Dignity Health Medical Group Nevada

PATIENT INFORMATION

Please complete ALL pages of this form. Your physician will review the form with you during your appointment.

Last Name _____ First Name _____ Middle Initial _____

Date of Birth ____/_____/_____ Age _____ SSN _____ Gender ____ Marital Status_____

Address _____ City _____ State _____ Zip _____

Phone Number ( ) _____ Cell Number ( ) _____

Work Number ( ) _____ Email address: _____

Patient Contacts

Emergency Contact **Name** _____

Relationship _____

Home Phone ( ) _____

Work Phone ( ) _____

Cell Phone ( ) _____

Primary Care Physician Information

PrimaryCarePhysician_____

OfficePhoneNumber_____

FaxNumber_____

Referring Physician Information

Referring Physician _____

Office Phone Number _____

Fax Number _____

Cardiologist Information

Name _____

Ethnicity

☐Caucasian ☐African American ☐Asian ☐Native American/Alaskan ☐Hispanic/Latino

☐Middle Eastern ☐Pacific Islander ☐Other ☐Do not wish to disclose

Advance Directive: ☐ Yes ☐ No

Healthcare Proxy _____ Living Will _____ DNR plus copy of document_____

Other _____

Dignity Health Medical Group Nevada

INSURANCE INFORMATION

(**Please fill out ALL insurance information** and present your insurance cards to the front office receptionist)

Primary Insurance

Health Plan _____ ID# _____

Subscriber's Name _____ Subscriber's SSN _____

Subscriber's Date of Birth _____ Effective From _____ to _____

Group # _____ Telephone # _____ Employer _____

Circle Plan Type HMO PPO POS EPO Other

Secondary Insurance

Health Plan _____ ID# _____

Subscriber's Name _____ Subscriber's SSN _____

Subscriber's Date of Birth _____ Effective From _____ to _____

Group # _____ Telephone # _____ Employer _____

Circle Plan Type HMO PPO POS EPO Other

Person Responsible for Payment ("Guarantor")

If SELF please check ☐

If same as patient information please check ☐

Responsible Party Name _____ Relationship to Patient _____

Street Address _____ SSN _____

City _____ State _____ Zip _____ Sex M F

Home Phone _____ Date of Birth _____

Work Phone _____

Cell Phone_____

Guarantor's Employer

Name: _____

Address: _____

Phone #: _____ Contact: _____

REVIEW OF SYSTEMS

Are you currently experiencing problems in any of the following areas?

1	General	Yes	No	If "YES" Briefly Explain
Recent weight loss or gain				
General Fatigue				
Fever				
Night sweats				
Difficulty sleeping				
Other				
2	**Integumentary**	**Yes**	**No**	**If "YES" Briefly Explain**
Bruise easily				
Rash or Hives				
Birthmarks				
Tattoo(s)				
Skin Lump(s)				
Unexpected hair loss				
Keloids				
Breast Lumps				
Breast Discharge				
Other				
3	**Eyes**	**Yes**	**No**	**If "YES" Briefly Explain**
Pain				
Redness				
Loss or change in vision				
Dryness				
Double Vision				
Flashing Lights				
Other				
4	**Genitourinary**	**Yes**	**No**	**If "YES" Briefly Explain**
Difficulty urinating				
Pain or burning on urination				
Blood in urine				
Cloudy urine				
Frequent urination				
MEN				
Penis Discharge/sore/rash				
Erection difficulty or impotence				
Other				
WOMAN				
Vaginal discharge/sore/rash				
Vaginal dryness				
Irregular periods				
Other				

5	Respiratory	Yes	No	If "YES" Briefly Explain
Shortness of breath				
Difficulty breathing				
Chronic cough				
Coughing up blood				
Wheezing				
Other				
6	**Ears, Nose, Mouth & Throat**	**Yes**	**No**	**If "YES" Briefly Explain**
Ringing in ears				
Loss of hearing				
Sinus congestion				
Runny nose				
Nosebleeds				
Loss of smell				
Bleeding gums				
Loss of taste				
Loose teeth				
Infected teeth or gums				
Hoarseness of voice				
Difficulty swallowing				
Other				
7	**Cardiovascular**	**Yes**	**No**	**If "YES" Briefly Explain**
Chest pain or pressure				
Irregular heartbeat				
Swollen legs or feet				
Heart murmur				
Other				
8	**Gastrointestinal**	**Yes**	**No**	**If "YES" Briefly Explain**
Nausea/Vomiting				
Vomiting up blood				
Stomach pain				
Constipation				
Diarrhea				
Blood in stool				
Heartburn				
Other				
9	**Musculoskeletal**	**Yes**	**No**	**If "YES" Briefly Explain**
Muscle ache/pain				
Muscle Weakness				
Joint Pain or Swelling				
Other				

10	Neurological	Yes	No	If "YES" Briefly Explain
Headache				
Dizziness				
Fainting or loss of consciousness				
Memory loss				
Slurred speech				
Other				
11	**Psychiatric**	**Yes**	**No**	**If "YES" Briefly Explain**
Depression				
Anxiety attacks				
Other				
12	**Endocrine**	**Yes**	**No**	**If "YES" Briefly Explain**
Hot flashes				
Heat sensitivity				
Cold sensitivity				
Other				
13	**Hematological/Lymphatic**	**Yes**	**No**	**If "YES" Briefly Explain**
Bleeding tendency				
Swollen tender glands				
Other				
14	**Allergy/Immunology**	**Yes**	**No**	**If "YES" Briefly Explain**
Hay fever				
Frequent Infections				
Poor Healing				
Other				

PHYSICIAN SIGNATURE _____ DATE:
REVIEWED AND UPDATED _____ DATE:
REVIEWED AND UPDATED _____ DATE:
REVIEWED AND UPDATED _____ DATE:

CURRENT ILLNESS

Location of Problem: Chest _____ Arm _____ Leg _____ Abdomen _____ Back _____ Other _____

On a scale of 1 - 10, with 10 being the worst, circle the number that best describes the problem:

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

When did you first notice the problem? Today ____ 2 days ago _____ 2 weeks ago _____ 1 month ago _____

Does anything help or make the problem worse? Moving Around ☐ Standing up ☐ Lying on side ☐ Other: _____

Does anything help or make the problem worse? Moving Around ☐ Standing up ☐ Lying on side ☐ Other: _____

Is there anything else occurring at the same time? Yes ☐ No ☐ Explain: Rash ☐ Nausea ____ Headache ☐ Fever ☐

Other: _____

Is the problem constant or variable? Dull then sharp ____ Very sharp then leaves ____ Constant ____ Other: _____

Does the problem interfere with your normal activities? Yes ☐ No ☐ Explain: _____

How long does the problem last? 30 min ☐ 1 hour ____ It is always there ____ Other: _____

PATIENT MEDICAL HISTORY QUESTIONAIRE

Patient Height: _____ft: _____in. Patient Weight _____lbs. _____kg A g e: _____

Medications (list all medications you currently take – including over the counter medications, vitamins, and herbs):

Name of Medicine	Dosage & How Often	How long have you taken it?
EXAMPLE: Xanax	0.5 mg Once daily	3 years
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medication Allergies/Reactions

List any drug or substance you have had an adverse reaction to in the past; such as penicillin, latex, iodine, etc...

Name of Medication or Substance	**Allergy/reaction to medication or substance**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Local Pharmacy: Name: _____ Phone: _____

Cross Streets: _____ Fax: _____

Mail Order Pharmacy: Name: _____ Phone: _____

Address: _____ Fax: _____

MEDICAL HISTORY

Condition or Disease	Yes	No	Details
Abdominal aortic aneurysm			
Acid Indigestion, reflux (GERD)			
Anemia, low blood count			
Antibiotic resistant infection (MRSA)			
Anxiety			
Arthritis			
Asthma			
Blood clot in leg/lung			
BPH, prostate problems, enlargement			
Cancer			
Carotid artery blockage			Circle one: Right ◯ Left ◯ Both ◯
Chest pain, Angina			Since:
Colitis			
Congestion Heart Failure			When:
Depression			
Diabetes			Since: Insulin? Pills?
Emphysema (COPD)			
Gout			
Heart Attack			When:
Heart Catheterization			When:
Heart/Coronary Angioplasty			When:
Hepatitis			
High blood pressure			Since:
High cholesterol			Since:
Heart rhythm problem			Type:
Hiatal Hernia			
HIV/AIDS			
Kidney failure			Since:
Kidney stones			
Parkinson's Disease			Year Diagnosed:
Pregnancies:			How many:
Stomach ulcer			
Stroke/mini stroke			With Paralysis Without Paralysis
TB Exposure			
Thyroid			Type: Hyper Hypo

List any disease/conditions that “run in your family”

SURGICAL HISTORY

Surgery/Procedure	Yes	No	Year
Abdominal aortic aneurysm			
Appendectomy			
Breast Biopsy			
Breast Enlargement			
Breast Lumpectomy			
Breast Removal (Cancer)			
Carotid artery surgery			Right ◯ Left ◯
Coronary artery bypass			
Cataract removal			Right ◯ Left ◯
Gallbladder removal			
Heart valve surgery			
Hemorrhoid surgery			
Hernia repair			
Hip replacement			Right ☐ Left ☐
Hysterectomy			Subtotal ☐ Total ☐
Internal cardiac defibrillator			
Knee replacement			Right ◯ Left ◯
Lung surgery			
Pacemaker surgery			
Prostate surgery (TURP)			
Thyroid gland removal			Partial ◯ Total ◯
Varicose vein stripping			Right ◯ Left ◯
Other abdominal surgery			Type
Other vascular surgery			Type
Other:			

FAMILY HISTORY

Condition or Disease (check all that apply)	Mother	Father	Sister(s)	Brother(s)
Age if alive				
Age when deceased				
Aneurysm (brain)				
Angina				
Blood clot in leg/lung				
Cancer				
Carotid disease				
Diabetes				
Heart Disease				
Herniated/slipped disc				
Hepatitis				
High blood pressure				
Kidney disease				
Lung disease				
Lupus				
Multiple sclerosis				
Obesity				
Schizophrenia				
Stroke				
Thyroid problem				
Other:				

PATIENT QUESTIONAIRE

Social History and Risk Factors:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Living Situation: ☐ Independent ☐ with children ☐ Assisted Living ☐ Nursing Home

☐ Employed *Occupation* _____ ☐ Un-Employed ☐ Retired

Level of Education

What is your highest level of formal education? _____

Habits/Lifestyle

Do you consume alcoholic beverages? ☐ Yes ☐ No How many drinks per day: _____

Do you consume caffeine? ☐ Yes ☐ No How much per day: _____

Tobacco Use – Are you a ☐ Current smoker? ☐ Former smoker ☐ Never smoked

If a current smoker, how many years have you been smoking? _____

How many cigarettes per day? _____

Have you ever used street drugs? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No How often? _____

Type of diet _____

Have you ever broken a bone? ☐ Yes ☐ No If Yes, which one(s)_____

Have you had any exposure to toxic substances? ☐ Yes ☐ No

If Yes, what kind(s) _____ (example: pacemaker, screws, shunt, shrapnel)

Do you have any metal or implants ☐ Yes ☐ No If Yes, what kind(s)_____

Do you have ever had a blood transfusion? ☐ Yes ☐ No If Yes, when?_____

Do you have any tattoos? ☐ Yes ☐ No If Yes, how many?_____

Do you have any birthmarks? ☐ Yes ☐ No If Yes, how many and where?_____

Do you wear: ☐ Dentures ☐ Glasses ☐ Contacts ☐ Hearing Aids

Sexual History

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No

Do you consider yourself at risk for exposure to AIDS? ☐ Yes ☐ No

Do you know your HIV status? ☐ Yes ☐ No If yes, when were you last tested? _____

Other Relevant Social Factors

Is your problem related to an accident or injury? ☐ Yes ■ No Is an attorney involved? ☐ Yes ☐ No

Have you spent time in a third world country ■ Yes ☐ No If yes, when? _____

Dignity Health Medical Group Nevada

Date of request: _____

I Authorize:_____

To disclose **ALL** information concerning my treatment history to:

Dignity Health Medical Group Nevada CVT Clinic

(•) Dr. Robert Wiencek ( ) Dr.CJ Park ( ) Dr.Michael Wood

7190 S. Cimarron Rd
Las Vegas, NV 89113
Ph: 702.675.3240
Fax: 702.982.6347

Patient Name (print):_____

Date of Birth: _____ Last 4 of SSN#: _____

Patient/Guardian Signature: _____

Parent/Guardian Name (print): _____

Witness: _____

Dignity Health Medical Group Nevada

JOINT NOTICE OF PRIVACY PRACTICES FOR MEDICAL INFORMATION

Effective April 14, 2003, the law requires that Dignity Health Medical Group Nevada give patients a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit.

Patient Initials _____

CONSENT AND ASSIGNMENT OF BENEFITS

Dignity Health Medical Group Nevada is contracted to various health insurance programs, including Medicare, and accepts assignments only for those health insurances. If a contract exists between my insurance company and DHMGN-St Rose Specialty Clinic, the clinic will file my health insurance. I request that payment be made by my insurance on my behalf to Dignity Health Medical Group Nevada. I agree to pay any portion of my charges rendered by Dignity Health Medical Group Nevada Clinic that my contracted health insurance determines is my responsibility. In the event a charge is determined to be cosmetic, I agree to pay for the cosmetic services in full at the time service is rendered.

If I do not have a health insurance plan that Dignity Health Medical Group Nevada Clinic is contracted with, I agree to pay all fees in full at the time services are rendered.

I understand that I am ultimately responsible for payment of my medical bill. If it becomes necessary for Dignity Health Medical Group Nevada Clinic to collect payment, I understand that I will be responsible for legal costs, including attorney's fees.

I understand that as a result of refusal to sign this form, or if I have altered this form in any way, Dignity Health Medical Group Nevada Clinic may refuse to diagnose and treat me. I have the right to revoke this consent and assignment of benefits in writing except for services that have already occurred.

Patient Initials _____

By initialing above each section and signing below, you acknowledge receipt of the Joint Notice of Privacy Practices for Medical Information and understand the Assignment of Benefits as the patient, the patient's personal representative, the patient's authorized agent or an individual involved in the patient's medical care.

Print Patient Name: _____ Witness Signature: _____

Patient Acknowledgement Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____
(If signed by someone other than patient)

Refusal to Consent

Patient has refused to sign the financial obligation consent.

Staff Member's Name: _____ Signature: _____

Dignity Health Medical Group Nevada

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Dignity Health Medical Group Nevada to release my records and any information to the following individuals.

1. _____ **Relation to Patient:**_____
2. _____ **Relation to Patient:**_____
3. _____ **Relation to Patient:** _____
4. _____ **Relation to Patient:** _____
5. _____ **Relation to Patient:** _____

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature