PERSONAL INFORMATION

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ III

Last Name: ______________________ First Name: ______________________ Middle Initial: ____

Preferred Name: ______________________ Date of Birth: __________________ Sex: ☐ M ☐ F

Social Security # ____________ Email: _________________________ Email reminders? ☐ Y ☐ N

Mailing Address: ____

City: ____________________________________ State: ______________ Zip: __________________

Pharmacy: ____________________________ Primary Care Physician: ________________________

Occupation: ____________________________ Employer: ____________________________________

Does your job require: ☐ lifting ☐ pulling ☐ pushing ☐ prolonged sitting/standing

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed Language: ☐English ☐ Other: ______________

Race: ☐White ☐Alaska Native ☐Other: ___________ Ethnicity: ☐Hispanic/Latino ☐NOT Hispanic/Latino

Is it OK to leave a message about your appointment?

Home Phone: ___________________________ ☐ Yes ☐ No

Cell Phone: _____________________________ ☐ Yes ☐ No

Work Phone: ___________________________ ☐ Yes ☐ No

Emergency Contact Name: _____________________________________

Emergency Contact Phone: ___________________ Relationship: __________________

PERSON RESPONSIBLE FOR THE BILL

☐ SAME AS ABOVE (if not, fill out below)

Full Name: ________________________________ Phone: ____________________

Date of Birth: _______________________________ Sex: ☐ Male ☐ Female

Address: __________________________________ City: ________________ State: ___ Zip: ______

INSURANCE INFORMATION

Primary Insurance: ______________________ Secondary Insurance: ______________________

Policy#/Member ID/Subscriber #: ___________ Policy#/Member ID/Subscriber #: _____________

Name on card: ___________________________ Name on card: ____________________________

Date of birth of policy holder: _______________ Date of birth of policy holder: _________________

I authorize Mountain View Surgery to bill my insurance on my behalf: _______________________________
Signature

I authorize Mountain View Surgery to obtain external prescription history _______________________
Initials

PERSONAL & HEALTH INFORMATION PRIVACY POLICY

YOUR PERSONAL AND HEALTH INFORMATION

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment and as such would like to inform you of our privacy practices and procedures. This privacy notice describes how your personal and health information will be used and disclosed and how you can gain access to this information. Please read it carefully. Should you have any questions regarding these policies please do not hesitate to ask.

As part of our registration process, you and your family's personal and health information will be collected. This information is very important in the development of an effective treatment plan and we ask that you provide the most complete and accurate information as possible. Information such as; name, address, phone number, birth date, social security number, employer information, health history, insurance policy and coverage information will be collected from you and other health care entities you utilize. Throughout the course of your treatment we will also collect your health information regarding diagnosis, outside treatment plans, progress reports and any test lab results and or imaging studies you obtain from other health care facilities such as hospitals, laboratories, other physician offices, and imaging facilities.

HOW YOUR INFORMATION WILL BE USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of personal and health information will only be used upon receipt of your written authorization. We do not sell your personal and health information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

☐ I have read, understood, and agree to this Privacy Policy.

☐ Patient Name (printed): ________________________ Signature: _____________________ Date: ____________

MEDICAL HISTORY

NAME: ___________________________ DATE: _________

YOUR SYMPTOMS

What is the reason for your visit? ____
Is your visit the result of a work related injury? ________ If yes, please provide claim information
In the last 2 weeks have you had:

- ☐ fever/chills
- ☐ fainting
- ☐ low blood pressure
- ☐ weight loss
- ☐ chest pain
- ☐ dizziness
- ☐ nausea/vomiting
- ☐ diarrhea
- ☐ abdominal pain

PREVIOUS MAJOR SURGERIES

Date and Type of surgery:

____

____

____

SAFETY

With whom do you live? _____________________ Do you feel safe in your home? _______
Have you fallen in the last year? ___________ If yes:
How many times? ____________________ Were there any injuries? _____________________

TOBACCO/ALCOHOL HISTORY

Do you use smokeless tobacco? ________________
Do you smoke cigarettes or vape? ________________ If yes to either:
When did you start? ____________________ How often? _______________________
How many cigarettes/day? ______________ How soon after waking? ________________
Are you interested in quitting? __________________________________
Do you drink alcohol? __________________ If yes:
How often? __ daily __ 2-3 x weekly __ 2-3 x monthly __ once monthly
How many drinks at one time? ___________
How often in the last year did you have 6 or more drinks in one day? _________
Recreational drugs? _________ Marijuana use? ______ If yes, how often? ______________

FAMILY HISTORY

Do you have any family history of the following: (Specify which family member)
Diabetes ____________ High blood pressure ____________ Heart disease ____________
High cholesterol ___________ Colon cancer ___________ Breast cancer ____________
Lung disease __________ Mental health issues ____________

YOUR HEALTH

Do you have any of the following medical problems?

- ☐ AIDS/HIV/Hepatitis
- ☐ Immune Disorder Specify: ________________
- ☐ Anemia
- ☐ Cancer Specify: ___________________
- ☐ Heart disease
- ☐ Coronary Artery disease
- ☐ Diabetes Type I ______ Type 2 _______
- ☐ Epilepsy/seizures
- ☐ Migraines/frequent headaches
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease Specify: __________________
- ☐ Liver disease Specify: __________________
- ☐ Lung disease Specify: __________________
- ☐ Nerve disorder Specify: __________________
- ☐ History of stroke
- ☐ Gastric reflux/heartburn
- ☐ Substance abuse
- ☐ Are you pregnant? Yes ______ No ________ Possibly _________

ALLERGIES

☐ No known allergies

Please list any medication allergies and your reaction:

Allergy: _______________________________ Reaction: ______________________________

Allergy: _______________________________ Reaction: ______________________________

Allergy: _______________________________ Reaction: ______________________________

Allergy: _______________________________ Reaction: ______________________________

Allergy: _______________________________ Reaction: ______________________________

MEDICATION INFORMATION

Please list all medications you are currrently taking. It is **very important** that you include blood thinners and weight loss medications:

Medication: ____________________________ Dose/frequency: _________________________

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