Sunset Hills Family Practice
2510 Wigwam Pkwy Ste 102 Henderson, NV 89074
Phone: 702-553-4823 Fax: 702-476-4608

## Patient Information Form (Please Print)

Today's Date: ________________________

**Patient**

☐ Single

☐ Married

☐ Divorced

☐ Widowed

☐ Other

| **Last** **First** **MI** | **Date of Birth** **Age** |
|---|---|
| **Address** **City** **State** **Zip** | |
| **Sex** ☐ **Male** ☐ **Female** **Are you a student** ☐ **Yes** ☐ **No** | |
| **Home Phone Number** | **Cell phone Number** |
| **Email Address** | **May we email PHI to email provided?** ☐ **Yes** ☐ **No** |
| **Name of Employer** | **Employer phone number** |

**Additional Information**

Preferred Metho of Contact? ☐ Home Phone ☐ Cell phone
May we send appointment and treatment reminders via text message and voicemail? ☐ Yes ☐ No

**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Afrian American ☐ Caucasian ☐ Hispanic ☐ Other
☐ Declined to Answer

**Ethnicity** ☐ Hispanic ☐ Non-Hispanic **What language do you prefer?** ☐ English ☐ Spanish ☐ Other ____________________

**Name of Pharmacy :** ___________________________________ **Pharmacy Phone number:** _____________________________
**Pharmacy Address/Cross Streets**: ___________________________________________________________________________________

### Responsible Party

| **Responsible Party** ☐ **S**elf ☐ Spouse ☐ Guardian ☐ Other | | | |
|---|---|---|---|
| **Last** | **First** | **MI** | **Phone Number** |
| **Address** | | | |
| **City** | **State** | **Zip Code** | |

### In Case of Emergency

| **Name** | **Relation** |
|---|---|
| **Address** | **Phone Number** |

### Insurance Information

| **Primary Insurance** | **Member/Policy ID** |
|---|---|
| **Address** | **City,State, Zip** |
| **Name of Policy Holder** | **Date of Birth** |
| **Secondary Insurance** | **Member/Policy ID** |
| **Address** | **City, State Zip** |
| **Name of Policy Holder** | **Date of Birth** |

______________________________________________ ________________________

**Patient Signature** **Date**

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## **Patient Information Form**

Patient's Name : ___________________________________ Guardian's Name (If under 18) ___________________________

| Allergies to Medication or Environmental | |
|---|---|
| **Medication or Other Environmental** | **Reaction** |
| | |
| | |
| | |

| Family History | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Condition** | **Mother** | **Father** | **Maternal Grandparents** | **Paternal Grandparents** | **Brother** | **Brother** | **Sister** | **Sister** | **Addt'l Siblings** |
| **Cancer** | | | | | | | | | |
| **Diabetes** | | | | | | | | | |
| **Heart Attack** | | | | | | | | | |
| **High Blood Pressure** | | | | | | | | | |
| **High Cholesterol** | | | | | | | | | |
| **Stroke** | | | | | | | | | |
| **Other** | | | | | | | | | |

If your mother, father or siblings are deceased, please list their age at the time of their death and the cause:

| Relationship | Cause of Death | Age at Death | Relationship | Cause of Death | Relationship |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Your Health History**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Abnormal Heart Rhythm | | | Chronic Pain | | | Heartburn/GERD | | | Obesity |
| | Allergies | | | Chronic Kidney Disease | | | Heart Murmur | | | Osteoporosis |
| | Anemia | | | Depression | | | Hepatitis | | | Peripheral Vascular Disease |
| | Anxiety/Stress | | | Diabetes | | | High Blood Pressure | | | Seizures/Epilepsy |
| | Asthma | | | Emphysema/COPD | | | High Cholesterol | | | Sleep Apnea |
| | Arthritis | | | Gallbladder Disease | | | HIV/AIDS | | | Stomach Ulcers |
| | Atrial Fibrillation | | | Gout | | | Irritable Bowel Syndrome | | | Stroke |
| | Colitis or Crohn's Disease | | | Headache./Migraines | | | Kidney Failure | | | Thyroid Disease |
| | Cancer | | | Heart Attack/Failure | | | Kidney Stones | | | |

| Preventative Health History<br>Check if you have had any of the following preventative health screening exams (Mo./Yr) | | | | | | | OB/GYN History | | |
|---|---|---|---|---|---|---|---|---|---|
| **Test** | **Date** | **Results** | **Physician** | | **Vaccine Type** | **Date** | | Number of Pregnancies | |
| Colonoscopy | | | | | | | | Number of full term births | |
| Cholesterol screening | | | | | | | | Number of premature babies | |
| Cardiac Stress Test | | | | | | | | Number of abortions/miscarriages | |
| Bone Density | | | | | | | | Number of Living Children | |
| Mammogram | | | | | | | | | |
| Breast Exam | | | | | | | | | |

Accidents – Trauma

| Have you ever had a severe accident? ☐ Yes ☐ No Do you have any metal pins/plates in your body? ☐ Yes ☐ No If yes, please describe |
|---|
| |

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Name: ________________________________________________ Date: ______________________

**Past Surgical History**

| Date | Surgery | Date | Surgery |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Please list any additional medical information:** ______________________________________________________________________
______________________________________________________________________________________________________________

**Health Habits History**

Do you now or have you ever smoked? □ Yes □ No If yes, how long have/did you smoke? ________ How many packs per day? ________
Did you quit? □ Yes □ No If yes, what year did you quit? _______________
How many alcoholic beverages do you drink per week? ________________ How many days per week do you exercise? _____________
In the past 6 months, have you had a regular problem with pain? □ Yes □ No If yes, where? ___________________________________
Do you wear glass/corrective lenses? □ Yes □ No Do you wear a hearing aid? □ Yes □ No

Do you use any of the following equipment?

| **Device** | **Yes/No** | | **Device** | **Yes/No** | | **Device** | **Yes/No** |
|---|---|---|---|---|---|---|---|
| Cane | | | Walker | | | Bi-pap (sleep apnea) | |
| Electric Scooter | | | Wheelchair | | | C-pap (sleep apnea) | |

Do you follow a healthy diet? □ Yes □ No Please describe what type of diet you follow- well balanced, low card, low fat, etc: _____________
______________________________________________________________________________________________________________

| **List All Prescription Medications, Vitamins, and Herbal Supplements** | | | |
|---|---|---|---|
| Name | Dose | Frequency | Ordering Provider |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Physicians List**
**(Please list any other physicians currently assisting in your care)**

| **Specialty** | **Physician** | | **Specialty** | **Physician** | | **Specialty** | **Physician** |
|---|---|---|---|---|---|---|---|
| **Allergy/Immunology** | | | **Hematology** | | | **Pain Management** | |
| **Cardiology** | | | **Nephrology** | | | **Podiatry** | |
| **Chiropractor** | | | **Neurology** | | | **Psychiatry/Mental Health** | |
| **Dental** | | | **OB/GYN** | | | **Pulmonary Medicine** | |
| **Dermatology** | | | **Oncology** | | | **Rheumatology** | |
| **Endocrinology** | | | **Opthamology** | | | **Sleep Medicine** | |
| **Gastroenterology** | | | **Optometrist** | | | **Urology** | |
| **General Surgery** | | | **Orthopedics** | | | **Other** | |

Do you have an advanced directive/will? □ Yes □ No
If yes, please supply the office with a vopy for your chart. If no, would you like one? □ Yes □ No

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## Services and Policies

**Initial: ______ Financial and Billing Responsibilities**: All co-payments, co-insurance, deductibles and balances are due at the time of services and will be collected at check-in. We accept cash, credit and debit cards for payment at check-in. NO exceptions will be made. Visits or procedures that are not covered by your insurance will be paid at the time of visit. We provide receipts for every patient. You should present your current insurance card at each visit. If your insurance status changes you must notify the office immediately or may be financially responsible for all services rendered. If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly. All accounts will be considered delinquent after 90 days. These accounts will be placed with a collection agency and will be subject to all collection and court cost necessary to collect the outstanding balance.

**Initial: ______ Appointment cancellations**: We require a 24 hour cancellation notice or a $50 fee will be assessed for the office visit.

**Initial: ______ Late Arrivals**. If you are more than 10 minutes late your appointment may be rescheduled to a later time or another day. If we have to reschedule you for another day there may be a same day cancellation fee.

**Initial: ______ Refills**: All refill requests will be addressed within 48 hours of receipt or a request form from the pharmacy. This allows time to review your chart notes and respond. An appointment may be required.

**Initial: ______ TeleHealth Visits**: These visits are billed to the patient and/or insurance company like standard office visits. All payments are due prior to the telehealth visit taking place.

**Initial: ______ Labwork**: Please be aware of the laboratory that your insurance plan uses for the blood and tissue samples. We collect lab specimens in the office for the patient's convenience. We do not perform the billing or know the associated costs for those services.

**Initial: ______ Urine Drug Screens**: Our office conducts mandatory urine drug screens on all patients who receive a medication that is labeled by the DEA as a schedule medication. You may be required to pay for this if your insurance does not cover. The drug screening can be done as often as the provider feels is necessary.

**Initial: ______ Paperwork Fees**: There is a $20 fee for any form that is (1) page and requires the provider's signature. If it is more than (1) page there will be a $50 charge.

**Initial: ______ Authorizations**: It is the goal of every staff member in this office to help facilitate the treatment of each patient. Insurance companies may require authorization for procedures and medication. The insurance companies use authorization as a way to monitor costs. Each company has difference requirements and a separate set of medical necessity guidelines. It is impossible to know every company's policy for each medication and/or procedure. Our office provides the requested information but cannot dictate if it will be approved. Should you have an issue with something not being approved those concerns should be directed to the insurance company.

**Patient Name: ____________________________________________________________________**

**Patient Signature: __________________________________________________________** **Date: ______________________**

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**Patient Health Information Consent Form**

We would like you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning your records. Before we can provide any health care we will require you to read and sign this consent form stating that you understand and agree on how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning your privacy of your health information we encourage you to read the HIPAA Notice that is available to you at the front desk.

1. I understand and agree to allow Sunset Hills Family Practice to use my PHI for the purpose of treatment, healthcare operations, and coordination of care. I agree to allow Sunset Hills Family Practice to summit requested PHI to my Health Insurance Company (or companies) provided to us by the patient for the purpose of payments. Please be advised that this office will limit the release of all PHI to the minimum.
2. I understand that I have the right to examine and obtain a copy of my own health care records.
3. I understand that this written consent can be obtained every six months for all subsequent care given to me in this office.
4. I understand that I have the right to request to revoke this consent at any time during my care.
5. For your security and rights to privacy, all staff of Sunset Hills Family Practice has been trained in HIPAA regulations and records privacy to enforce those procedures in our office. WE have taken all precautions to ensure that your medical information will not be released to anyone.
6. I understand that I have the right to file a formal complaint regarding any possible violations of these policies and procedures.
7. I understand if I refuse to sign this consent for purpose of treatment, payment and health care serices, our physicians have the right to refuse service.

In addition, I also give consent to Sunset Hills Family Practice to disclose my protected health information to the following person/people.

Name: _______________________________________________ Relationship: ________________________

Name: _______________________________________________ Relationship: ________________________

I fully understand and accept the terms of this consent.

Patient's Name: ____________________________________________ Date of birth: ___________________

Patient's Signature: _____________________________________________ Date: _____________________