2701 N. Tenaya Way, Ste. 200
Las Vegas, NV 89128
O: (702) 370-4309
F: (480) 626-6798

Patient's Information

Name _____

Address _____

_____

_____

Home Phone _____

Cell Phone _____

Birth Date _____

Social Security # _____

Emergency Contact Information

Name #1 _____

Phone _____

Relationship to patient _____

POA? Y N

Contact before visits? Y N

Name #2 _____

Phone _____

Relationship to patient _____

POA? Y N

Contact before visits? Y N

Where should bills be sent? (Billing address)

_____

_____

Primary Insurance Information

Company _____

Claims address _____

_____

Group # _____

Policy/ID # _____

Name on Card _____

Secondary Insurance Information

Company _____

Claims address _____

_____

Group # _____

Policy/ID # _____

Name on Card _____

Other Physicians Seen — name and specialty

_____

_____

_____

Home Health

Agency _____

Phone _____

How did you hear about us?

_____

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Pt Name:_____DOB: _____

General Consent for Treatment

I request and authorize any health care services my provider and his/her designee(s) may deem advisable and in my best interest, including routine diagnostic examinations, radiology and laboratory procedures. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or tests performed. I understand that excluding emergency or extraordinary circumstances, no invasive or interventional procedures will be performed without giving me the opportunity to give informed consent after having the expected risks and benefits explained.

Responsibility for Payment/Assignment of Benefits

I assign and authorize payment, for all services rendered, directly to The Doctor Is In from my insurance company or third-party payer including, but not limited to, Medicare, Medicaid, commercial health insurance, automobile insurance, and any other benefits/coverage for which I am eligible. I consent to the use of my health information by The Doctor Is In for purposes of my treatment, obtaining payment for services provided, and for health care operations of The Doctor Is In, all as permitted under federal and state laws and regulations.

I understand that I am financially responsible for any charges not covered by my health care benefits, including, but not limited to, deductibles, co-payments, and non-covered services. I understand that it is my responsibility to notify The Doctor Is In of any changes in my health care coverage.

Privacy Practices/Patient Rights and Responsibilities

I acknowledge that I have received a copy of the "Patient Rights and Responsibilities", which includes information about how my health information may be used and disclosed as required by the Health Insurance Portability and Accountability Act (HIPAA). I have had the opportunity to review this information before signing this form.

I have read this consent form, or it has been read to me, my questions have been answered to my satisfaction, and I am satisfied that I understand its contents.

_____ _____

Signature of Patient or Legal Representative Date of Signature

_____

Printed name and relationship to patient, if applicable

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Patient's name_____Today's Date _____

Birthdate_____Height_____Weight _____

Person completing this form_____ Relationship to patient _____

Pharmacy name/address_____ Phone # _____

Current medications and supplements (may also attach separate list, include dose and instructions)

Name of medications	Dose	Instructions

Allergies:

Medication/Substance	Reaction

Recent Hospitalizations:

Hospital	Dates	Reason for hospitalization/Diagnosis

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Medical History:

- ☐ Heart disease
- ☐ Heart attack
- ☐ Stroke
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart murmur
- ☐ COPD/emphysema
- ☐ Asthma
- ☐ Pneumonia
- ☐ Dementia
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Hypothyroidism
- ☐ GERD/Heartburn
- ☐ Stomach ulcers
- ☐ Cirrhosis/liver disease
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Back problems
- ☐ Hard of hearing
- ☐ _____
- ☐ _____
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ UTI/Bladder infection
- ☐ BPH/Prostate trouble
- ☐ Cancer (types)_____
- ☐ _____
- ☐ _____

Surgical History:

- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Bypass surgery
- ☐ Cardiac angioplasty/stents
- ☐ Other heart surgery
- ☐ Prostate surgery
- ☐ Colonoscopy
- ☐ Back surgery
- ☐ Knee replacement
- ☐ Hip replacement
- ☐ Set fracture
- ☐ Cancer surgery
- ☐ Cataract Removal
- ☐ _____
- ☐ _____

Family History:

Family Member	Age at death	Cause of death/Medical history
Father		
Mother		
Others		

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Social History:

Marital Status_____ Lives with _____

Do you have any children? If so, how many, and where do theylive? _____

_____

Education_____ Occupation _____

Religion_____

Smoking history: Never Past Current How much daily?_____When quit? _____

Alcohol history: Never Past Current How much daily?_____When quit? _____

Drug abuse history: Never Past Current What drugs? _____

Immunization History:

Flu shot Y N Date_____Shingles Y N Date _____

Pneumonia Y N Date_____Other_____ Date _____

Review of Systems — please circle any that you are having (current or recent):

Fever/Chills	Ear pain	Chest pains	Urinary incontinence	Falls
Weight loss	Sore throat	Nausea	Burning with urination	Depression
Weight gain	Difficulty swallowing	Vomiting	Nighttime frequency	Anxiety
Wear glasses	Dental pain	Constipation	Joint pains	Insomnia
Vision loss	Wear dentures	Diarrhea	Joint swelling	Tiredness
Eye pain	Nasal congestion	Abdominal Pain	Joint instability	Leg swelling
Eye discharge	Runny nose	Heartburn	Weakness	Rash
Wear hearing aid	Cough	Blood in stools	Memory loss/confusion	Open sores
Hearing loss	Shortness of breath	Bowel	Easy bruising	Dizziness

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Authorization to Release Medical Records

Patient Name:_____ DOB: _____

By my signature below, I authorize _____

_____

_____

_____

To release my medical records to: □ The Doctor Is In
2701 N. Tenaya Way, Ste. 200
Las Vegas, NV 89128

□ _____

_____

_____

_____

Records to be released: □ Past 2 years □ Past 1 year □ All available records

□ Lab results □ H&P □ Discharge summary □ ER records—visit date _____

□ Diagnostic testing results □ Consults □ Operative notes □ Immunization record

□ Other_____

_____ _____
Signature of Patient or Legal Representative Date of Signature

_____
Printed name and relationship to patient, if applicable

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Patients' Bill of Rights and Responsibilities

Quality of care:

- You have the right to high-quality care by a competent staff.
- You have the right to be treated with courtesy, respect, and dignity without discrimination in respect to race, religion, gender, age, sexual orientation, or diagnosis.
- You have the right to receive treatment that supports and respects your individuality, choices, and beliefs.
- You have the right to participate in choices about your care, including the right to refuse any recommended treatment.

Information, Voice, and Choice:

- You have the right to receive information about your health, diagnoses, and treatment explained in a way that you understand.
- You have the right to make advance directives and have your wishes followed.
- You have the right to receive assistance from a family member or other representative of your choice in making decisions about your care and protecting your patient rights.
- You have the right to complain and have your concerns reviewed. Complaints may be sent to: Privacy Officer 2430 W. Ray Rd., Suite 3 Chandler, AZ 85224.

Privacy

- You have the right to receive privacy in treatment and care for your personal needs.
- You have the right to have the confidentiality of your medical records protected. Except as permitted by law, your medical and financial records will not be released without your written consent.
- You have the right to review your own medical record per state law and request amendment of information you feel is inaccurate.

It is your responsibility

- To treat your health care provider with consideration and respect.
- To be honest about matters relating to you as a patient, including accurate and complete information about your current complaints/concerns, past medical and surgical history, hospitalizations, medications, and other information pertinent to your health and medical care.
- To provide us with accurate address, telephone number, contact and insurance information, and update as necessary.
- To provide us with a current copy of your advance health care directives.
- To ask questions if you do not understand what you have been told about your health or what you are expected to do.
- To report any new or unexpected changes in your condition to your health care provider.
- To follow the treatment plan you have agreed to with your health care provider.
- For any adverse outcomes resulting from failure to follow your health care provider's recommendations for care or treatment.
- To be available for appointments as scheduled or to notify The Doctor Is In as soon as possible prior to the appointment to allow appropriate rescheduling.
- To assure the financial obligations for your healthcare are fulfilled as promptly as possible.