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 ☐ Online/Practice Website ☐ Family/Friend (Name)_____
☐ Insurance ☐ Newspaper ☐ Television ☐ Other_____

Name:_____ DOB:_____

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.

Billing Issues: ☐ Yes ☐ No Medical Issues: ☐ Yes ☐ No

Name:_____ Phone: _____ Relationship to patient:_____

Name:_____ Phone: _____ Relationship to patient:_____

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 practioner(s), their assistants and/or designees to administer any 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.

_____**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 health care providers, 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 preauthorizations 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.

_____ I have been offered or accepted a copy of the Notice of Privacy Practices

_____ I have declined a copy of the Notice of Privacy Practices

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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: (please circle) **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:**_____ **Prevnar 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 circle 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/tearfulness 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)

NAME:_____ DOB:_____ DATE:_____

PERSONAL MEDICAL HISTORY - Please circle Y or N to all diagnoses that apply to you and add notes as needed

ARE YOU ADPOTED? Yes No

General History		
Chronic Fatigue	Y	N
Chronic Pain	Y	N
Disabilities	Y	N
Fibromyalgia	Y	N
Long-Term Steroid Use	Y	N

Allergy		
Environmental/Food	Y	N
Seasonal	Y	N
Other	Y	N
_____		

Eyes		
Cataracts	Y	N
Glaucoma	Y	N
Macular Degeneration	Y	N
Other Eye Condition	Y	N
Date of Last Eye Exam		

Ear, Nose, Throat		
Ear Infection, recurrent	Y	N
Hearing Deficit	Y	N
Sinusitis, recurrent	Y	N
Vertigo	Y	N
Other Ear, Nose or Throat Condition	Y	N

Dental
Date of Last Dental Exam

Endocrine/Metabolic		
Diabetes-Type:	Y	N
Thyroid Problems	Y	N
Other Endocrine/Metabolic Condition	Y	N

Respiratory		
Asthma	Y	N
COPD/Emphysema	Y	N
Pneumonia	Y	N
Oxygen Use	Y	N
Other Respiratory Condition	Y	N

Sleep		
Restless Leg Syndrome	Y	N
COPD/Emphysema	Y	N
Other Sleep Condition:_____	Y	N

Cardiac		
Angina (Heart Pain)	Y	N
Atrial Fibrillation	Y	N
Heart Failure	Y	N
Hyperlipidemia (high cholesterol)	Y	N
Hypertension (high blood pressure)	Y	N
Heart Disease	Y	N
MI (heart attack) - Date:	Y	N
Arhythmia/Palpitations	Y	N
Other Cardiac Condtion	Y	N

Vascular		
Blood Clots	Y	N
CVA/Stroke	Y	N
Peripheral Artery Disease	Y	N
Other Vascular History:	Y	N

Gastrointestinal		
Diverticulitis	Y	N
GERD (heartburn)	Y	N
GI Bleeding	Y	N
Irritable Bowel Syndrome (IBS)	Y	N
Other Gastrointestinal Condition	Y	N

Renal		
Chronic Kidney Disease	Y	N
Kidney Stone	Y	N
Dialysis (hemodialysis or peritoneal)	Y	N
Other Renal Condition:	Y	N

Genitourinary		
UTI (bladder infections)	Y	N

Musculoskeletal Disorders		
Arthritis	Y	N
Bone Loss - Date of Last DEXA:	Y	N
Sciatica	Y	N
Scoliosis	Y	N
Other Musculoskeletal Condition:	Y	N

Autoimmune		
Connective Tissue Disorder	Y	N
Lupus	Y	N
Rheuumatoid Arthritis	Y	N

Hematologic		
Anemia	Y	N
Bleeding Disorder/Tendency	Y	N

Cancer
Type
Type:

Infectious Diseases		
AIDS/HIV	Y	N
Hepatitis - Type:	Y	N
Tuberculosis	Y	N

Neurologic		
Seizures	Y	N

Genetic/Congenital		
Genetic/Congenital Condition	Y	N

Events		
Blood Transfusion	Y	N
Gunshot Wound	Y	N
Head/Injury/Concussion	Y	N
Motor Vehicle Accident	Y	N
Other Major Medical Event(s)	Y	N