Adult History Form

Patient Name: _____ Date of Birth: _____

Medical History: (Please check all that apply)

☐ Depression	☐ Anxiety	☐ PE/DVT	☐ Asthma
☐ Osteoporosis	☐ Heart Disease	☐ High Cholesterol	☐ Seizure Disorder
☐ MRSA/Staph	☐ High Blood Pressure	☐ Thyroid Disorder	☐ Diabetes

☐ Cancer Cancer Type _____

☐ Other: _____

Are you allergic to any medications, food? If so, please list what and the reaction:

_____

_____

Please list all your medications and supplements, including dosage and instructions:

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

Please list all surgeries:

_____

_____

Please list all hospitalizations:

_____

_____

Please list all the health care providers seen in the previous 10 years:

_____

_____

Family History: (Please check all that apply)

	Alive (Age)	Deceased (Age)	Asthma	DVT/ PE	Heart Disease	High Blood Pressure	High Cholesterol	Diabetes	Cancer	Cancer Type
Father										
Mother										
Siblings										
Grandparents										

Social History: (Please check all that apply)

Tobacco Use:

☐ Never ☐ Former Smoker quit date: _____

☐ Daily Smoker ☐ 5 or less/day ☐ ½ to 1pack/day ☐1 to 2 packs/day

Are you interested in quitting? ☐Yes ☐No

Alcohol Use

Have you had a drink of alcohol in the last year? ☐Yes ☐No

How often do you drink? ☐ Monthly or less ☐ 2 to 4/month ☐ 2 to 3/week ☐ 4 or more/week

Recreational Drug Use

☐ Never ☐Past Use ☐Currently Using:_____

Current Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Live-in/how long? _____

Do you exercise? ☐ Yes ☐ No If yes, what kind and how often? _____

Do you travel overseas? ☐ Yes ☐ No If yes, where to? _____

When was your last? (Please check all that apply)

Lab: _____ Mammogram: _____Pap Smear: _____Colonoscopy: _____

Bone Density: _____Stress Test: _____Sleep Study: _____Chest XRay: _____

MRI/CT Scan: _____Ultrasound: _____Flu Shot : _____TDaP Vaccine:_____

Patient Signature: _____ Date: _____

Carol Swartz, M.D. Ronna Alcartado, APRN
1701 County Rd Ste. H
Minden, NV 89423
(775) 782-3933
(775) 782-1127 – Fax

PATIENT INFORMATION FORM – ADULT

Patient Name: _____ Date of Birth: _____

Gender: ☐Female ☐ Male ☐ Transgender Patient Marital Status: ☐ Single ☐Married ☐Divorced ☐ Partner

Patient Mailing Address: _____

Patient Street Address (if different): _____

Patient Home Phone: _____ Patient Cell Phone: _____

Patient Social Security Number: _____

E-mail Address: _____

Patient Employer Name: _____ Work Phone: _____

Patient Emergency Contact Name: _____

Patient Emergency Contact Number: _____ Relationship: _____

Local Pharmacy Name & Location: _____

Mail Order Pharmacy: _____

Insurance Policyholder Name: _____

Insurance Policyholder SS# & DOB: _____

OK to leave detailed message at home? ☐ Yes ☐No
OK to leave detailed message on cell? ☐ Yes ☐No
OK to text/email appointment confirmation? ☐ Yes ☐No

Race: ☐Asian ☐ Native Hawaiian ☐ African American ☐ White ☐ Hispanic ☐ Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic/Latin ☐ Not Hispanic

Primary Language: ☐ English ☐Spanish ☐Indian (including Hindi and Tamil) ☐ Russian ☐ Other

Translator Required: ☐Yes ☐ No

Mountainview Medical Associates

Patient Name: _____ Date: _____

E-PRESCRIBE CONSENT

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Mountainview Medical Associates can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Mountainview Medical Associates to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

FINANCIAL AGREEMENT:

I understand that although I may own one or more insurance policies, I, not the insurance companies, am responsible for payment of all charges incurred in my treatment by Mountainview Medical Associates, and any co-payment will be paid TODAY.

I hereby authorize the release of any information acquired in the course of my examination or treatment to legal counsel, the insurance companies I have insurance through, and/or physicians to who I may agree to see at the request of Mountainview Medical Associates. I further authorize Mountainview Medical Associates to obtain medical information from any source deemed necessary for my treatment.

I hereby authorize and assign any payments directly to Mountainview Medical Associates for any surgical and/or medical benefits otherwise payable to me for services, not to exceed the contracted rate for those services. My consent in hereby granted to use this original or a copy as equally valid authorization.

In an effort to serve you better, it is important that you understand that it is your responsibility:

- **To know your insurance.**
- **To know if Mountainview Medical Associates is a contracted provider for your insurance.**
- **To know if you need prior authorization for procedures.**
- **To know if procedures (x-rays, labs, etc.) have to be done at a specific facility.**
- **To know if you have a co-payment, a yearly deductible, and if that deductible has been met.**

There are hundreds of insurance companies and it is not possible for our staff to know the specific requirements of each policy.

HIPAA

I, _____ (print patient/guarantor name) hereby acknowledge that I have access to a paper copy of practice's notice of privacy practices.

If a family member or friend calls or comes into the office requesting information regarding your current condition or any account related issues, who may we release this information to?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient/Guarantor Signature _____ **Date:** _____

For Office Use Only

□ Acknowledgment refused:
Describe efforts to obtain signature:
State patient's reason for refusal:

Employee Signature: _____ Date: _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ **Date of Birth:** _____
Last First Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider:

Name: _____

Address: _____

Fax Number: _____ Phone Number: _____

to disclose my health information during the term of this Authorization to the recipient that I have identified.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information:
Mountainview Medical Associates 1701 County Rd Ste. H, Minden, NV 89423 (P) 775-782-3933 (F) 775-782-1127.

Purpose: I understand that the specific purpose of the Authorization is at the request of the patient.

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental, or physical condition and any treatment received by me **

☐ All of my health information described above except for the following:

_____

☐ Only the following records or types of health information: (Insert dated of treatment, types of treatment, or other designation:

_____

Terms: This authorization is to remain in place until the provider fulfills this request.
Refusal to sign/right to revoke: I may refuse to sign or may revoke this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my health care provider.
Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Officer at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Print Name: _____

Signature of Witness: _____

**** NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law or mental health records that are protected by the Lanterman-Petris-Short Act.**