

Advanced Medical & Wellness

3150 N. Tenaya #540 Las Vegas, NV 89128 Phone 256.0121 Fax 256.2620

Patient Registration Form

Please Type or Print Legibly

Welcome to Our Practice!

Patient Name _____
Last Name First Name Middle Initial

Responsible Party (if patient is a minor) _____

Street Address _____

City _____ State _____ Zip _____ Sex M F Age _____

Primary Phone # _____ Secondary Phone # _____

Birth Date _____ SS# _____ Single Married Divorced Widowed

Email address _____

Email addresses are used in the event we have incentives, discounts, or updates on our practice

Employer _____

Employer Address _____

Employer Phone _____

Primary Language Spoken English Spanish Other _____

Race White African American Indian Asian Other _____

Ethnicity Hispanic Non-hispanic

Spouse's Information

Spouse Name _____
Last Name First Name Middle Initial

Spouse Birth Date _____ Spouse SS# _____

Spouse Address Same as above (if different) _____

Spouse Employer _____

Emergency Contact Information

(Use different contact numbers than those above)

Emergency Contact _____ Phone _____

Emer Contact Address _____

Relationship _____

Primary Insurance Information

Insurance Co. Name _____

Name of Policy Holder _____

Policy Holder SS# _____ Policy Holder DOB _____

Policy ID# _____ Group# _____

Secondary Insurance Information (if any)

Insurance Co. Name _____

Name of Policy Holder _____

Policy Holder SS# _____ Policy Holder DOB _____

Policy ID# _____ Group# _____

Pharmacy Information

Pharmacy Name _____ Phone _____

Pharmacy Address/ Cross Streets _____

Do you have a living will/Advanced Healthcare Directive? Yes No If yes, please bring copy to office

How were you referred to our practice? Friend/Relative, is so name: _____

Yellow Pages Newspaper Hospital Mail Physician, is so name: _____

Other _____

I understand that healthcare insurance is a contract between me and my insurance company. As a courtesy, Advanced Medical & Wellness will bill my insurance for services rendered. Because insurance companies vary in the amount they will pay for various services, it is ultimately my responsibility to pay the portion of the bill not paid by my insurance company (unless otherwise restricted by law or an agreement we might have made with insurer). It is also my responsibility to be prepared to pay any office visit copays, co-insurance, deductibles and all other non-covered services. Any charges incurred by non-payment, including collection and court costs are responsibility to the patient.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare 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.

Signature (parent/guardian if patient is a minor): _____ Date: ____/____/____

Patient Name _____

ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information relating to all claims form benefits submitted on my behalf by Advanced Medical & Wellness. I further agree and acknowledge that my signature on this document authorizes Advanced Medical & Wellness to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted and that I will be bound by the signature as though I had personally signed each claim form.

A photocopy of this assignment shall be considered as effective and valid as the original. I, hereby authorize

(Name of Insurance Company)

to pay and hereby assigns directly to Advanced Medical & Wellness all benefits, if any, otherwise payable to me for services as described on the attached claim forms.

(Insured's Authorized Signature)

(Date)

INSURANCE BILLING

Advanced Medical & Wellness will bill primary medical insurances as well as secondary medical insurances, pending that we are contracted with that insurance. Advanced Medical & Wellness does not bill third party or tertiary insurances. Advanced Medical & Wellness does not accept attorney liens or worker's compensation claims.

(Insured's Authorized Signature)

(Date)

NON-DISCRIMINATION POLICY

Advanced Medical & Wellness does not discriminate in the delivery of health care services based on race, ethnicity, national origin, religion, age, sex, mental and physical disabilities, sexual orientation, genetic information or source of payment.

NO SHOW POLICY

Advanced Medical & Wellness values the demand on your time as well as that of our schedule and the appointment availability for all our patients. In order to accommodate these needs, we ask that notice be given for any cancellation or reschedule no later than 24 hours of your appointment time. Appointments not cancelled or rescheduled prior to the scheduled appointment will be subject to a charge. Because this charge cannot be billed to insurance, the patient will be responsible for any applicable charges. The fees are as follows:

Established Patient
** \$25 if < 24 hr notice

Diagnostic Testing
\$50 per test if < 48 hr notice

PICTURE ON FILE

As a medical facility, we like to offer privacy and security. Advanced Medical & Wellness asks that your picture is taken for your file so we can guarantee your own identity protection. We especially do this in the event of treating and dispensing any narcotic prescriptions to you.

I have read the above and understand the reasoning. I consent to having my picture taken

(Signature of Patient)

(Date)

Patient Name _____

CONSENT FOR RELEASE OF INFORMATION

Federal law (HIPAA) requires that we obtain your consent before disclosing any medical information to other individuals. Please tell us who you allow us to speak with regarding your medical condition, especially in the event of hospitalization or emergency.

I, _____ hereby authorize the staff of Advanced Medical & Wellness to
(Name of insured)

discuss my medical condition, diagnoses, tests, treatment, and prognosis, with the following individuals upon request:

INDIVIDUAL

RELATIONSHIP

This authorization will remain in effect until revoked in writing by me.

(Signature of Patient)

(Date)

(Signature of Parent of Legal Guardian)

(Relationship)

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Advanced Medical & Wellness Notice of Privacy Practices. By signing below I am “only” giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices. Advanced Medical & Wellness Notice of Privacy Practices is prominently displayed in the waiting room for me to read at any time.

(Print Patient Name)

(Date)

(Signature of Patient)

Patient Name _____

Past Medical History

Please list all your CURRENT medications and doses (include medicines and supplements not needing a prescription):

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies or reactions to medications:

Medication	Reaction	Medication	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate if you have had any of the following problems IN THE PAST?

	Yes	No		Yes	No
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Polyps (colon or other)	<input type="checkbox"/>	<input type="checkbox"/>
If yes what kind? _____			Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
If yes at what age? _____			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

If needed for any yes above, please explain: _____

Have you had any operations? If yes, list:

Type of operation	Reason for operation	Date of operation
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for reasons other than operations? If yes, list:

Reason for hospitalization	Dates of hospitalization
_____	_____
_____	_____

Family History

Have any members of your family (parents, siblings, children, etc.) had any of the following conditions?

	Yes	No	Family Relationship	Age at Onset	Living	Age of Death
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Anemia/Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Bowel/Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Y/N	_____

Patient Name _____

Siblings Brothers: No. _____ Health _____ Sisters: No. _____ Health _____
Children Sons: No. _____ Health _____ Daughters: No. _____ Health _____

Personal Habits

Do you smoke? Yes No If yes: How many years? _____ How many packs per day? _____
If No: Have you ever smoked? Yes No How many years? _____ How many packs per day? _____
When did you quit smoking? _____
Have you ever used illicit drugs (marijuana, cocaine, etc.) Yes No
If yes, please explain: _____
Do you drink alcohol? Yes No If yes: How many drinks per day _____ or week _____ or month _____
Do you exercise regularly? Yes No If yes, what do you do? _____
Are you sexually active? Yes No Do you and your sexual partner practice safe sex? Yes No
Do you know your HIV status? Yes No If no, do you want to be tested for HIV Yes No
(risk factors include sexual activity with at-risk individuals, intravenous drug use, blood transfusions between 1979-1985)
Hazardous chemical exposure Yes No Where? _____
Traveled outside the U.S. Yes No Where? _____
Religion _____ Occupation _____

Dietary History

Please list any diets/weight loss programs that you have participated in:

Type of diet/weight loss program	Amount of weight lost	Date(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Symptoms

Please indicate if you have any of the following problems NOW:

CONSTITUTIONAL

- _____ Cold symptoms
- _____ Difficulty caring for self
- _____ Abrupt changes in daily activity

NEUROLOGIC

- _____ Headaches
- _____ Dizziness
- _____ Muscle weakness

HEENT

- _____ Vision changes
- _____ Mouth problems
- _____ Sinus pain

CARDIOVASCULAR

- _____ Chest pain
- _____ Shortness of breath
- _____ Irregular heartbeats

PULMONARY

- _____ Cough
- _____ Lung tightness
- _____ Wheezing

GASTROINTESTINAL

- _____ Indigestion
- _____ Constipation or diarrhea
- _____ Blood in stools
- _____ Difficulty swallowing

ENDOCRINE (*AMS Male **Sleep)

- _____ Weight change*
- _____ Appetite change
- _____ Fatigue**

EATING

- _____ less than 3-4 fruit or vegetable servings daily
- _____ at least 3-4 fruit or vegetable servings daily

UROLOGIC (AMS-Male)

- _____ Burning with urination
- _____ Awakening from sleep to urinate
- _____ Change in sexual desire/performance **
- _____ Erectile dysfunction

REPRODUCTIVE (MRS- No HRT, **WHS- HRT)**

- _____ Abnormal or heavy vaginal bleeding
- _____ Hot flashes**
- _____ Breast changes
- _____ Leaking of urine

DERMATOLOGIC

- _____ Rashes
- _____ Changing moles
- _____ Abnormal skin spots

EMOTIONAL/SLEEP (*Identi-T **PHQ *Sleep)**

- _____ Mood swings*
- _____ Anxiety or depression**
- _____ Poor Sleep***
- _____ Stress *
- _____ Snoring/Sleep Apnea*

MUSCOSKELETAL

- _____ Leg cramps
- _____ Arthritis
- _____ Back pain

EXERCISES: aerobics/weight lifting

- _____ less than 2hrs weekly
- _____ at least 2 hrs weekly

TIME TO RELAX

- _____ Never
- _____ Weekly
- _____ Daily