PATIENT DEMOGRAPHIC INFORMATION

(Please Print)

Today's Date:				Provider(s):		

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	SSN:	Date of Birth: / /	Age:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former or maiden name:	Marital Status (circle one): Single Married Separated Widow Divorced

Sex at Birth: ❑ M ❑ F	Current Gender: ❑ Male ❑ Female ❑ Transgender ❑ Other ❑ I do not wish to report	Sexual Orientation: ❑ Heterosexual ❑ Lesbian/Gay ❑ Bisexual ❑ I do not wish to report	Veteran: ❑ Yes ❑ No

Race/ Ethnicity: ❑ American Indian/ Alaska Native ❑ Asian ❑ Black/ African American ❑ Hispanic or Latino ❑ Native Hawaiian and Other Pacific Islander ❑ White Non-Latino/ Caucasian ❑ Other ❑ Decline	Preferred Language:
	Additional Languages Spoken:

Home Address (Street):	City, State, Zip Code:
Telephone Number:	Email:

Circle (if applicable):
Homeowner Rent Homeless Seasonal worker Immigrant/ Refugee/ Asylum Seeker

How did you hear about FirstMed Health and Wellness?

Pharmacy Name and Address:	Pharmacy Telephone Number:

Other family members seen here:

INSURANCE INFORMATION

Person responsible for Payment/ Guarantor:	Birth date: / /	Address (if different):	Telephone Number:

Is the Guarantor a patient here? ❑ Yes ❑ No	Patient's relationship to Guarantor: ❑ Self ❑ Spouse ❑ Child ❑ Other	Is the patient covered by insurance? ❑ Yes ❑ No

Primary Insurance Name:	Identification Number:	Group Number:

Primary Insurance Address:

Secondary Insurance Name:	Identification Number:	Group Number:

Secondary Insurance Address:

400 Shadow Lane Ste. 106 Las Vegas, Nevada 89106 ▪ Fax 702-826-4757
3343 S. Eastern Ave Las Vegas, Nevada 89169 ▪ Fax 702-731-1020
Main Line 702-731-0909 ▪ www.firstmednv.org

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IN CASE OF EMERGENCY	
Please list below any person(s) you authorize FirstMed Health and Wellness Center to contact and release information about your health status, ***in case of an emergency***: **Name(s):**	
Relationship to Patient:	**Telephone Number:**

CONSENT TO LEAVE VOICEMAIL MESSAGES

I consent for FirstMed Health and Wellness Center to leave a voicemail message on my phone regarding appointment information at the following phone number: (_____)_____________ ________ (initial)

❑ I **do** give permission to leave relevant medical information, such as test results, treatment information, etc., on my answering machine or voice mail. ________ (initial)

Or, ❑ I **do not** give permission to leave relevant medical information on my answering machine or voice mail. ________ (initial)

HIPAA PRIVACY PRACTICE NOTICE

This notice describes how your medical information may be used, disclosed, and how you can get access to this information. All requested information should be relevant to the care and well-being of the individual served and should be considered Protected Health Information (PHI), in accordance with the Federal Health Insurance Portability & Accountability Act (HIPAA) of 1996. Signature of this Privacy Notice shall serve as acknowledgement that FIRSTMED HEALTH & WELLNESS CENTER may use and/or share information for treatment, payment, and overall healthcare operations that may include linkage of care, counseling, billing, and quality assurance. The use of sharing of any information not directly related to services and support shall have prior authorization. Only in life threating medical emergency will the sharing of medical information be necessary without written consent or authorization.

Rights of the Individual: The individual, in writing, may request restrictions on the use or sharing of any information, received confidential communication, inspect and receive copies of shared information, receive an accounting of shared information, and amend or revoke authorization.

Duties of Covered Entity: Maintain privacy and provide notice of legal duties and privacy practice, abide by this effective notice and any restriction agreements and provide notice of revised privacy practices.

Patient/ Legal Guardian Signature:	Printed Name:	Date:

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PATIENT MEDICAL HISTORY

(Please Print)

Patient's Last Name:	**First:**	**Middle:**	**Date of Birth:** / /
Reason for Today's Visit:			

PAST MEDICAL HISTORY

(Check all that apply)

- ❑ ADD/ADHD
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune Disorder (e.g. Lupus)
- ❑ Cancer (type): ________________
- ❑ Cataracts
- ❑ Cirrhosis
- ❑ Clotting Disorder
- ❑ COPD/ Emphysema
- ❑ Deaf/ Hard of Hearing
- ❑ Depression
- ❑ Diabetes
- ❑ Gallstones
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heartburn/ GERD
- ❑ Headaches
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV positive/ AIDS
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Migraines
- ❑ Osteoporosis
- ❑ Positive TB Test
- ❑ Seizure Disorder
- ❑ Stroke (CVA/TIA)
- ❑ Thyroid Disease
- ❑ Other: ______________

____

____

____

CURRENT MEDICATIONS

(Please list any medications that you are taking. Include non-prescription medications, vitamins or supplements)

Allergies to medications: ❑ Yes ❑ No **Please list:**

Name of medication	Dose	How often you take this?	How long you have taken this?

SURGERIES		HOSPITALIZATIONS	
Type	**Date**	**Type**	**Date**

Patient/ Legal Guardian Signature:	**Printed Name:**	**Date:**

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CONSENT FOR HEALTHCARE TREATMENT		
I, ______________________________ (name of patient), consent to any medical diagnosis and treatment, laboratory studies, imaging, prescription history, evaluation by in-house caseworker, and referral to other healthcare providers that are deemed necessary and advisable by a licensed physician or nurse practitioner at FirstMed Health & Wellness Center. I have the right to consent or refuse consent to any proposed therapeutic course, absent emergency circumstances.		
Patient Signature:	**Printed Name:**	**Date:**

CONSENT FOR HEALTHCARE TREATMENT OF MINOR CHILD		
I authorize and consent to allow FirstMed Health & Wellness Center ("FirstMed"), including its physicians and nurse practitioners, to provide medical, behavioral, and mental examination, diagnosis, and treatment to the Minor Child, including, without limitation, injury or illness examinations, preventative examinations, laboratory testing, x-ray examinations, prescriptions, referrals to other healthcare providers, and any other medical care deemed advisable by FirstMed. I authorize and consent to allow FirstMed full access and use of the Minor Child's medical, behavioral, and mental health history and records. I authorize and consent to allow FirstMed to contact me via email or by phone correspondence at the email address and/or phone number listed below regarding prognosis, diagnosis, treatment, and any other issue regarding the Minor Child. I understand that I am responsible for the financial costs and expenses incurred by FirstMed for the services rendered to the Minor Child. I represent, warrant, and guarantee that I have the legal authority to make health care decisions on behalf of the Minor Child and that I have full authority to execute this Consent. I understand that this Consent shall remain in effect indefinitely for all future and subsequent health care services provided by FirstMed to the Minor Child until I revoke this Consent by delivering a written notice of revocation to FirstMed. Such revocation will not be effective until delivered and actually received by FirstMed.		
Parent/ Legal Guardian Signature:	**Printed Name:**	**Date:**
Parent/ Legal Guardian Phone Number:	**Parent/ Legal Guardian Email:**	
Parent/ Legal Guardian Address:		

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AUTHORIZATION OF USE AND RELEASE OF INFORMATION

(Please Print)

Patient's Last Name:	**First:**	**Middle:**	**Date of Birth:** / /
Home Address:		**City, State, Zip Code:**	

Please list any family members, friends, significant others, medical providers or Agencies whom we may inform about your medical condition or release of medical records or information to:	
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

I hereby authorize____________________________to release my medical/behavioral health records to FirstMed Health & Wellness Center. My medical/ behavioral health record is to include the following:

❑ Medical Records ❑ Behavioral Health Records ❑ Radiology Reports ❑ Pathology Reports ❑ Lab Reports ❑ Other:	**Duration**: This authorization shall become effective immediately and shall remain in effect until for one year. **Revocation**: My written revocation will be effective upon receipt, but will not be effective to the extent the requester or others have acted in reliance upon this authorization. **Redisclosure**: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

This information is requested for following purposes (Check all that apply):

❑ Medical ❑ Legal ❑ Personal ❑ Behavioral Health ❑ Other: __________________________

Patient/ Legal Guardian Signature:	**Printed Name:**	**Date:**

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PATIENT RESPONSIBILITY FORM

FirstMed Health and Wellness Center (“FirstMed”) is committed to providing quality, comprehensive medical and behavioral health care, in an environment of respect and dignity. In order to ensure that we can provide you with exceptional care, please read the following below and sign that you acknowledge understanding of our policies.

- I understand that it is my responsibility to notify FirstMed 24 hours prior to my scheduled appointment if I am unable to attend and need to reschedule or cancel it. If I do not call 24 hours prior, I understand that I will be considered a “No-Show” to my appointment. After 3 consecutive “No-Shows,” I will be notified by certified mail that FirstMed will no longer be able to provide services to me.
- I understand that it is my responsibility to arrive 10 - 15 minutes ***prior*** to my appointment. Arriving late for my appointment without calling will be considered a “No-Show” and another patient may be placed in my appointment slot.
- I understand that if I do not have an appointment but wish to be seen, that I will be scheduled as a “Walk-In” in the next available opening in the Provider’s schedule.
- I agree to provide my medical or behavioral health provider correct and complete medical and mental health history information, e.g. allergies, past and present illnesses, medications and hospitalizations, and agree to update this information should it change.
- I will ask my provider questions when I do not understand any part of my care plan.
- I acknowledge that I need to schedule an appointment for prescription refills. Refills require an appointment with a provider.
- I understand that FirstMed does not typically provide chronic pain management, but will refer me to an appropriate provider to ensure continued care.
- I understand that I need to sign an “Authorization of Use and Release of Information” form in order for my provider to be able to coordinate care with other parties involved in my care.
- I agree to provide staff with current and complete demographic and insurance information, each time I see my provider.
- I understand that I am financially responsible for all charges that are not covered by my insurance, such as copays, deductibles, and coinsurance and that these are due upon receipt, unless other financial arrangements have been made between myself and FirstMed.
- I understand that if I cannot pay my bill in full, I am obligated to the payment plan agreement and can apply for a Sliding Fee Scale Discount.
- I understand that I am responsible for confirming with my insurance carrier the participating provider status of FirstMed Health and Wellness Center and understand that I will be responsible for any charges incurred from an Out of Network status.
- I authorize FirstMed Health and Wellness Center to release information necessary to file and/or process a claim with my insurance company.
- I agree to follow FirstMed’s rules for conduct, and respecting the rights and property of it’s staff and other people in the office.

I have read and understand the above information and agree to comply with the above terms for services rendered by FirstMed Health & Wellness Center.

Patient/ Legal Guardian Signature:	**Relationship to Patient:** ❑ Self ❑ Parent ❑ Other:
Printed Name:	**Date:**

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