NEW PATIENT INFORMATION

PATIENT'S NAME	S.S. #	MARTIAL STATUS S M W D SEP	SEX F M	BIRTH DATE (mm/day/year)	AGE
MAILING ADDRESS	CITY & STATE		ZIP CODE	HOME PHONE #	
PATIENT'S OR PARENT'S EMPLOYER	OCCCUPATION (INDICATE IF STUDENT)			BUSINESS PHONE / EXT#	
SPOUSE OR PARENT'S NAME	S.S.#			BIRTH DATE (mm/day/year)	
SPOUSE OR PARENT'S EMPLOYER	OCCCUPATION (INDICATE IF STUDENT)			BUSINESS PHONE / EXT#	

PLEASE READ:

ALL CHARGES ARE DUE AT THE TIME OF SERVICES, PAYMENT METHOD: __ CASH __CHECK __ CREDIT CARD

PERSON RESPONSIBLE FOR PAYMENT	MAILING ADDRESS, CITY AND STATE	ZIP CODE	HOME PHONE #
PRIMARY INSURANCE COMPANY	DEDUCTIBLE	COPAY	POLICY NUMBER / GROUP NUMBER
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TRATED BY OUR PHYSICIAN BEFORE? PLEASE INCLUDE NAME.			
HOW DID YOU HEAR ABOUT HIGH DESERT FAMILY MEDICINE?			

ALL PROFESSIONAL SERIVCES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS, HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

NAME OF POLICY HOLDER________________________________ I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to HIGH DESERT FAMILY MEDICINE for any service furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits may apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.O, 3801-3612 provides penalties for withholding this information)

Acknowledgement of Receipt of Privacy Notice – I have been presented with a copy of this provider's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law, I understand the contents of the notice, and subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice.

Signature ______________________________ Date______________________

NAME: AGE: DOB: / / DATE: / /

FAMILY HISTORY: (please circle appropriate answer)

Has any blood relative ever had:

		Who?
Cancer	no yes	________
Tuberculosis	no yes	________
Diabetes	no yes	________
Heart Trouble	no yes	________
High Blood Pressure	no yes	________
Stroke	no yes	________
Epilepsy	no yes	________
Mental Illness	no yes	________
Suicide	no yes	________
Congenital Deformities	no yes	________

ALLERGIES – Are you allergic to:

Penicillin or Sulfa	no yes
Aspirin, Codeine or Morphine	no yes
Mycins or other drugs	no yes
Any other drugs	no yes
Any food allergies	no yes
Adhesive tape	no yes
Nail Polish	no yes
Tetanus antitoxins or Serums	no yes

INJURIES – Have you had any:

Broken bones?	no yes
Sprains or dislocations?	no yes
Lacerations (extensive)?	no yes
Concussions or head injury?	no yes

TRANSFUSIONS – Have you had:

Blood or plasma transfusions? no yes

WEIGHT:

Now: 1 year ago

Maximum When?

Personal History (please circle appropriate answer)

ILLNESSES – Have you ever had:

Measles or German Measles	n / y	Anemia or Jaundice	n / y
Rheumatic Fever/Heart Disease	n / y	Epilepsy	n / y
Whooping Cough	n / y	Migraines headache	n / y
Scarlet Fever or Scar Latina	n / y	Tuberculosis	n / y
Pneumonia or Pleurisy	n / y	Diabetes	n / y
Diptheria or Smallpox	n / y	Cancer	n / y
Influenza	n / y	High or low blood pressure	n / y
Arthritis or Rheumatism	n / y	Nervous breakdown	n / y
Bone or joint disease	n / y	Food or drug poisoning	n / y
Polio or Meningitis	n / y	Hay Fever or Asthma	n / y
Bright's Dis or Kidney Infection	n / y	Hives or eczema	n / y
Gonorrhea or Syphilis	n / y	Frequent colds or sore throat	n / y
Frequent Infection or boils	n / y	Any other disease	n / y

SURGERIES (Please include date)

Habits- Do you:

Sleep well	no yes
Use alcoholic beverages	no yes
Every day	no yes
Smoke	no yes
How much________	
Exercise	no yes
How much ________	
Eat a balanced diet	no yes

Women ONLY:

Menstrual History:

Age of onset________

Regular ________ Irregular ______

Cycle ____ days from start to start

Usual duration _________ days

Flow

Heavy ___ Medium_____ Light ____

Number of Pregnancies ___________

List any drugs, medications or vitamins you are taking:

SYMPTOMS (please circle appropriate concerns)

Eye disease	Mouth	Albumin, sugar or pus in urine	Headaches:	Breath	Ulcers
Eye injury	Throat	Difficulty in urinating	Frequent	Hallucinations	Indigestion
Impaired sight	Voice	Venereal infections	Severe	Chest pain or Angina pectoris	Colitis or other bowel disease
Ear disease	Unexplained large changes in weight	Varicose veins	Migraines	Frequent or chronic cough	Hemorrhoids rectal bleeding
Impaired hearing	Swelling of ankles, hands	Fainting spells	Dizziness	Spitting up blood	Constipation or Diarrhea
Skin disease	Kidney disease or stones	Loss of consciousness	Depressions or Anxiety	Night sweats	Recent change in bowel action
Enlarged glands	Bladder Disease	Convulsions	Extreme tiredness or weakness	Recent change in appetite or eating habits	Gall Bladder
Goiter or Thyroid Abnormality		Paralysis	Heart palpitations or fluttering	Stomach trouble	Liver Disease
Trouble with: Nose or Sinuses			Shortness of breath		

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I ________________________ understand that as part of my health care, High Desert Family Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information or applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand the High Desert Family Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that High Desert Family Medicine reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should High Desert Family Medicine change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

I give my permission to: _____Leave messages at my home regarding appointments scheduled

_____ Leave messages at my home for lab results, medication questions / refills

I wish to have my health information disclosed to: (family member) ______________________________

I hereby consent for Dr. Daniel Skotte, associates and staff at High Desert Family Medicine to treat me and access my patient health information during the course of my treatment, I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

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Patient's Signature Date Printed Name