North Canyon Buhl Clinic

NEW PATIENT INTAKE FORM

Patient Name____
Last First Middle

Male _____ **Female** _____ **SSN(Required)**______-_____-________ **Date of Birth** ______/_______/__________

Physical Address ___________________________________City_______________ State________ Zip__________

Mailing Address (if different) ______________________________________City__________ State____ Zip______

Home Phone ________________________________ **Cell Phone**_____________________________________

Email address ____ **Patient Portal**: Yes____ No____

We will not use your email for solicitation. ***Are you interested in our Patient Portal? If so, please mark above, it is utilized for your health care needs. Thank you-***

Marital Status: Married ___ Single___ Divorced___ Separated ___ Widowed/remarried___ Significant other___

Patients or Parents Employer ____________________________________ **Work Phone** _________________________

If minor child; list name of parent/head of household: ____

Parent/guarantor date of birth: ______________________Phone number if different: (____) ____________________
(MM/DD/YYYY)

Person to contact in case of emergency? ________________________________ **Phone** _________________________

Relationship to patient: ____

CONSENT VERIFICATION:

Consent to use of answering machine and/or voicemail messaging: I hereby consent to the use of my answering machine and/or voicemail for the purpose of relaying important information regarding my treatment or care, including, but no limited to confirmation of appointments, changes in medication, results of lab tests, special instructions for testing procedures.
I also consent to members of my family receiving this information in my absence. This consent will remain in effect until I rescind the consent in writing. I have filled out an Authorization to Release and/or Obtain Medical Information form.

____ ______________________
Signature of Patient/Patient Representative **Date (MM/DD/YYYY)**

Persons who can call and receive your medical information:

Name:	Relationship	Phone#:
____________________________________	_________________________________	_________________________________
____________________________________	_________________________________	_________________________________

Health History

Allergies to medications? ***None*** □ ***What happens?***

Medications ***None*** □

Name of Medication	***Strength/Dosage***	***How many times a day do you take it?***

Medical History: Please check all that apply and describe any problems you have ever had with any of the listed topics:

Please read carefully-	Yes	No	
SKIN, HAIR, NAILS, TEETH Skin Problems? Do you wear dentures?			Additional Comments: ____ ____.
EYES, EARS, NOSE, THROAT Glasses? Hearing aids?			Additional Comments: ____ ____.
HEART PROBLEMS Have you had a heart attack? Do you have high cholesterol? High blood pressure?			Additional Comments: ____ ____ ____ ____.
LUNGS/BREATHING PROBLEMS?			
STOMACH PROBLEMS?			Additional Comments:
LIVER / PANCREAS PROBLEMS?			If so, for how long?
BOWEL PROBLEMS?			If so, for how long?
KIDNEY PROBLEMS?			If so, for how long?
ARTHRITIS/JOINT PROBLEMS?			Please describe:
HORMONE DEFICIENCIES?			
Have you ever had a stroke? Have you ever had seizures?			Additional Comments:
ANEMIA / BLEEDING PROBLEMS			Please describe:
CANCER?			Type:
DIABETES?			If so, for how long? ____________________ Pills or Insulin Type:________________________________

Health History Cont. Please read carefully-	**Yes**	**No**	
THYROID PROBLEMS?			Please describe:
***Women*:** How many pregnancies? ________ How many deliveries? __________ Number of Miscarriages? ___________ Date of your last menstrual period? ________________________________ Have you had a hysterectomy? **Y N**			Additional Comments: ____ ____ ____ ____ ____ ____ ____.
Have you ever suffered from an addiction? Drugs and/or Alcohol?			Additional Comments: ____
Have you ever had a Venereal Disease?			Other problems: ____ ____ ____ ____ ____.
Have you ever suffered from depression?			
Have you every suffered from anxiety?			
Previous Doctors and hospitals that have provided medical care for you: Please list city/state where they are located:			Previous PCP/Clinic/Hospital: __________________________________ ____ ____. Location: ____ ____

***Other Illness/Injury:* ____.**

***Please list previous hospitalizations and dates:* ____**
____.

Preventative: Have you ever had any of these tests, and when was the testing done?

	Colonoscopy	**Bone Density**	**Mammogram**	**PAP**	**PSA**	**Eye Exam**	**Foot Exam (If diabetic)**	**Rectal Exam**
Date								
Normal								
Abnormal								
Due Date								
Where?								

***Surgical History and Dates:* ____**
____
____.

ADVANCE DIRECTIVE INFORMATION:
Do you have an Advance Directive? Yes ______ No ______
Definition: *a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.*
Do you have a Medical Power of Attorney? Yes _____ No ____ Do we have it on file? Yes ____ No ____
If so, please name: ____
Code Status: **Full Code**- All lifesaving measures □ **DNR**-Do Not Resuscitate □
I would like to talk to the doctor about this? Yes: ______ No: ______

Patient Signature: ____ **Date***:* ____________________________

North Canyon
MEDICAL CENTER

NCMC Consent, Physician Acknowledgement, Release of Information & Financial Agreement

___________ **Consent for Treatment**
(Patient Initials)
I, the undersigned, have been informed and understand the necessary treatment and procedure which may be performed by physicians, nurses, and employees of North Canyon Medical Center. Authorization is granted for such treatment and procedures.

___________ **Notice & Acknowledgment of On-Site Physician Presence**
(Patient Initials)
Patients of North Canyon Medical Center ("NCMC") are entitled to make informed decisions regarding their medical care. NCMC has trained staff available to respond to emergencies at all times; however, a physician may not be present at NCMC twenty-four (24) hours per day, seven (7) days per week. If a medical emergency arises while a physician is not on-site or otherwise available to respond, patients will be treated by other healthcare providers trained to respond to emergencies on call to respond to NCMC on a 24/7 basis. In addition, NCMC always has a physician available by telephone to help address emergency situations.

___________ **Release of Information / Patient Rights and Responsibilities**
(Patient Initials)
North Canyon Medical Center may disclose all or any part of this record to the patient's insurance carrier and/or to any consulting physician or health care facility. I, the undersigned, received a copy of my Patient Rights and Responsibilities.

___________ **Financial Agreement/Assignment of Insurance**
(Patient Initials)
I, the undersigned, agree that in consideration of the services rendered to the patient, I am obligated to pay the account of North Canyon Medical Center according to the policies and terms of the hospital.
I, the undersigned, agree that the benefits of any insurance policy covering the patient are hereby assigned to the hospital for application on patient's account and that I am obligated to pay any charges not covered by this agreement.

___________ **Collection Costs and Procedures**
(Patient Initials)
If your account becomes delinquent, you agree to pay any additional charges to collect your unpaid bills, including but not limited to, reasonable attorney fees, court costs and collection agency fees, By signing this policy, you do acknowledge that we reserve the right to release any patient information and any medical records to our collection agency deemed necessary to assist their staff and their attorneys in the collection of this debt.

By signing below, you confirm that you have read and understand North Canyon Medical Center's Consent for Treatment, Notice and Acknowledgment of On-Site Physician Presence, Release of Information and Financial Policy and that you agree to its contents.

____ ____
Patient Name: Please Print **(**Last, First, Middle Initial**)** **Patient Signature and/or (**Patient Guarantor**)**

____ **Date:** ______________________________
Relationship to Patient (Guarantor)

Patient has signed HIPAA; signed consent on file: Yes ☐ **No** ☐

NCMC Employee (Witness) Signature: ____

North Canyon
MEDICAL CENTER

North Canyon Medical Center
Notice of Privacy Practices

Effective Date: March 2, 2010

Acknowledgement: I have received a copy of this notice.

____________________	____________________	______________
Printed Name:	Signature:	Date:

Patient Name: ____________________

DOB: ____________________
(MM/DD/YYYY)

This form will be retained in your medical record.