CARSON VALLEY HEALTH

NEW PATIENT INFORMATION

CVH Senior Care
1516 Virginia Ranch Road Gardnerville, NV 89410
775.783.4823 (phone) – 775.783.4806 (fax)
seniorcare@carsonvalleyhealth.org

Primary Care Ironwood
897 Ironwood Drive Minden, NV 89423
775.782.1610 (phone) – 775.783.0627 (fax)
ironwoodpc@carsonvalleyhealth.org

Primary Care Virginia Ranch Road
1520 Virginia Ranch Road Gardnerville, NV 89410
775.782.1550 (phone) - 775.782.1579 (fax)
jobspeak@carsonvalleyhealth.org

Primary Care Minden Village
1649 Lucerne Street Minden, NV 89423
775.782.1603 (phone) – 775.782.3417 (fax)
mindenfamily@carsonvalleyhealth.org

Primary Care Topaz Ranch
3919 Carter Drive Wellington, NV 89444
775.783.3096 (phone) – 775.266.4074 (fax)
topazranch@carsonvalleyhealth.org

Please fill out these forms and mail, drop-off, or fax them back to the office where your appointment is scheduled, no later than three (3) business days prior to your first appointment.

PATIENT DEMOGRAPHICS

Name: _____ PCP: _____

Address: _____ Language: _____

_____ Email: _____

Phone: _____ SSN: _____

Sex: _____ DOB: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

GUARANTOR INFORMATION

Name: _____ Phone: _____

Address: _____

_____ Relationship: _____

Employer: _____ Phone: _____

Address: _____ Employment Status: _____

PRIMARY INSURANCE

Subscriber Number: _____

Subscriber: _____

Payor Address: _____

Payor Name: _____

_____

Plan: _____ Members: _____

Relationship: _____ Group Number: _____

SSN: _____ DOB: _____

Employer: _____ Employment Status: _____

SECONDARY INSURANCE

Subscriber Number: _____

Subscriber: _____

Payor Address: _____

Payor Name: _____

_____

Plan: _____ Members: _____

Relationship: _____ Group Number: _____

SSN: _____ DOB: _____

Employer: _____ Employment Status: _____

OFFICE POLICY: I understand and agree to the following rules set forth by Carson Valley Health;
1) Payment is required at the time of service. If I cannot pay my co-payment at time of service, my appointment may be rescheduled.
2) If I am more than 5 minutes late for an appointment, my appointment may be rescheduled.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:
I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. In the event that legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree to pay reasonable attorney's fees and such other costs as the court determines is proper. I authorize Carson Valley Health to verify credit with the CVH contracted credit agency, my employment history, credit history and any other information deemed necessary in conjunction with my account(s). I hereby assign all proceeds of insurance to this office (a copy of this assignment is as valid as the original). I authorize the release of all medical information necessary to process any claims on my behalf. I also request payment of medical and/or government benefits to this office.

Patient's signature _____ **Date** _____

Signature of responsible party _____ **Date** _____

CARSON VALLEY HEALTH

Primary Care Clinics
Patient Questionnaire -- Adult

Last Name:	**First Name:**	**DOB:**	☐F ☐M
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**Occupation:**	
Previous or referring doctor:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Immunizations (Include approximate year or age)			
	☐ Tetanus	☐ Pneumonia/Pneumovax	☐ Hepatitis A
	☐ Influenza (Flu)	☐ Prevnar 13	☐ Hepatitis B
	☐ Gardasil (HPV)	☐ Shingles vaccine/Zostavax	☐ Covid

Past or Present Medical History: (check all that apply to you)

☐ Alcohol/ Drug problem	☐ Emphysema/COPD	☐ Liver Disease	☐ Blood Clots
☐ Anemia	☐ Heart – Attack	☐ Osteoporosis	☐ Peripheral Artery Disease
☐ Anxiety	☐ Heart–Coronary Artery Dis.	☐ Prostate problem	☐ Neuropathy
☐ Arthritis	☐ Heart- Heart Failure/ CHF	☐ Psychiatric- Depression	☐ Sleep Apnea
☐ Asthma	☐ High Blood Pressure	☐ Psychiatric Disorder--other	☐ Heart Murmur
☐ Atrial Fibrillation	☐ High Cholesterol	☐ Seizure Disorder	☐ Migraines
☐ Dementia	☐ Hypothyroidism (low)	☐ Stroke	☐ Hepatitis
☐ Diabetes	☐ Hyperthyroidism (high)	☐ Ulcers of the Stomach	☐ Diverticulosis
☐ Cancer—	☐ Kidney Disease	☐ STD/ sexual infection	☐ Colon Polyps
Type:		☐ Abnormal Pap Test	☐ Positive TB test

Surgeries (Include Year or Age at time of surgery)

☐ Appendectomy	☐ Tonsillectomy	☐ C-Section (Cesarean)
☐ Cardiac Bypass (CABG)	☐ Hernia Repair	☐ Hysterectomy- Partial
☐ Cardiac Angioplasty/Stent	☐ Prostate Surgery	☐ Hysterectomy- Total
☐ Gallbladder Laparoscopic	☐ Vasectomy	☐ Tubal Ligation
☐ Gallbladder Open	☐ Cataract Surgery: ☐ Left ☐ Right	☐ Breast Surgery: ☐ Left ☐ Right
☐ Orthopedic (type):		
☐ Other Surgery:		

Screening Tests	Approx Date:	Where was test done?		Approx Date:	Where was test done?
Cholesterol Test			Pap Smear		
Colonoscopy			Mammogram		
Prostate Test			Bone Density Test		
Dental Exam					
Eye Exam		☐ Glasses ☐ Contacts ☐ Cataracts			

CARSON VALLEY HEALTH

Primary Care Clinics
Patient Questionnaire -- Adult

Last Name: First Name: DOB:

MEDICATIONS: List prescribed and over-the-counter medications. **Pharmacy**:		
DRUG NAME:	DOSE:	DIRECTION:

ALLERGIES/ REACTIONS to Medications:	
DRUG NAME:	REACTION/ COMMENTS:
LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND REACTIONS:	

SEXUAL HEALTH			
☐ Sexually active	☐ Not currently sexually active	☐ Never sexually active	# partners in past year:
History of Sexually Transmitted Infection ? ☐ No ☐ Yes Type/date:			
Current contraception method:		Previous methods:	
# children:	**For Women:** (# pregnancies:) (# miscarriages:) (# abortions:)		

HEALTH HABITS AND PERSONAL SAFETY

Tobacco	**Cigarette use:**	☐ Never	☐ Former smoker. Quit date or age:		
		☐ Current smoker----	# packs/day:		# years:
	Other tobacco use:	☐ Pipe	☐ Cigars	☐ Vape	☐ Chewing tobacco

CARSON VALLEY HEALTH

Primary Care Clinics
Patient Questionnaire -- Adult

Last Name: First Name: DOB:

Alcohol	Do you drink alcohol? ☐ No ☐ Yes : ☐ 0-1 time/month ☐ 2-4 times/month ☐ every week	
	What type(s) of alcohol do you drink?: ☐ Beer ☐ Wine ☐ Liquor	
	How many drinks do you consume when drinking? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 6+	
Drugs	Have you used recreational or street drugs within the last 2 years?	☐ Yes ☐ No
	Have you ever used recreational drugs with a needle?	☐ Yes ☐ No

FAMILY HEALTH HISTORY				
Family Member			Age	MEDICAL CONDITIONS (Indicate Healthy or: diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer &type)
Mother		☐ Living ☐ Deceased		
Father		☐ Living ☐ Deceased		
Grandmother *Mother's Side*		☐ Living ☐ Deceased		
Grandfather *Mother's Side*		☐ Living ☐ Deceased		
Grandmother *Father's Side*		☐ Living ☐ Deceased		
Grandfather *Father's Side*		☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		

Reviewed by/ Date:

CARSON VALLEY HEALTH

System Review for Adults---
New Patient or Annual Preventive Visit

Name: **Today's Date:**

Date of Birth:

Check the box if you are currently experiencing any of the following:

GENERAL:
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain > 10 lbs
- ☐ Weight loss > 10 lbs

SKIN:
- ☐ Rash
- ☐ New/changing skin lesion
- ☐ Nail changes
- ☐ Hair loss

EYES/EARS/NOSE/THROAT:
- ☐ Vision changes
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Hoarse voice
- ☐ Sore throat
- ☐ Sneezing
- ☐ Sinus problems
- ☐ Lump in neck

RESPIRATORY:
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Night sweats
- ☐ Bloody sputum
- ☐ Productive cough
- ☐ Dry cough
- ☐ Shortness of breath

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Racing heart
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Leg pain with walking
- ☐ Ankle or Leg swelling
- ☐ Decreased exercise tolerance
- ☐ Awakening at night due to trouble breathing

GASTROINTESTINAL:
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Acid reflux
- ☐ Rectal bleeding

MUSCULOSKELETAL:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Muscle weakness

HEMATOLOGIC:
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Enlarged lymph nodes

NEUROLOGIC:
- ☐ Headaches
- ☐ Dizziness/vertigo
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Difficulty walking
- ☐ Seizures
- ☐ Tremor
- ☐ Frequent falls

PSYCHIATRIC:
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Insomnia/sleep problems
- ☐ Psychiatric treatment

ENDOCRINE:
- ☐ Change in appetite
- ☐ Cold or heat intolerance
- ☐ Increased thirst
- ☐ Changes in sex drive
- ☐ Hair loss or excess growth

ALLERGIC/IMMUNOLOGIC:
- ☐ Allergy/Hayfever symptoms
- ☐ Itching
- ☐ Frequent infections
- ☐ Exposure to infection

BREAST:
- ☐ Breast lump/mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Rash on breast

GENITOURINARY:
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Difficulty passing urine
- ☐ Hernia

MEN:
- ☐ Difficulty starting stream
- ☐ Change in urine stream
- ☐ Penile discharge
- ☐ Testicular pain or mass
- ☐ Erection difficulties

WOMEN:
- ☐ Pelvic pain
- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Excessive vaginal bleeding
- ☐ Bleeding after menopause
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Pain with intercourse

Reviewed by/Date:

CARSON VALLEY HEALTH

Medical Office Policies

A Note About Your Insurance Policy

It is your responsibility to know your insurance. You should know your policy's contracted providers, need for prior authorization for procedures, specific facility for lab work & x-ray, copayment amount and your yearly deductible.

A Note About Office Policies

- Co-payment is required at the time of service. If you cannot pay your co-payment, your appointment may be rescheduled.
- If you are late for your appointment, your appointment may be rescheduled.

A Note About Prescriptions

Requests for refills are to be submitted through MyChart or called in to your pharmacy even if the prescription has no refills left. The pharmacy will have the information needed to make sure you get the proper medication. Please allow 48 to 72 hours to process.

A Note About Authorizations and Referrals

If your doctor referred you to a Specialist:

- Please allow our office up to 5 working days to obtain authorization from your insurance for routine procedures.
- Please allow the specialist's office 3-7 working days to call you to schedule your appointment. If you have not heard from them by this time, please contact them directly.
- X-rays and Labs generally do not need authorization and generally require no authorization from your insurance. However, Ultrasounds, MRI's and any Nuclear Tests will require authorization and scheduling will be contacting you.

Authorization To Use and Disclose Health Information

Our Notice of Privacy Practices is available. If you would like a paper copy for your records, please let the receptionist know.

PLEASE CHOOSE ONE:

☐ If a family member or friend calls or comes into the office on your behalf requesting information regarding your medical record (i.e.: samples, labs, appointments, prescriptions, letters, etc.), you authorize CVH to release or discuss your information with:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

-OR-

☐ I DO NOT wish my medical record to be released or discussed with anyone other than myself.

I understand that this does not apply to information needed to process any and all claims by insurance, or the sharing of information between providers, or their staff for the continuance of my Medical care.

Messages/Voicemail

If you authorized us to leave a detailed message with you or a family member/spouse/friend, please indicate below.

- It is OK to have a message left on my cell phone/answering machine? YES/NO

I have read & understood the above information regarding office policies.

Patient Name_____ Date of Birth _____

Signature_____ Date_____

Patient Consent Form

For Electronic Exchange of Individual Health Information

HealtHIE Nevada is a nonprofit organization that connects the health care community and enables the sharing of information electronically and securely to improve the quality of health care services. To learn more about the health information exchange (HIE), read the **Patient Information Brochure**. You can ask the doctor that gave you this form for it, or you can visit the website at www.HealtHIENevada.org.

Details about patient information in HealtHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers and pharmacies), will have access to your health information. It can only be used to:
   - Provide you with medical treatment and related services
   - Evaluate and improve the quality of medical care provided to all patients

2. **Types of information included and where it comes from:** The information about you comes from participating organizations that have provided you with medical care. These may include hospitals, physicians, pharmacies, clinical laboratories and other health care organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this **Consent Form**. This information may relate to sensitive health conditions, including, but not limited to:
   - Alcohol or drug use problems
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Birth control / abortion (family planning)
   - Sexually transmitted diseases

3. **Improper access or disclosure of your information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada state law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.

4. **Effective period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it.

5. **Revoking your consent:** You may revoke your consent at any time by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

   Note: Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and state laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada state law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

You are entitled to receive a copy of this **Consent Form** after you sign it.

For Internal Use Only: MRN_____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please print)

PATIENT NAME_____
Last *First* *Middle*

PREVIOUS NAME(S)_____ **GENDER:** M☐ F☐

STREET ADDRESS/P.O. BOX_____

CITY_____ **STATE**_____ **ZIP CODE**_____

PHONE NUMBER _____ **EMAIL**_____

DATE OF BIRTH _____(MM)_____(DD)_____(YYYY)

☐ **Nevada Medicaid Patients: PLEASE READ.** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.538). When a patient is no longer a Medicaid recipient, it is her/his responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK A or B) Nevada Medicaid Patients are exempt from making a selection.

Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **A. I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **B. I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____
Signature of patient, parent (for children under 18) or authorized representative Date Time

If I sign this form as the patient's authorized representative, I understand that all references in this form to "I," "me" or "my" refer to the patient.

_____ _____ _____
Name of authorized representative (printed) Relationship Date Time

_____ _____
Address of authorized representative Phone number

FOR INTERNAL USE ONLY
Name of Organization:_____ Name of Witness:_____
As a witness to this consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card or other evidence of identity customarily relied upon in health care.