WELCOME TO OUR PRACTICE!

MOUNTAIN FAMILY MEDICINE
9710 S. McCarran Blvd., Reno, NV 89523-9203

PATIENT INFORMATION [*Please Print Clearly in Ink – Complete All Information]* *MANDATORY IF BOLD & MARKED WITH **

Last Name:	First Name:		Middle Initial:
Mailing Address:	City:	State:	Zip Code:
Place of Residence: (*If other than mailing address*)	City:	State:	Zip Code:
Home Telephone #:	Cell #:		Work Phone #:
****Birthdate: / /**	Age:	Sex (*Circle One*): Male Female	****Social Security #:**
Marital Status (*Circle One*): Single Married Widow Divorced		Driver's License #:	State of Issue:
Race:	Ethnicity:	Preferred Language:	Email:

EMPLOYMENT INFORMATION:

Employed (*Circle One*): Yes No		Student (*Circle One*): Full-Time Part-Time	
Employer/ School:	Employer/School Telephone #:		Occupation/ Grade Level:
Employer/School Mailing Address:	City:	State:	Zip Code:

EMERGENCY CONTACT/SPOUSE INFORMATION**

Emergency Contact Name:	Relationship:	Telephone #:
Spouse (*If different than above*):	Full Address:	Telephone #:

RESPONSIBLE PARTY/GUARDIAN INFORMATION [*If Patient is a Minor*]**

Name:**	Relationship:	Telephone #:
Full Address:	Home Telephone #:	Work Telephone #:
****Birthdate: / /**	****Social Security #:**	Sex (*Circle One*): Male Female

PRIMARY INSURANCE INFORMATION [Copy of Insurance Card Required at Check-in]**

Primary Insured's Name:**	Full Address:		
Home Telephone #:	Work Telephone #:	Employer:	Relationship to Patient:
Birthdate** / /	**Primary Social Security #**:**		Sex (*Circle One*): Male Female
Insurance Company:	ID #:	Group #:	Telephone #:
Insurance Company Full Address:			

SECONDARY INSURANCE INFORMATION [Copy of Insurance Card Required at Check-in]**

Secondary Insured's Name:**	Full Address:		
Home Telephone #:	Work Telephone #:	Employer:	Relationship to Patient:
Birthdate:** / /	**Secondary Social Security #**:**		Sex (*Circle One*): Male Female
Insurance Company:	ID #:	Group #:	Telephone #:
Insurance Company Full Address:			

Physician/Provider of Record: _____

MEDICAL INFORMATION

Allergies [this includes medications and food allergies]****	**[******List additional on back of form*******]**
1.	2.
3..	4.
5.	6.

Current Medications [including any controlled substances & over-the-counter meds]****	**[******List additional on back of form*******]**
1.	Dosage:
2.	Dosage:
3.	Dosage:
4.	Dosage:
5.	Dosage:

Previous Surgeries or Serious Medical Illness/Hospital Admittances		**[******List additional on back of form*******]**
Date:	Explain:	Where:
Date:	Explain:	Where:
Date:	Explain:	Where:
Date:	Explain:	Where:

Last Pap:**	**Last Mammo**:**	**Last Colonoscopy**:**	**Last Prostate Exam**:**
Date of Most Recent DT booster:	**Pneumovax:**	**Flu Vaccine:**	
Listed on State Immunization Registry?	**(*Circle One*) Yes No Unknown**	**List Other State Registry:**	
Advanced Directive Provided? Yes or No	**Power of Attorney Provided? Yes or No**	**Other Medical Directives Provided? Yes or No**	

Family History – Has anyone in your immediate family been diagnosed with the following? [****Please circle all that apply*******]**		**How Many Alcoholic Beverages do you consume Daily _____ Weekly _____ Monthly _____**	
Cancer COPD Heart Failure Heart Attack Diabetes TB0 Stroke High Blood Pressure High Cholesterol Eye Disease		**Do You Take Any Illicit Drugs?** **Yes ____** **No ____** **List: _____**	**Are You Addicted to Any Narcotics?** **Yes ____ No ____** **List: _____**
Are you currently a Tobacco User? [*Circle One*]: Yes No	**If applicable, when did you quit?_____**	**Do you have any problems with falling or stability? Describe: _____**	

I was referred to the office by: _____

PATIENT NAME: _____ DATE OF BIRTH**: _____**
[Please Print Name]

1. **I authorize the release of any medical records to a designated referral physician and/or facility in order to ensure proper follow-up and continuity of care. I also agree that if my insurance company or governmental benefits agency requires that I sign an HIE Patient Consent Form for electronic release of my individual health information and I refuse I will be denied service. I agree that a copy of my medical records may be released by mail, fax, telephone or electronic transmission as deemed necessary by Mountain Family Medicine and my physician. I understand that confidentiality of my records cannot be guaranteed by these methods.**

2. **I understand that I must bring my current insurance card(s) and photo ID for all appointments and that there is a minimum $25.00 co-payment due at time of check-in for services to be performed unless otherwise specified by my insurance company. Self-pay patients shall pay the entire amount due at checkout to be entitled to any discount for early payment. I understand that any unreasonable past due payments are to be paid to Mountain Family Medicine before further services may be performed at the time of each subsequent visit.**

3. **I understand that I will be responsible to immediately reimburse Mountain Family Medicine for the total amount of any NSF or rejected payments returned by my financial institution, together with reimbursement of any fees/charges incurred by Mountain Family Medicine and an additional penalty assessed by Mountain Family Medicine in the amount of $25.00. Any subsequent payments to Mountain Family Medicine may require payment via Cash, Bank Check or Money Order, at their discretion.**

4. **I understand that Mountain Family Medicine has a 24-hour cancellation policy in place and that I may be personally charged $50.00 for any missed appointments without the required notification. Additionally, if I miss a new patient appointment without notification, I may not schedule a subsequent appointment unless pre-approved by my provider.**

5. **I understand that, pursuant to federal and pharmaceutical regulations, if I refuse to provide my social security number to Mountain Family Medicine, my provider will not be able to e-prescibe any medication prescriptions or refills on my behalf and this may result in a delay of service. I further understand that if my insurance company or governmental benefits agency requires that I provide my personal (or my responsible party/guardian's) social security number to Mountain Family that I will be denied services until it is provided.**

6. **I understand that it is my responsibility to contact my pharmacy for any prescription renewals at a minimum of 48 to 72 hours in advance of my medication prescription expiring or running out and they will contact my provider for authorization to refill. Additionally if I have any controlled substance/narcotic refills due I will need to contact the provider's office at least 48 to 72 hours prior to my medications running out in order to get any refill prescriptions prepared by the provider.**

7. **I understand that any minor children who are not being seen in the office by a provider shall not remain in the reception area unsupervised or I may be asked to reschedule my appointment.**

8. **I understand that due to potential health & safety issues, the only animals allowed in the practice are certified service animals and I will be asked to remove any others from the premises immediately, whether brought in by myself or someone accompanying me to the office for service or my appointment will have to be rescheduled.**

9. **I understand that if I am a non-English speaking patient it is my responsibility to bring an adult translator with me to any scheduled appointments or have someone who can translate for me available to speak with my provider or Mountain Family Medicine staff members if I call into the office.**

10. **I understand that I have filled out a form for Mountain Family Medicine not only listing my emergency contact information (on this document) but a separate form referenced as "Family & Friends Release of Protected Health Information" which designates the only individuals who my provider or Mountain Family Medicine staff members may speak with regarding any aspects of my medical care or condition. I also understand that I am responsible to modify this form should my personal status change in the future to amend or change the individuals listed.**

PATIENT/RESPONSIBLE PARTY/GUARDIAN SIGNTURE: _____

DATE SIGNED: _____

Note: If at any time you would like to change the information you have provided us, please let us know. Thank you.

MOUNTAIN FAMILY MEDICINE