Western Mountain Medical Center

2482 W Horizon Ridge Pkwy, Suite 100
Henderson , NV 89052
Phone: 702.906.1480
Fax: 702.463.2766

New Patient Registration

Last Name First Name MI

Patient's Home Phone Number Patient's Cell Number

Patient's Work Phone Number Patient's Email Address

Mailing Address

City State Zip

Date of Birth Age Sex Social Security

Race: Hispanic Not Hispanic Refused to Report

Marital Status: Married Single Divorced Widowed

Patient Employer

Employment Status:

Retired Full Time Part Time Unemployed Student Other

Incapacity Contact: Name Relation

Phone Cell

Emergency Contact; Name Relation

Phone Cell

Ethnicity: American Indian Alaska Native Asian Native Hawaiian Other Pacific White

Black or African American Hispanic Other Race Other Pacific Islander **Refused to Report**

Local Pharmacy: Name Address

City State Zip

Mail Order Pharmacy: Name Address

City State Zip

Phone Fax

Language: English Indian includes Hindi Spanish Russian Other

Patient/ Parent or Guardian Signature _____ Date

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Patient Name DOB Phone

Insurance Information

Primary Insurance Patient is Policy Holder Yes No

Secondary Insurance Patient is Policy Holder Yes No

Insured Information (If other than patient) : Need to Scan Insured ID and Insurance Card

Policy Holder/Subscriber Relationship to Patient

Address City State Zip

Social Security Date of Birth

Policy Holder Employer Work Phone Number

Do You have a Living Will Power of Attorney DNR If checked, please supply copies

Release of Information:

I hereby give permission to the person(s) listed below to receive information about the care of the named patient

Name(s): Relationship to Patient

Authorization for Claim Payments and Reviews

Assignment and Coordination of Insurance Benefits - I hereby authorize direct payment of medical benefits to Western Mountain Medical Center PC for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to release information - I hereby authorize Western Mountain Medical Center to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Medicare and Medicaid - I certify that the information given by me applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Physician Assistants / Nurse Practitioners / Medical Students - I understand PA, NP, medical students and other health care professional students may participate, under the supervision of Physician in my care.

By signing below, I certify i have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductible, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Western Mountain Medical Center PC. I understand and agree this document will remain in effect for all future physician office visits to Western Mountain Medical Center PC.

Patient Signature _____ Date

Please Print Name

Relationship to Patient

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Patient Name _____ DOB _____ Phone _____

Billing Information

Billing is done as courtesy to you. I understand that my medical insurance is a contract between myself, and the insurance carrier. I also understand that your office will not become involved in my disputes between myself and the insurance company regarding deductibles, co-payments, covered charges, secondary insurances, "usual and customer" charges, etc.....other than to supply information as necessary.

Initial On Each Line

_____ Its **Patient** responsibility to give correct insurance information.

_____ Its **Patient** responsibility to prove primary and secondary information.

_____ Its **Patient** responsibility to notify us if your insurance changes.

_____ Its **Patient** responsibility to know if your secondary insurance covers your deductibles and Co Pay.

_____ Its **Patient** responsibility to know what is covered by your insurance company and you are ultimately responsible for all fees to Western Mountain Medical Center PC. We will bill only once, If information given us is incorrect, we will not be responsible. You will be billed for amount due. You will be expected to pay the balance in full and then you may bill your own insurance for reimbursement.

Collections Policy - Any attorney and collection fees will be added to your outstanding balance.

I fully understand the terms for billing.

Patient Signature _____ Date _____

Prescription For Narcotics Notice

It has become the policy of this office to limit the prescription for controlled substances to include:

(1) Temporary or acute systems on an occasional or as needed basis. **(2)** Conditions that are well documented by diagnostic test results. **(3)** Amounts not to exceed the 30-day supply as written on the RX.

WE REFER CHRONIC PAIN CONDITIONS TO A PAIN MANAGEMENT SPECIALIST:

We may pull a pharmacy profile on patients who request narcotics on a frequent basis to insure these medications are not being obtained by other providers in addition to our practice.

We reserve the right to discontinue the provision of care to any patient who

(1) *Attempts to fraudulently obtain narcotics from the practice.* ***(2)*** *Attempts to obtain narcotics from the practice and other provider.****(3)*** *Exceeds the dose limit prescribed.****(4)*** *Harasses the staff or the providers for narcotics medications and refilling of these prescriptions. It is the best interest of our patients that we make these provisions and any attempt to jeopardize the relationship of the providers and patient is strongly discouraged. We reserve the right to drug test any patient at any time. By Signing below, i acknowledge receipt and acceptance of the above listed provisions*

Patient Signature _____ Date _____

Witness Signature _____ Date _____

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Patient Name DOB Phone

I Certify that i have been made aware of Western Mountain Medical Center's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This **notice** describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Western Mountain Medical Center's health care operations.The **notice** also describes my rights and Western Mountain Medical Center's duties with respect to my protected health information.I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of the facility and on Western Mountain Medical Center's web site at www.wmmcpc.com. I may request that a copy be mailed to me by calling 702-906-1480.

Western Mountain Medical Center reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Western Mountain Medical Center's web site at www.wmmcpc.com to view the most current version.

Signature of Patient or Personal Representative _____ Date

Name of Patient or Personal Representative Date

Description of Personal Representative's Authority

Patient Identification

Acknowledgement of Receipt of Notice of Privacy Practices

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Name: Phone: Date:

Reason for Visit

How is your general health?

Excellent Good Fair Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name Dosage Frequency

Name Dosage Frequency

Name Dosage Frequency

Name Dosage Frequency

Name Dosage Frequency

Allergies

Are you allergic to any of the following?

- Adhesive Tape
- Antibiotics
- Latex
- Barbiturates (Sleeping Pills)
- Aspirin
- Iodine
- Codeine
- Sulfa
- Local Anesthetics

Do you have any other allergies?

Name Reaction

Name Reaction

Past Medical History

- Alcoholism
- Allergies
- Anemia
- Anxiety Disorder
- Arthritis
- Asthma
- AIDS / HIV
- Back Problems
- Bleeding Disorder
- Blood Disease
- Blood Transfusion
- Cancer
- Diabetes
- Depression
- Ear Problems
- Eating Disorder
- Epilepsy
- Glaucoma
- Gout
- Heart Disease
- Heart Problems
- Hepatitis - A, B, or C
- High Blood Pressure
- High Cholesterol
- Joint Disorder
- Kidney Disorder
- Liver Disorder
- Lung Disease
- Measles
- Migraines
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic Fever
- Stroke
- Skin Disorder
- Stomach Ulcer
- Substance Abuse
- Thyroid Disorder
- Tuberculosis
- Venereal Disease

Any other Medical Problem:

Hospitalizations & Surgeries

Reason Date

Reason Date

Women Only:

of Pregnancies # of Miscarraiges # of Abortions # of Living

Last Pap Smear Last Mammogram Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

- Alcoholism
- Allergies
- Alzheimer's
- Anemia
- Anxiety
- Arthritis
- Asthma
- AIDS/HIV
- Bleeding Disorder
- Blood Disorder
- Cancer
- Depression
- Diabetes
- Epilepsy
- Genetic Disorder
- Glaucoma
- Heart Disease
- Hepatitis
- High Cholesterol
- High Blood Pressure
- Joint Disorder
- Kidney Disease Liver
- Disorder
- Lung Disease
- Migraines Psychiatric
- Disorders
- Osteoporosis Stroke
- Substance Abuse
- Thyroid Disorder

Details:

Lifestyle Factors

Are you sexually active?

Yes No # of partners in past year

Do you wish to be checked for STDs?

Yes No

Has anyone in your home ever physically or verbally hurt you?

Yes No

Have you ever smoked?

Yes No # of years # packs/day

Do you smoke now?

Yes No # packs/day

Do you use recreational drugs?

Yes No types? # times/week

How much alcohol do you drink per week?

drinks/week

How much caffeine do you drink per day?

drinks/day

How often do you exercise?

times/week

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HEALTH MAINTENANCE: When was your last?

Physical
Colonoscopy
Upper Endoscopy
Males: Prostate Blood Test (PSA)
Cholesterol Blood Test
Bone Density Test
Tetanus Shot
Pneumonia Vaccine
Flu Vaccine

HOW WOULD YOU LIKE TO BE CONTACTED WITH ABNORMAL TEST RESULTS, LABS, ETC.?

Telephone # May we leave a message on a machine? YES NO

May we leave a message with a spouse or relative? YES NO

Patient Signature_____ Date

OR

Guardian Signature_____ Date