

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

Race:

Address: _____ Apt #: _____

 Caucasian Asian

City: _____ State: _____ ZIP: _____

 African American Pacific Islander

Phone Number: () _____ - _____

 Hispanic/Latino Native American

Cell Number: () _____ - _____

 Do not wish to answer

Work Number: () _____ - _____

 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: _____

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: _____

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

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			
Diabetes	Y	N	Since:	Thyroid	Y	N	Hyperthyroidism		
						Hypothyroidism			
			-Insulin	Other					
			-Pills	Female Only					
			-Diet	Menstrual / Menopausal					
Emphysema (COPD)	Y	N		Method of Birth Control					
Gout	Y	N		# of pregnancies					
					# of miscarriages				
					# 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					Gardasil				
Cholesterol/Glucose Panel Fasting					Hepatitis A/B				
Male					Female				
Date of Last:					Date of Last:				
PSA					Mammogram				
					Pap Smear				
					Bone Density				

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

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

400 S Rampart Blvd., #240

Las Vegas, NV 89145

Phone: 702-304-5934

Fax: 702-588-3375

Patient Name (Print): _____

Date of Birth: _____

Social Security #: _____

Patient/Guardian Signature: _____

Witness: _____