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: ( ) ________ - _______________

Race:

□ Caucasian □ Asian

□ African American □ Pacific Islander

□ Hispanic/Latino □ Native American

□ Do not wish to answer

□ Other: ____________________________

Email Address: ____

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: ( ) ________ - _______________

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 -without ovaries			Other		

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

8205 W Warm Springs Road, Suite 210

Las Vegas, NV 89113

Phone: 702-616-7660

Fax: 702-616-7713

Patient Name (Print): ____

Date of Birth: __________________________ **Social Security #:** ______________

Patient/Guardian Signature: ____

Witness: ______________________________