Trilogy Medical
CENTERS FOR INTEGRATIVE MEDICINE

ADULT PATIENT REGISTRATION FORM *Please Print* ☐ MALE ☐ FEMALE

Name_____ Birth Date_____
Last First M

Address_____ City_____ State_____ Zip_____

Home Phone (___) _____ Daytime Phone (___) _____

Social Security #_____ Cell Phone_____

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_____ Social Security #_____

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 BUSINESS DAYS PRIOR, OR YOUR ACCOUNT WILL BE CHARGED THE FULL AMOUNT OF YOUR APPOINTMENT. **PAYMENT IS DUE AT TIME OF VISIT BY EITHER CASH, CHECK, OR CREDIT CARD.**

WE REQUIRE you or others accompanying you to **NOT** wear colognes, perfumes, scents, essential oils, flower essences, or scented lotions to the office. **We keep a scent free office for people with chemical sensitivities.**

PLEASE SIGN AND RETURN AT LEAST ONE WEEK PRIOR TO YOUR APPOINTMENT.

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 JEFF D. LESTER, D.O.

SIGNATURE_____ DATE_____

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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._____ _____

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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 (I.E. 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.			

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FAMILY HISTORY:

PERSON	**AGE** (alive or deceased?)	**HEALTH PROBLEMS**
FATHER		
MOTHER		

SIBLINGS (Brother or Sister)

OTHER ILLNESSES THAT RUN IN THE FAMILY LINEAGE

ENVIRONMENTAL ALLERGIES

Substance	Reaction

REVIEW OF SYSTEMS: Give details to be discussed.

MIND: *Describe any difficulties Emotionally or Mentally.*

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HEAD, EYES, EARS, NOSE & THROAT:

RESPIRATORY:

CARDIOVASCULAR:

GASTROINTESTIANL: *(Any Scoping with Dates)*

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

URINATION:

SEXUALLY TRANSMITTED DISEASES	**DATE**	**TREATMENT**

BIRTHS OR ADOPTIONS (*Son or Daughter & Date)*

MISCARRIAGES / ABORTIONS *(Number & Date)*

GYNECOLOGICAL / PROSTATE / TESTICAL, ETC *(Any Troubles & Date Last Checked)*

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

SPINE & EXTREMITIES: *(Specify Neck or Back Abnormalities—i.e. Cramping, Pain, or Numbness)*

BONE DENSITY TESTS:

SLEEP:

DREAMS: *(Recurrent Themes)*

ENERGY: *(When Low & High)*

TEMPERATURE: *(Generally feel warm or chilly)*

TIME OF DAY PROBLEMS OCCUR:

OTHER:

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E-MAIL AGREEMENT

Trilogy Medical, Inc.
Jeff D. Lester, D.O.
280 W Hamilton Ave
Campbell, CA 95008
Phone (408) 844-0010 Fax (669) 300-6912
Email: info@trilogymedical.net

E-Mail is a welcome way to consult with our office regarding problems and questions. Monthly newsletters may be sent regarding updates and promotions. **No emergency material is to be communicated by e-mail.**

For Doctor to read e-mails:

$40.00	½ page
$60.00	Full page

There is no charge for the staff to receive e-mails regarding setting up an appointment or sending remedies.

REMEDY BY MAIL

Homeopathic remedies can be sent to you by mail, by the following procedures;
1. Call or e-mail with which remedy or remedies are needed ie: daily dose, booster dose(LM1) or high dose.
2. Include your credit card number if not already on file. For efficiency please arrange to have your credit card on file (your number will be protected).
3. Shipping and Handling is $8.00.

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Credit Card Number (Visa, Mastercard, Discover Accepted).

_____ Credit Card Number

_____ Expiration Date

_____ Card Verification # (3 digit # on back of card)

_____ Billing Zip Code

_____ I understand & agree with the above policies

_____ Date