canyon
medical clinic

New Patient Forms

Name ______________________________ SS# ______________

Address ____

City ______________________________ State ________ Zip ____

Home Phone ________________ Cell Phone ________________

Birthdate ________________ Marital Status ________________

Primary Insurance Information

Insurance Company ____________________________________

Group Number ________________ ID Number ________________

Subscriber ________________ Employer ________________

Birthdate ________ SS# ____________ Relationship to patient ____________

Secondary Insurance Company ____________________________

Group Number ________________ ID Number ________________

Subscriber ________________ Employer ________________

Birthdate ________ SS# ____________ Relationship to patient ____________

Emergency Contact Name ________________________ **Phone** __________

Relationship to patient ____________________________________

Medical History

Medication Allergies

Medication ______________________________ Reaction ___________________________________

Medication ______________________________ Reaction ___________________________________

Medication ______________________________ Reaction ___________________________________

List All Current Medications

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Medication _________________________ Dosage ___________ Frequency ____________________

Pharmacy Information

Pharmacy Name ____

Address ____

Phone Number ____

Health Maintenance Screening History

Date of Most Recent Bloodwork ___________ Results ___________________________________

Date of Most Recent Colonoscopy ________ Results ___________________________________

Date of Most Recent Mammogram _______ Results ___________________________________

Date of Most Recent Bone Density Exam ___ Results ___________________________________

Date of Last Pap Smear ___________________ Results ___________________________________

Vaccinations

Date of Last Tetanus Booster or TdaP _______________

Date of Last Flu Vaccine _______________

Date of Last Shingles Vaccine _______________

Date of Last Pneumonia Vaccine _______________

Surgeries

Type of Surgery ____ Date _______________________

Type of Surgery ____ Date _______________________

Type of Surgery ____ Date _______________________

Type of Surgery ____ Date _______________________

Type of Surgery ____ Date _______________________

Women's Health

Date of Last Menstrual Period _______________

Total Number of Pregnancies _______________

Number of Live Births _______________

Pregnancy Complications ____

Age of First Menstruation ______________________ Age of Menopause ___________________

Personal Medical History

Disease/Condition

Alcoholism Current _____ Past _____ Comments ______________________________

Asthma Current _____ Past _____ Comments ______________________________

Cancer Current _____ Past _____ Comments ______________________________

Depression/Anxiety Current _____ Past _____ Comments ______________________________

Bipolar/Suicidal Current _____ Past _____ Comments ______________________________

Diabetes Current _____ Past _____ Comments ______________________________

Date of last bloodwork _______________

Date of last retinal exam _______________

Date of last foot exam _______________

Emphysema Current _____ Past _____ Comments ______________________________

Heart Disease Current _____ Past _____ Comments ______________________________

High Blood Pressure Current _____ Past _____ Comments ______________________________

High Cholesterol Current _____ Past _____ Comments ______________________________

Thyroid Disease Current _____ Past _____ Comments ______________________________

Kidney Disease Current _____ Past _____ Comments ______________________________

Migraines Current _____ Past _____ Comments ______________________________

Stroke Current _____ Past _____ Comments ______________________________

Other Current _____ Past _____ Comments ______________________________

Other Current _____ Past _____ Comments ______________________________

Other Current _____ Past _____ Comments ______________________________

Other Current _____ Past _____ Comments ______________________________

Family Medical History

Disease/Condition/Family Member Affected

Alcoholism Current _____ Past _____ Comments ______________________________

Asthma Current _____ Past _____ Comments ______________________________

Cancer Current _____ Past _____ Comments ______________________________

Depression/Anxiety Current _____ Past _____ Comments ______________________________

Bipolar/Suicidal Current _____ Past _____ Comments ______________________________

Diabetes Current _____ Past _____ Comments ______________________________

Emphysema Current _____ Past _____ Comments ______________________________

Heart Disease Current _____ Past _____ Comments ______________________________

High Blood Pressure Current _____ Past _____ Comments ______________________________

High Cholesterol Current _____ Past _____ Comments ______________________________

Thyroid Disease Current _____ Past _____ Comments ______________________________

Kidney Disease Current _____ Past _____ Comments ______________________________

Migraines Current _____ Past _____ Comments ______________________________

Stroke Current _____ Past _____ Comments ______________________________

Other Current _____ Past _____ Comments ______________________________

Other Current _____ Past _____ Comments ______________________________

Other Current _____ Past _____ Comments ______________________________

Other Current _____ Past _____ Comments ______________________________

Social History

Occupation ______________________

Employer ______________________

Shift ______________________

Marital Status ______________________

Number of Children ______________________

Other Health Issues

Tobacco Use

Type ______________

Amount ______________

Frequency ______________

How Long ______________

Quit Date______________

Alcohol

Type ______________

Amount ______________

Frequency ______________

Recreational Drugs

Type ______________

Amount ______________

Frequency ______________

Sexual Health

Sexually active? ______________

Birth control Method ______________

Exercise

Type ______________

Duration ______________

Frequency ______________

Diet

Quality of Diet ______________

Sleep

Quality of Sleep ______________

Average Amount of Sleep ______________

Safety

Bike Helmet Use ______________

Seat Belt Use ______________

Working Smoke Detectors in Home ____

Guns Stored Properly and Secured ____

Violence

Is violence at home, your neighborhood, or at work a concern for you? ______________

Comments ______________

Other Providers/Specialists

Specialty ____

Provider's Name __________________________ Last Visit _______________________

Specialty ____

Provider's Name __________________________ Last Visit _______________________

Specialty ____

Provider's Name __________________________ Last Visit _______________________

Specialty ____

Provider's Name __________________________ Last Visit _______________________

Additional Information

Travel Outside of the U.S. in the Last 30 Days ___________________________________

____

Military Service

Branch ________________________

Deployment ____________________

Location _______________________

Canyon Medical Clinic Thanks You for Serving!

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Treatment and Billing Consent

As a courtesy to you, we will submit your health care services to your insurance company using the benefit explanation provided to our office during our verification process. However, benefits quoted to our office are not a guarantee of payment; therefore, if your insurance carrier does not pay, you will be responsible for the payment of your account balance.

If your insurance carrier has not paid the submitted charges within 60 days from the date of service, it then becomes your responsibility to pay your account in full. It is your responsibility to contact your insurance carrier to determine the status of your claim.

I authorize Canyon Medical Clinic to release my medical records or other information necessary to process my claims. I authorize direct payment of my medical benefits to Canyon Medical Clinic.

I, ______________________________ attest by my signature below that I understand and accept the policies of Canyon Medical Clinic.

____ ______________________

Patient/Guardian Signature Date

Practice Policies

We value all our patients and are committed to providing you with quality care.

- Please allow 48 hours for us to process refill requests
- Please silence your cell phone during your visit
- Cancelled appointments require 24-hour notice
- Missed appointments are subject to a $25 fee
- Referrals may take 14 days to 30 days based on insurance carrier policies
- Please do not discuss your medical information with other patients
- Patients that have a deductible must pay $45 (including copays) at time of visit
- I have been given Advance Directive information
- I have read the policies of Canyon Medical Clinic and agree to follow them

______________________________ Patient/Guardian signature

_______________ Date

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Patient Consent Form
HIPAA

Under the Health Insurance Portability & Accountability Act of 1996, you have certain rights to privacy. For detailed information regarding these rights, please visit www.hhs.gov/ocr/privacy.

In general, your patient information will be used in order to:

1. Plan, conduct and direct your treatment and follow up among multiple health care providers involved in your treatment.
2. Conduct normal healthcare operations such as quality assessment and physician certification.
3. Obtain payment from third party payers

You have the right to review a Notice of Privacy Practices prior to signing this consent form.

Canyon Medical Clinic has the right to change its Notice of Privacy Practices from time to time and you may contact us during regular business hours to obtain a copy of our Notice of Privacy Practices.

____
Please Print Patient Name

______________________________ ____________________
Signature of Patient/Guardian Date