Spring Valley Family Care

New Patient Registration

Name: _____ Gender: M F DOB:_____ Marital Status: _____

Address:_____SS # _____

Phone: _____ Cell: _____ Employer: _____

Responsible Person's Name (if different than above) _____Phone Number_____
Responsible Person's Address
_____

Primary Insurance Information	Secondary Insurance Information
Insurance Type_____	InsuranceType_____
Policy Holder_____	Policy Holder_____
Policy Holder's DOB _____	Policy Holder's DOB_____
Policy Holders Relation_____	Policy Holders Relation _____

Please provide a copy of your updated insurance cards so that we may bill appropriately.

Do you have Advance Directives, such as a Living Will or Medical Power of Attorney? ◊Yes ◊No

What is your preferred pharmacy? _____ City, State:_____

Medication Allergies:
_____

Last Tetanus: _____ Last Flu Shot: _____ Last pneumonia shot: _____ Immunizations up to date: ◊yes ◊no

Do you see any other Medical Providers? ◊No ◊Yes, list
_____

Have you ever used: Cigarettes/tobacco? ◊ No ◊ Yes , #packs per day _____ for # years _____ If quit, what year? _____

Do you drink alcohol? ◊No ◊ Yes, how much _____ Use street drugs? ◊ No ◊ Yes, what? _____

Do you exercise regularly? ◊ No ◊Yes, how often? _____ What type? _____

Have you ever had a colonoscopy? ◊ No ◊Yes, when_____

Women only: Last Mammogram _____ Last Pap_____ Last period? _____Are they regular? _____

Do you use Birth Control? _____ What type? _____ # of Pregnancies _____ # of deliveries _____

Any family history of Breast or Cervical Cancer? ◊ No ◊Yes, who_____

Spring Valley Family Care

Past Medical History: Mark all that apply

Anemia Arthritis Asthma Bleeding Disorders Blood Clots
Blindness Hearing loss Bone fractures Breast disease Cancer High Cholesterol Depression Anxiety Diabetes Eczema/Psoriasis
Bladder infections Stomach ulcers/GERD Glaucoma Migraines Heart attack
Palpitations Congestive Heart Failure Hemophilia Hepatitis liver disease
High blood pressure Irritable bowel, colitis Kidney disease Mental illness Pneumonia
Osteoporosis Seizures Stroke Thyroid disorder Tuberculosis
Urinary incontinence Kidney Stones

Other medical problems, please list

_____
_____
_____

Surgeries, please list with dates if known:

_____
_____
_____

Family History: Check each family member that has each of the medical problems listed

	Mother	Father	Brothers	Sister	Son	Daughter
High blood pressure	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart attack	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____
Lung Cancer	_____	_____	_____	_____	_____	_____
Colon cancer	_____	_____	_____	_____	_____	_____
Prostate Cancer	_____	_____	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____	_____	_____
Cervical Cancer	_____	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____	_____
Bleeding disorders	_____	_____	_____	_____	_____	_____

Please circle any symptoms which are currently having:

GENERAL _____Fever _____Chills _____Sweats _____Fatigue _____Weight Loss _____Vision Loss _____Blurring _____Eye Discharge _____Ringing in Ears _____Ear Discharge _____Earache _____Decreased Hearing _____Nasal Congestion _____Nosebleeds _____Difficulty Swallowing	CARDIOVASCULAR _____Near Fainting _____Chest Pain _____ Paplpitations _____Unable to Lie Flat _____Shortness of Breath _____Swelling of feet Lungs _____Cough _____Shortness of Breath _____Coughing up Blood _____Wheezing _____Snoring	_____Vomiting Blood _____Nausea _____Vomiting _____Yellow Skin Color _____Abdominal Pain ____ Bloating _____Hemorrhoids _____Diarrhea _____Change in Bowels _____Constipation _____Dark, Tarry Stools _____Blood in the Stools ____Blood in Urine	____Nighttime Urination _____Urinary Urgency _____Erectile Dysfunction MUSCULOSKELETAL _____Muscle Cramps _____Joint Pain _____Joint Swelling _____Back Pain _____Stiffness _____Muscle Weakness _____Arthritis _____Gout Skin _____Skin Cancer _____Itching _____Rash	NEUROLOGICAL _____Trouble with Concentration _____Poor Balance _____Headaches _____Poor Coordination _____Numbness _____Falling Down _____Tingling _____Seizures _____Weakness _____Dizziess _____Tremors _____Fainting _____Memory Loss _____Sleep Disorder

Please List all Medications:

Please list all over the counter Medications, Vitamins and Supplements:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Spring Valley Family Care

Treatment Consent and Authorization:

(check all that apply)

◊ I Authorize Spring Valley Family Care to provide necessary treatment for my medical condition.

Release of Information

◊ I authorize Spring Valley Family Care and its staff to use and disclose the protected health information. When it's appropriate and necessary, we provide the minimum necessary information to those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

◊ I authorize the release of any medical or other information to my insurance companies necessary to process

◊ I authorize Spring Valley Family Care to share information about my condition, treatment plan and test results only with the persons listed:

_____

_____

_____

I understand that my insurance policy is a contract between myself and my insurance company; Spring Valley Family Care is not involved.
If I have questions or concerns regarding my coverage for office visits, procedures, lab work, medications, or particular conditions I am responsible for obtaining this information. I agree to pay in full for all services considered "non-covered" services per my insurance **policy** if I choose to have the service provided.

If my insurance company does not pay in consideration of the services provided, or I do not have insurance, I agree to pay all charges from Spring Valley Family Care. Should the account become deliquent, I understand that my account will be referred on to a collection agency and I might be asked to seek treatment elsewhere until my account is reconciled.

Signature:

_____

_____

HIPAA

Spring Valley Family Care upholds the standards of the HIPAA laws. As a patient, we want you to know:

• We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.

• You may refuse to consent to the use of or disclosure of your personal health information, but **this must be in writing**.

• Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). This information is critical in making appropriate medical decisions.

I acknowledge that I have read, understand and/or agree to the information presented above:

Signature:

_____

_____