3100 if you have any questions.

I have read and understand the policy stated above:

INSURED SIGNATURE: _____ Date: _____

MEDICATIONS

List of All Medications (include dose and frequency): Include over the counter medications

(1) _____ (6) _____

(2) _____ (7) _____

(3) _____ (8) _____

(4) _____ (9) _____

(5) _____ (10) _____

List of Allergies and Reactions: (Rash, Difficulty Breathing, Swelling, Nausea, etc.)

_____

_____

_____

FAMILY HISTORY

	If Living		If Deceased	
	Age	Medical History (circle one)	Age at Death	Cause
Father		Heart Disease Stroke Diabetes Cancer None		
Mother		Heart Disease Stroke Diabetes Cancer None		
Siblings (First Names)				
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		
Children (First Names)				
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		
☐ M ☐ F		Heart Disease Stroke Diabetes Cancer None		

MEDICAL HISTORY

Medical History (Check if you have experienced any of the following problems in the last 6 months and explain if appropriate)

General Well-Being

- ☐ Fatigue/Weakness
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Weight Gain
- ☐ Weight Loss

Eyes

- ☐ Glaucoma

Ears, Nose, Mouth, Throat

- ☐ Sleep Apnea

Musculoskeletal

- ☐ Joint Pain
- ☐ Arthritis
- ☐ Back Injury or Surgery

Skin

- ☐ Rashes

Cardiovascular (Heart)

- ☐ Defibrillator/Type_____
- ☐ High Blood Pressure
- ☐ Pacemaker/Type _____
- ☐ Prior Balloon Angioplasty/Stent Date _____
- ☐ Prior Heart Attack Date_____
- ☐ Prior Heart Surgery Date _____
- ☐ Prior Vascular Surgery or Procedure
- ☐ Shortness of Breath
- ☐ Dizziness/Syncope

Gastroenterology (Abdomen)

- ☐ Abdominal Pain or Heartburn
- ☐ Acid Reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Ulcers
- ☐ Intestinal Disease_____
- ☐ Gallbladder Disease
- ☐ Liver Disease_____
- ☐ Cirrhosis of the Liver
- ☐ Hepatitis
- ☐ Other Disease_____

Neurologic

- ☐ Alzheimer's Disease
- ☐ Brain Injury
- ☐ Convulsions/Seizures
- ☐ Dizziness
- ☐ Insomnia
- ☐ Memory Loss or Confusion
- ☐ Migraines or Headaches
- ☐ Numbness
- ☐ Stroke
- ☐ Weakness
- ☐ Other Disease_____