

Name: _____
Last First MI Prefers to be called/Nickname

Date of Birth: _____ Gender: _____ SSN: _____

Mailing Address: _____

CITY STATE ZIP

Primary Phone: _____ Secondary phone: _____

Work Phone: _____ Personal Email: _____

Marital Status: Single Life Partner Married Divorced Separated Widowed Declined

Race: American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander
 Black or African American White Declined

Religion: _____ Declined

Ethnicity: Do you consider yourself to Hispanic or Latino? Yes No Declined

Preferred Language: English Other (please specify): _____

EMPLOYER: _____ **Occupation:** _____

Status: Part-time Full-time Self-employed Retired Active Military Disabled Student Unemployed

EMERGENCY CONTACT

Name: _____ Relation to Patient: _____
LAST FIRST

Home Phone: _____ Cell: _____

PARTY RESPONSIBLE FOR PAYMENT Check if same as patient

Name: _____ DOB: _____

Address: _____

CITY STATE ZIP

Home Phone: _____ Cell: _____ Relation: _____

SIGNATURE _____ **DATE** _____
(Patient or Authorized Representative)

How did you hear about our practice?

Referring Physician
Insurance

Online/Practice Website
Newspaper

Family/Friend (Name) _____
Television Other _____

PREFERRED TELEPHONE/MESSAGE & COMMUNICATION AUTHORIZATION

Mountain View Family Health Care, PC is committed to ensuring the privacy and confidentiality of your medical/personal information. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To assist us in protecting your privacy, please complete the following information:

Preferred number to contact you: _____ Home Cell Work

May we leave a voicemail if no answer? Yes No

May we discuss information with someone other than you regarding your medical care (medication changes, laboratory results, billing issues, appointments, etc.)? If so, please list the name(s) in the space(s) below.

Please provide your email address if you would like to receive an invitation to our patient portal. Our portal allows you to message us, request refills, review records, and pay your bill, as well as several other things.

E-mail address _____

Billing Issues: Yes No

Medical Issues: Yes No

Name: _____ Phone: _____ Relationship to patient: _____

Name: _____ Phone: _____ Relationship to patient: _____

In the future, we may send text messages for appointment reminders or other communication to your cell phone. Do you consent to this service? YES NO

Patient Signature: _____ Date: _____

PLEASE COMPLETE IF PATIENT IS A MINOR (Less than 18 years old):

Age of minor: _____ Name of person completing form: _____
Please Print Relationship

If Parent of Legal Guardian is unavailable to accompany minor to appointment, please list authorized caretaker(s):

Name: _____
Please Print

Name: _____
Please Print

If minor is able to attend appointment unaccompanied, I agree to be financially responsible:

Parent or Legal Guardian Signature: _____ Date: _____

CONSENT AND AUTHORIZATIONS – Please initial each item.

_____ **Consent for Health Care Services** - I authorize physician(s), nurse practitioner(s), their assistants and/or designees to administer treatment as may be necessary or advisable in my diagnosis and treatment at Mountain View Family Health Care, PC. This authorization includes, but is not limited to, medical services, diagnostic procedures, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers medically necessary. My health care provider will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that Mountain View Family Health Care, PC may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered by the practice.

_____ **Consent for Communication with Health Professionals and Pharmacies** – I authorize Mountain View Family Health Care, PC to obtain or provide information, as requested from other health care providers and pharmacies for the purpose of quality, continuity of care.

_____ **Other Medical Services** - I understand that I may receive services from professionals who provide care to me who are not employees or agents of Mountain View Family Health Care, PC. These professionals may include other healthcare providers as requested by my health care provider to participate in my care such as radiology, pathology, and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from Mountain View Family Health Care, PC. **I understand that, in some cases, these professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.**

_____ **Preauthorization Requirements** - I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians/nurse practitioners' charges, as well as charges recommend to me such as specialist consultation, MRI, CAT scan colonoscopy, etc. I also understand that my insurance may require an office visit with my primary health primary care provider prior to seeing a specialist. It is my responsibility to contact my insurance to verify the need for referral. If a referral or prior authorization is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit or procedure.

_____ **Assignment for Direct Payment** - I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my providers. I understand that I am financially responsible to the practice or my providers for charges not covered or paid pursuant to this authorization.

_____ **Financial Agreement** – I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and of physicians/ nurse practitioners rendering services not otherwise paid by my health insurance or other payer. **Estimated patient responsibility is due at the time of service.** Any remaining charges are due upon receipt of the bill. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. If I default on my debt, I agree to pay all reasonable legal expenses necessary for the collection of any debt. **I consent to be contacted my regular mail, by email or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well, as to the use of technology including auto-dialing and/or prerecorded messages in contacting me.**

_____ **Acknowledgement of Notice of Privacy Practices** – I acknowledge that Mountain View Family Health Care, PC has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Mountain View Family Health Care's website. I understand this acknowledgement in no way affects the care I shall receive at Mountain View Family Health Care, PC.

SELECT ONE - I have **ACCEPTED** **DECLINED** a copy of the Notice of Privacy Practices.

I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE BEEN OFFERED COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

Printed Name

Signature

DATE

RELATIONSHIP or REASON WHY PATIENT IS UNABLE TO SIGN IF OTHER THAN MINOR

Name: _____ DOB: _____

PERSONAL MEDICAL AND FAMILY HISTORY

Please check applicable boxes.

TOBACCO USE: None Quit Date _____
 Cigarettes Packs/Day _____ Number of years smoked _____ Pipe/Cigar
 Smokeless Tobacco Electronic or E-cigarette Secondhand smoke exposure

ALCOHOL USE: None Daily Occasional Trying to Cut Down In Recovery
Amount per week: _____

DRUG USE: None Past Use Current
 Marijuana Amphetamines Cocaine Designer/Club
 Route: Smoke Inject Ingest Topical

How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?

None One or More

ADVANCE DIRECTIVE

Do you have a living Will/DNR? YES NO
Do you have a Durable Power of Attorney? YES NO

If yes: _____

Please Print Name

Phone Number

IMMUNIZATIONS:

Please provide any known dates or full immunization record(s).

Tetanus or Tetanus/Pertussis: _____ Influenza: _____ Shingles: _____ Meningitis _____

Hepatitis A: _____ Hepatitis B: _____

HPV: _____ Pneumovax: _____ Pevnar 13 : _____

Other: _____

ALLERGIES: Known Drug Allergies: YES No

(Please add additional sheet if necessary)

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other Allergies (latex, adhesive, food, environmental)

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

SIGNATURE: _____ DATE: _____

(Patient or Authorized Representative)

Name: _____ DOB: _____

FAMILY HISTORY

What illness/conditions/diagnoses are in your family?

If known, document the age of onset in the box for the appropriate disease and family member.					
	Father	Mother	Sibling(s)	Paternal Grandparent(s)	Maternal Grandparent(s)
Alcoholism/ Substance abuse					
Asthma					
Blood clots					
Breast cancer					
Colon cancer					
Prostate cancer					
Other cancer(s)					
Dementia					
Diabetes					
Heart disease					
High blood pressure					
High cholesterol					
Kidney disease					
Liver disease					
Lung disease					
Mental health/psychiatric					
Stroke					
Thyroid condition(s)					
Other					

SIGNATURE: _____ DATE: _____
(Patient or Authorized Representative)

Patient Name: _____ DOB: _____

Please select all that you've experienced over the **LAST TWO WEEKS**

General/ Constitutional	Appetite change Excessive sweating Fatigue	Fever Chills Insomnia	Night sweats Weight gain Weight loss	None
Eyes	Blurred Vision Wear corrective lenses Double vision	Dry eye Eye irritation Eye Pain	Vision loss Spots in vision	None
Ear, Nose & Throat	Ear Pain Hearing loss Tinnitus/ringing Vertigo (dizziness, balance problems) Facial pain	Bleeding gums Postnasal drainage Nose bleeds Nasal congestion Nasal drainage	Sore throat Mouth sores Hoarseness Dental pain	None
Cardiovascular	Exertional dyspnea (trouble breathing) Nocturnal dyspnea (trouble breathing)	Palpitations (irregular heartbeat) Decreased exercise tolerance	Chest pain Exertional dyspnea	None
Respiratory	Cough Sputum production Coughing up blood	Wheeze Pain with inspiration (deep breath) Shortness of breath	Snoring	None
Gastrointestinal	Abdominal pain Bloating Food intolerance Nausea	Trouble swallowing Heartburn Change in bowel habits Constipation	Diarrhea Vomiting Bloody stools Black stools	None
Genitourinary	Change in urine stream Dysuria (painful urination) Hematuria (blood in urine) Incontinence	Nocturia (overnight urination) Urinary frequency Urinary retention Menstrual changes/concerns	Urinary urgency Sexual dysfunction Vaginal discharge	None
Musculoskeletal	Back pain Joint instability Joint pain Joint swelling	Limited range of motion Leg pain at night Leg pain with exertion Neck pain	Stiffness Muscle cramps Muscle weakness Muscle aches	None
Integumentary/ Skin	Hair changes Lesions/changes in moles Breast masses	Pigment changes Rash Pruritus/persistent itch	Psoriasis	None
Neurologic	Abnormal gait/walking Focal weakness Headache(s) Confusion Memory problems	Seizures Decreased sensation Balance problems Restless legs Other neurologic concern	Speech problems Twitches/spasms Tremor Tingling Numbness	None
Psychiatric	Anxiety Decreased concentration Irritability Suicidal thoughts	Thought of hurting others Panic attacks Insomnia Mood swings	Sadness/tearful Depression Excessive sleep Hallucinations	None
Endocrine	Cold intolerance Heat intolerance	Excessive thirst Excessive hunger	Excessive urination	None
Hematologic/ Lymph	Bruising tendency Bleeding tendency	Swollen glands Recurrent infections		None
Allergy/ Immunologic	Eczema Immunocompromised	Seasonal allergies Hives/Urticaria		None
Any other symptoms:				

SIGNATURE: _____ DATE: _____
(Patient or Authorized Representative)

Patient Name: _____ DOB: _____

Your Care Team (other health care providers)

Provider: _____ Specialty: _____ Phone: _____
Provider: _____ Specialty: _____ Phone: _____
Provider: _____ Specialty: _____ Phone: _____

Procedures (list year):

Colonoscopy: _____ Sigmoidoscopy: _____ Stress Test: _____
EKG: _____
Mammogram: _____ DEXA Scan: _____

Please list any hospitalizations excluding surgeries/procedures

Hospitalized for	Year

Surgical History Please list surgeries/procedures and add notes as needed other than listed above

YEAR	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

MEDICATIONS: None

Please list any medications you are taking (including aspirin, vitamins and supplements), dosage, and how often you take.

Current Medications

Name of Medication	Dose	How often do you take	Reason for taking medication

PREFERRED PHARMACY

Local: _____ Mail Order: _____

SIGNATURE: _____ DATE: _____
(Patient or Authorized Representative)