Fountain Medicals **New Patient Intake Form**

How did you hear about us? _____

PATIENT INFORMATION: PLEASE PRINT

First Name: _____Middle_____ _____Last Name: _____

Date of Birth: _____ ___ Sex: Male: ____ Female: ____ Age: ____

Social Security # _____-_____-_____ Marital Status: _____

Address: _____City: _____ State: _____

Zip Code: _____ Home Phone: _____Cell Phone: _____

Email: _____

Employer: _____

Emergency Contact: _____Phone No._____Relationship: _____

**PRIMARY INSURANCE INFORMATION:**

Insurance Company: _____ Member ID: _____

Group # _____ Claims Mailing Address: _____ City: _____

State: ____ Zip Code: _____ Name of Insured: _____

Relationship to Patient: _____ Insured's Date of Birth: _____

Social Security # ____-_____-_____ Insurance Phone Number: _____

**SECONDARY INSURANCE INFORMATION:**

Insurance Company: _____ _____ Member ID: _____

Group # _____ Name of Insured: _____

Relationship to Patient: _____ Insured's Date of Birth: _____

Social Security # ____-_____-_____ Insurance Phone Number_____

**Patient's Pharmacy:**

Please list your pharmacy with address/ Location

_____

Fountain Medicals **MEDICAL HISTORY Date_____ ___**

**PATIENT'S QUESTIONAIRE; PLEASE ANSWER AS ACCURATELY AS YOU CAN**

**Chief Complaint**

Please list your most concerning health care problems at this time and duration of problem

_____

_____

**Past Medical History:**

Please list any serious medical conditions for which you have been treated / hospitalized in the past:

Problem Dates

1. _____ _____

2. _____ _____

3. _____ _____

**Past Surgical History:**

Please list any Surgical Procedures you have had and the approximate dates:

1. _____ _____

2. _____ _____

**Medications:**

List all of the Prescription Medicines or Over the Counter Drugs including herbs you are now taking and doses:

1. _____ _____

2. _____ _____

3. _____ _____

**Allergies:**

Food/Medication

_____

_____

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**Family History:**

Please list health disorder or condition that tend to run in your family and list what relative (father, grandmother, etc.)

1. _____ _____

2. _____ _____

**Social History:**

Please check beside any of the following you have used in the past or currently:

_____ Alcohol (beer, wine or spirits)

_____ Recreational Drug

_____ Tobacco (cigarettes, cigar, pipe)

_____ Coffee

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**AUTHORIZATION TO TREAT (PLEASE SIGN & DATE)**

I hereby authorize medical treatment for the above patient. I fully acknowledge that all office visits are on a cash basis and will be paid in full at the time of visit, unless otherwise contracted by my insurance. I further understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to Fountain Medical Associates and /or its providers, for any fees not covered by insurance. I also understand there might be a charge of $25.00 for a No-Shows or Cancellation without a 24-hour notice except for medical emergency situation.

Patient/Authorized Signature: _____ Date: ___/___/___

**NOTICE OF PRIVACY PRACTICES**

I, _____, Date of Birth_____ acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the practices use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Patient/Authorized Signature: _____ Date: ___/___/_____

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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient Name: _____ Date of Birth: _____
Date of Request _____

Address: _____ _____ ____ _____

RECEIVE RECORDS FROM: Physician /Facility
Name:_____Specialty_____

Phone # _____ Fax # _____

Address: _____ _____

**RELEASE RECORDS TO: FOUNTAIN MEDICAL ASSOCIATES Internal Medicine / Osuoha Chima M.D. 3599 S. Eastern Avenue, Las Vegas, NV 89169 Fax# 702-522-1653 Phone# 702-522-0701**

SELECT ALL THAT APPLY: Chart/Progress Notes /H&P____ Lab Reports ____ X-ray Reports____ Discharge Summary ___ All Records____ Other: _____

Purpose of releasing medical information: _____

Date(s) Requested _____

I understand that my express consent is required to release any health information relating to testing, diagnosis, and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42C.F.R. Part 2) prohibits anyone from making any further disclosure of these records without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Patient / Authorized Signature: _____ _____ Date: ___/___/_____

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**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS**

I hereby authorize Fountain Medical Associates providers and staff to disclose my protected health information to the following Family, Friends, and/or Caregivers:

Name: _____ Relationship: _____ Phone # _____
Name: _____ Relationship: _____ Phone # _____
Name: _____ Relationship: _____ Phone # _____

*I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department.

*I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment or payment of healthcare operations as cited in the Notice of Privacy Practices.

*I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not to sign this form to assure treatment.

*Unless, otherwise revoked or specified below, this authorization will remain indefinitely. I would like this authorization to expire on_____

Patient Signature: _____ _____Date: ___/___/_____

Guardian / Authorized Signature: _____Date: ___/___/_____

Fountain Medicals

# Permission for Telehealth Visits

**What is telehealth?**

- Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner.
- You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

**How do I use telehealth?**

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

**How does telehealth help me?**

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people.

**Will my telehealth visit be private?**

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.

**How much does a telehealth visit cost?**

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

**What does it mean if I sign this document?**

- If you sign this document, you agree that: We talked about the information in this document. We answered all your questions.

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Your name (please print) Date

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Your signature Date