Dignity Health Medical Group Nevada

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

Patient Information

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth: _____/_____/_____ Age:_____ SSN:_____-_____-_____

Gender: Male / Female Marital Status: M S D W

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____

Cell Number: ( ) _____ - _____

Work Number: ( ) _____ - _____

Email Address: _____

Race:

□ Caucasian □ Asian

□ African American □ Pacific Islander

□ Hispanic/Latino □ Native American

□ Do not wish to answer

□ Other: _____

Guarantor/Guardian Information (person responsible for payment or if patient is a minor)

Name: _____ Relationship: _____ Male / Female

Date of Birth: _____/_____/_____ Address is the same as above? □ Yes □ No, see below

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____ Cell Number: ( ) _____ - _____

Employer: _____ Work Number: ( ) _____ - _____

Emergency Contact

Emergency Contact Name: _____ Relationship: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Work Phone: ( ) _____ - _____

Primary Care / Referring Physicians

Primary Care Physician: _____Phone Number: ( ) _____ - _____

Referring Physician: _____Phone Number: ( ) _____ - _____

Dignity Health Medical Group Nevada

Insurance Information

Primary Insurance:

Insurance Name:_____ Plan Type: HMO PPO POS EPO Other

I.D. Number: _____ Group Number: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____

Employer: _____ Work Phone: ( ) _____ - _____

Secondary Insurance:

Insurance Name:_____ Plan Type: HMO PPO POS EPO Other

I.D. Number: _____ Group Number: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____

Employer: _____ Work Phone: ( ) _____ - _____

Social History:

Living Situation: □ Independent □ with Children □ Assisted Living
□ Spouse or Partner □ Nursing Home

□ Employed Occupation: _____ □ Un-employed □ Retired

Do you consume Alcohol? □ Yes □ No If yes, how often? _____

Tobacco use: □ Current Smoker □ Former Smoker □ Never Smoker

Current Smokers: Number of years you have been smoking:_____

Cigarettes per day: _____

Have you ever used street drugs? □ Yes □ No

Do you exercise? □ Yes □ No If yes, how often? _____

Advance Directive: □ **Yes** □ **No**

Healthcare Proxy:_____ Living Will:_____ DNR plus copy of document:_____

Other: _____

Local Pharmacy: Name: _____ Phone: _____

Cross Streets: _____

Mail Order Pharmacy: Name: _____ Phone: _____

Address: _____ Fax: _____

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 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 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 Dignity Health Medical Group, Dignity Health will file my health insurance. I request that payment be made by my insurance on my behalf to Dignity Health Medical Group, LLC. I agree to pay any portion of my charges rendered by Dignity Health Medical Group 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 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 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 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.

Patient Name: _____ Witness Signature: _____

Acknowledgement Signature: _____ Date: _____

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

REFUSAL TO CONSENT

Patient has refused to sign this form.

Staff Member Name : _____ Signature: _____

Dignity Health Medical Group Nevada

Family History

Relation	Age	State of Health	Age at Death	Cause of Death		Please mark if any blood relatives have had:		
						Disease	Relationship to you	Age at Onset
Father						Aneurysm		
Mother						Blood Clots		
Siblings						Diabetes		
						Heart Disease		
						High Blood Pressure		
						Mental Disorders		
						Stroke		
						Cancer_____		
						Colon Cancer		
						Breast Cancer		
						Other _____		

Please include Grandparents, Aunts, and Uncles in the chart above.

Medication Information

Medication	Dosage	Frequency	Reason
Example: Ibuprofen	800mg	Once Daily	Joint Pain

Medication Allergies (Please list all medications you have had a reaction of allergy to)

Name of Medication: Allergy or Reaction to medication

_____ _____

_____ _____

_____ _____

_____ _____

Dignity Health Medical Group Nevada

Health History

Please Select Yes or No for each of the following, and mark any applicable information							
Abdominal aortic aneurysm	Y	N		Heart Attack	Y	N	When:
Acid indigestion, reflux (GERD)	Y	N		Heart catheterization	Y	N	When:
Asthma	Y	N		Heart/coronary	Y	N	When:
Anemia, low blood count	Y	N		Heart rhythm problem	Y	N	Type:
Antibiotic resistant Infection (MRSA)	Y	N		Hepatitis	Y	N	
Anxiety	Y	N		Hiatal Hernia	Y	N	
Arthritis	Y	N		High Blood Pressure	Y	N	Since:
BPH – Prostate problems, enlargement	Y	N		High Cholesterol	Y	N	Since:
Carotid Artery Blockage (Neck Artery)	Y	N	-Right	HIV/AIDS	Y	N	
			-Left	Kidney Failure/Insufficiency	Y	N	Since:
			-Both	Kidney Stones	Y	N	
Chest Pain/Angina	Y	N	Since:	Parkinson's Disease	Y	N	
Colitis	Y	N		Stomach Ulcer	Y	N	
Congestive Heart Failure	Y	N	When:	Stroke/Mini Stroke	Y	N	-With
Cancer	Y	N	Type(s)				-Without Paralysis
Depression	Y	N		TB Exposure	Y	N	
				Thyroid	Y	N	Hyperthyroidism
Diabetes	Y	N	Since:				Hypothyroidism
				Other			
			-Insulin	**Female Only**			
			-Pills	Menstrual / Menopausal			
			-Diet	Method of Birth Control			
Emphysema (COPD)	Y	N		# of pregnancies			
				# of miscarriages			
Gout	Y	N		# of abortions			

General Health Care Management		Immunizations	
Date of Last:		Date of Last:	
Complete Physical		Tetanus	
EKG		Flu	
Chest X-Ray		Pneumovax	
Stress Test		Zostavax	
Colonoscopy		Gardisil	
Cholesterol/Glucose Panel Fasting		Hepatitis A/B	

Male		Female	
Date of Last:		Date of Last:	
PSA		Mammogram	
		Pap Smear	
		Bone Density	

Dignity Health Medical Group Nevada

Surgical History (Please provide the year of the Operation)

Procedure	Mark if Yes	Year	Procedure	Mark if Yes	Year
Appendectomy			Knee Replacement -R -L -B		
Bariatric Surgery			Mastectomy		
Breast Augmentation/Reduction			Open Heart Surgery		
Breast Biopsy –R –L -B			Pacemaker / Defibrillator		
Cataract –R -L -B			Prostate Resection		
Colon Resection			Shoulder Surgery -R -L -B		
Face Lift			Thyroid Resection - partial -total		
Foot Surgery -R -L -B			Tonsillectomy		
Gall Bladder Surgery			Tummy Tuck		
Hip Surgery -R -L -B			Varicose Vein Surgery		
Hysterectomy -with ovaries			Other		
-without ovaries					

I hereby certify that the above information is correct, to the best of my knowledge.

Patient or Parent/Guardian Name (Printed)

Patient or Parent/Guardian Signature **Date**

Dignity Health Medical Group Nevada

Authorization to Release Medical Records

I authorize the following entity where I have received care (typically your previous primary care doctor):

Practice or facility name**:**_____

Physician name**:**_____

Practice or facility fax number:_____

Practice or facility phone number:_____

To disclose all information concerning my treatment to:

Dignity Health Medical Group Nevada

10001 S. Eastern Ave. Ste. 101

Henderson, NV 89052

Phone: 702-616-5870

Fax: 702-616-5895

Patient Name (Print): _____

Date of Birth: _____ **Social Security #:** _____

Patient/Guardian Signature: _____

Witness: _____

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.P.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 DHMGN 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