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______________________

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 the healthcare providers, and/or their medical assistants 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 healthcare provider considers medically necessary. My health care provider will discuss with me the risks, benefits, and alternatives to recommended treatments. 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 healthcare providers and pharmacies for the purpose of quality, continuity of care. 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.

______**Other Medical Services -** I understand that I may receive services from professionals who provide care for me that 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.

_____ **Insurance Participation –** I understand that I am responsible for verifying that Mountain View Family Health Care is a participating provider with my health insurance plan. If I have a plan that requires a PCP/HMO I understand that it is my responsibility to verify that any authorizations are in place prior to receiving services or understand that I will be financially responsible for services rendered.

______ **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 and health care provider's 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.

______ **Co-payment/Co-insurance –** I understand that all copayments or amount, as indicated by my insurance company are due the day services are rendered. I understand that there is a $10.00 statement billing charge for billing this co-payment if it is not paid within 24 hours of your appointment.

______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 healthcare providers 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.

______**Collection Agency Assistance** – I understand that should I default on my account balance and collection agency services are initiated, I agree to pay all costs of collections; up to 45% of the balance, including attorney fees/court costs, which will be added to the balance of my account. This authorization shall remain in effect and may be applied to all future services rendered to me or my dependents for up to one year from the date of signing. This authorization may be withdrawn in writing before the one year has run, however the collection provision shall remain in effect for services already rendered and the Provider may refuse future medical care or services unless another agreement is signed allowing for collection fees and costs as set forth above.

______ No-Show/No Cancellation policy – I understand that there **MAY** be a charge of $25.00 for my first missed appointment without 24-hours' notice and that a second missed appointment without 24 hours' notice **WILL** result in a $50.00, which must be paid prior to your appointment being rescheduled. Patients/families missing multiple appointments with less than 24 hours' notice will be dismissed from the practice. A small courtesy on your part allows us to schedule patients in your place rather than have to send them to an urgent care or remain on a waiting list.

______ **Zero-Tolerance -** I understand that the healthcare providers and all staff at Mountain View Family Health Care deserve to be treated with respect and kindness while doing their job as directed by management, no matter what that job is. Cursing, threatening, demanding or otherwise intimidating or abusive actions or language will not be tolerated. This behavior will result in immediate dismissal from the practice.

______ 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 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 to Patient

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:__________ 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 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)