CARSON VALLEY HEALTH

NEW PATIENT INFORMATION

This new patient information packet is for new patients at the following Carson Valley Health clinics:

CVH Senior Care
1516 Virginia Ranch Road, Gardnerville, NV 89410
775.783.4823 (phone) | 775.783.4806 (fax)
Email new patient paperwork to seniorcare@carsonvalleyhealth.org

Primary Care Ironwood
897 Ironwood Drive, 2nd Floor
775.782.1610 (phone) | 775.783.0627 (fax)
Email new patient paperwork to ironwoodpc@carsonvalleyhealth.org

Primary Care Virginia Ranch
1520 Virginia Ranch Road, Gardnerville, NV 89410
775.782.1550 (phone) | 775.782.1579 (fax)
Email new patient paperwork to jobspeak@carsonvalleyhealth.org

Primary Care Minden Village
1649 Lucerne Street, Minden, NV 89423
775.782.1603 (phone) | 775.782.3417 (fax)
Email new patient paperwork to mindenfamily@carsonvalleyhealth.org

Primary Care Topaz Ranch
3919 Carter Drive, Wellington, NV 89444
775.783.3096 (phone) | 775.266.4074 (fax)
Email new patient paperwork to 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** _____

Medical Questionnaire

Name: Last	**First**
DOB (mm/dd/yyyy):	**Primary Phone:**
Mailing Address:	
Emergency Contact:	**Contact Phone:**

SOCIAL HISTORY

Marital Status: (*Check One)* ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Yes	No	
☐	☐	Are you living with your spouse or partner?
☐	☐	Do you have dependents at home? (If yes, how many?) # of Dependents _____
☐	☐	Is your sex life satisfactory?

Employment

☐ Full Time Where: _____
☐ Part Time Where: _____
☐ Unemployed How Long: _____
Are you exposed to fumes, dusts or solvents? _____

Education

(Check your highest level of education with years completed)
☐ Grade School ___ Years
☐ High School ___ Years
☐ College/Technical School ___ Years
☐ Postgraduate ___ Years

Alcohol Use:

☐ Never ☐ Current ☐ Former
If current or former, please answer the following:
What type(s) of alcohol do you drink? ☐ Beer ☐ Wine ☐ Liquor
How often: ☐ Rarely ☐ Moderately ☐ Daily
How much: ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10+
Illicit Drug Use: ☐ Yes ☐ No Type_____

Tobacco Use:

☐ Never ☐ Current ☐ Former ☐ Quit _____Years
If current or former, please answer the following:
Cigarettes per day: ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10+
Chewing tobacco cans per week ☐ < 1 ☐ 1 ☐ 2

MEDICAL HISTORY

History of Past Illnesses: Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Chickenpox	☐	☐	Measles	☐	☐	Tuberculosis
☐	☐	Congenital Abnormalities	☐	☐	Mumps	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Rheumatic Fever	☐	☐	Other. (Fill out below)
☐	☐	Heart Disease	☐	☐	Strokes	What: _____		

Have you ever been hospitalized or been under medical care for a prolonged condition? (If yes, what): _____
_____

Operations & Injuries

Yes	No	
☐	☐	Have you had any surgery? (If Yes, What and When)
☐	☐	Have you had any broken bones? (If Yes, What and When)
☐	☐	Have you had any head concussions or head injuries? (If Yes, Why and When)
☐	☐	Have you ever been knocked unconscious? (If Yes, When)

Record the Year you last had these done:

Chest X-Ray:	_____	Mammogram:	_____	Rectal Exam:	_____
Colonoscopy:	_____	Pap Smear:	_____	Tetanus Shot:	_____
Dexa Scan:	_____	Pneumonia Shot:	_____	TB Skin Test:	_____
EKG	_____	Prostate Exam:	_____		
Flu Shot:	_____	Shingles Shot:	_____		

FAMILY HISTORY

Has any blood relative had any of the following?

Yes	No	Relation
☐	☐	Arthritis
☐	☐	Bleeding Tendency
☐	☐	Cancer
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Gout
☐	☐	Heart Trouble
☐	☐	High Blood Pressure
☐	☐	Stroke
☐	☐	Suicide

Current Health Status of immediate family members:

Relation:	If Living,		If Deceased,	
	Age	Health	Age	Cause
Father:				
Mother:				
Sister:				
Brother:				
Spouse:				
Child:				

LIST OF CURRENT MEDICATIONS:

Please list ALL the medications INCLUDE: name, dosage, and frequency, vitamins, and over the counter medications.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy:

SYSTEMIC REVIEW Do you have any of the following? (Please check all those that apply.) Please notate current or past issues.

Allergies
- ☐ Food allergies
- ☐ Hives, eczema, or rash
- ☐ Medication allergies _____
- ☐ Seasonal allergies

Cardiovascular
- ☐ Chest pain and/or discomfort
- ☐ Difficulty walking
- ☐ Fainting
- ☐ Fatigue
- ☐ Heart attacks
- ☐ Heart murmur
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Insomnia
- ☐ Lightheadedness
- ☐ Racing/ skipping heartbeats
- ☐ Restless sleep
- ☐ Shortness of breath
- ☐ Swelling of extremities

Ears, Nose and Throat
- ☐ Chronic sinus trouble
- ☐ Difficulty swallowing
- ☐ Ear ache
- ☐ Ear disease
- ☐ Enlarged glands
- ☐ Hoarseness
- ☐ Impaired hearing
- ☐ Itching nose
- ☐ Neck stiffness
- ☐ Nose bleeds
- ☐ Ringing in the ears
- ☐ Sneezing or runny nose
- ☐ Sore throat
- ☐ Unconsciousness

- ☐ Endocrine
- ☐ Brittle hair
- ☐ Cold intolerance
- ☐ Excessive thirst or hunger
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Hormone therapy
- ☐ Known thyroid disorder
- ☐ Weight change

Eyes
- ☐ Blurring
- ☐ Double vision
- ☐ Eye disease or injury
- ☐ Glaucoma
- ☐ Headaches
- ☐ Irritation or itching
- ☐ Light sensitivity
- ☐ Vision loss

Gastrointestinal
- ☐ Abnormal pain
- ☐ Black or bloody stool
- ☐ Bleeding with bowel movements
- ☐ Bloating
- ☐ Constipation
- ☐ Cramping
- ☐ Diarrhea
- ☐ Dysphasia (trouble swallowing)
- ☐ Gallbladder disease
- ☐ Gas
- ☐ Heartburn or indigestion
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Liver disease
- ☐ Nausea
- ☐ Peptic ulcer
- ☐ Vomiting blood or food

General
- ☐ Chills
- ☐ Fatigued/tired
- ☐ Feeling sick
- ☐ Fevers
- ☐ Sweats
- ☐ Weight change (gain or loss)

Genitourinary
- ☐ Abnormal discharge or odor
- ☐ Blood in urine
- ☐ Burning or painful urination
- ☐ Frequent urination
- ☐ Inability to empty bladder
- ☐ Kidney pain/ stones
- ☐ Lack of sexual drive
- ☐ Loss of urine
- ☐ Nighttime urination
- ☐ Pelvic Pain
- ☐ Urinary incontinence/ lack of control
- ☐ Urinary straining

Hematologic
- ☐ Abnormal bruising
- ☐ Bleeding
- ☐ Anemia
- ☐ Enlarged lymph nodes
- ☐ Fevers
- ☐ Known blood disease
- ☐ Skin discoloration

Musculoskeletal
- ☐ Arthritis
- ☐ Back pain
- ☐ Difficulty walking
- ☐ Gout
- ☐ Joint or muscle pain
- ☐ Joint swelling or stiffness
- ☐ Varicose veins
- ☐ Weakness of muscles or joints

Neurologic
- ☐ Difficulty with concentration
- ☐ Difficulty with coordination
- ☐ Dizziness
- ☐ Excessive daytime sleeping
- ☐ Fainting
- ☐ Falling down
- ☐ Headaches
- ☐ Inability to speak
- ☐ Memory loss
- ☐ Paralysis
- ☐ Seizures
- ☐ Tingling/numbness
- ☐ Visual disturbances

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Eating disorder
- ☐ Frightening visions or sounds
- ☐ Insomnia
- ☐ Sense of great danger
- ☐ Suicide ideation

Respiratory
- ☐ Asthma or wheezing
- ☐ Chest discomfort
- ☐ Chronic frequent cough
- ☐ Difficulty breathing
- ☐ Fainting spells (past or present)
- ☐ Pleurisy and/or pneumonia
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Sleep disturbance
- ☐ Snoring
- ☐ Spitting up/ coughing blood
- ☐ URI (cold)

Skin
- ☐ Abnormal pigmentation
- ☐ Dryness or itching
- ☐ Excess sweating
- ☐ Frequent infection or boils
- ☐ Hives, eczema, or rash
- ☐ Jaundice
- ☐ Lesions
- ☐ Poor or abnormal healing
- ☐ Skin disease

(Men Only)
- ☐ Burning/discharge form penis
- ☐ Difficulty with erection/ ejaculation
- ☐ Frequent night urination
- ☐ PSA (Date:_____)
- ☐ Testicle pain/swelling
- ☐ Vasectomy

Gynecological (Women Only)
- ☐ Irregular periods
- ☐ Missed period
- ☐ Pain during intercourse
- ☐ Painful Periods

Age period started (age: ___)
How long do periods last? (# of days ___)
Number of pregnancies (#___)
Number of miscarriages (# ___)
First day of last period (Date:_____)

HEIGHT: _____ WEIGHT: _____

CVH Medical Office Policies

A Note About Your Insurance Policy

It is your responsibility to know your insurance. You should know your policies contracted providers, need for prior authorization for procedures, specific facility for lab work & x-ray, copayment amount and your yearly deductible.
Please help us help you. There are hundreds of insurance companies and it is impossible for our staff to know the specific requirements of each.

A Note About Prescriptions

Please notice the request to give us 48 to 72 hours to refill prescriptions. Requests for refills are to be called in to your pharmacy even if your prescription has no refills left. The pharmacy will have all of the information needed to make sure you get the proper medication. We will make every effort to meet your needs in a timely manner.

A Note About Authorizations and Referrals

If your doctor has referred you to a Specialist:

- Please allow our office up to five (5) working days to obtain authorization from your insurance for routine procedures.
- Please allow the specialists 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 an appointment and generally require no authorization from your insurance. However; Ultrasounds, MRI's and any Nuclear Tests will require authorization and we will be contacting you.

A Note About Leaving Messages

If you authorize us to leave detailed messages with a friend or family member or on an answering machine please indicate below.
Please circle ALL that apply:

Is it OK to have message left on answering machine? YES / NO
Is it OK to leave message with spouse or family member? YES / NO

If you would like us to leave messages with a friend or family member please add their name below.

Name	Phone Number	Relationship

I have read & understood the above information regarding *My Insurance Policy, Prescription Refills, Authorization and Referrals* and *Messages*

Patient Signature: _____ **Date** _____

Patient Name: _____ **Sex**: M / F

Birthdate: _____/_____/_____ **SSN#**_____

CARSON VALLEY HEALTH

I hereby acknowledge that I have received the Carson Valley Health Notice of Privacy Practices.

_____ _____

*Signature of Patient or *Legal Representative* ** Relationship to Patient*

_____ _____

Print Name *Date*

FOR CVH USE ONLY

Reason acknowledgment was not obtained:

_____

_____

CVH employee completing this form:

_____ _____

Please Print Name *Date*