Ralston Family Physicians

Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I have received a copy of Ralston Family Physicians Notice of Privacy Practices.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

Consent to Disclose Individually Identifiable Health Information (IIHI) to carry out Treatment, Payment and Health Care Operations (TPO)

By signing below, I am consenting to Ralston Family Physicians use and disclosure of my IIHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Ralston Family Physicians may decline to provide treatment to me.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

_____ _____
(Print Patient's Name) (Print Name of Patient or Legal Guardian)

I wish to be contacted in the following manner (check all that apply)

____ **Home Telephone**
- ___ Ok to leave message with detailed information
- ___ Leave message with call back number only

____ **Cellular Phone**
- ___ Ok to leave message with detailed information
- ___ Leave message with call back number only

____ **Work Telephone**
- ___ Ok to leave message with detailed information
- ___ Leave message with call back number only

Please list the name of person(s) that you are providing authorization/access to medical information / records and to pick up the following on your behalf:

Medical information / Records _____

Written Prescriptions / Sample Medication _____

PLEASE CHECK BOX IF YOU NOW HAVE , OR HAVE HAD IN THE PAST, ANY OF THE FOLLOWING PROBLEMS:

HEAD
- ☐ Trouble with severe headaches of migraines?
- ☐ Serious head injury or knocked unconscious?
- ☐ Fainting or dizzy spells?
- ☐ Epilepsy, seizure disorder?
- ☐ Stroke

EYES
- ☐ Wear glasses or contact lenses?
- ☐ See double or blurring of vision?
- ☐ Any eye injury?
- ☐ Any other eye problems?_____

EARS
- ☐ Decreased hearing on one or both ears?
- ☐ Ringing or buzzing?
- ☐ Frequent infections?

NOSE
- ☐ Frequent colds or stuffy nose?
- ☐ Sinus problems or hay fever?
- ☐ Frequent nosebleeds?

MOUTH
- ☐ Any sores or lumps on lips, tongue or mouth?
- ☐ Voice problems?
- ☐ Difficulty or pain with swallowing?
- ☐ Any problems with gums, teeth, tongue, mouth, or throat?

RESPIRATORY
- ☐ Wheeze when breathing?
- ☐ Pain associated with breathing?
- ☐ Cough up mucous or phlegm?
- ☐ Cough up blood?
- ☐ Easily out of breath?
- ☐ Frequent bronchitis or pneumonia?
- ☐ Tuberculosis or positive TB skin test?
- ☐ Abnormal chest X-Ray?

CARDIOVASCULAR
- ☐ Any pain, pressure or tight felling in chest?
- ☐ Heart racing or skipping?
- ☐ Painless swelling of feet and ankles?
- ☐ Shortness of breath when sleeping or lying flat?
- ☐ History of high or low blood pressure?
- ☐ History of heart disease of heart attack?
- ☐ Cramps in legs?
- ☐ Varicose veins?
- ☐ Pain, numbness, or discoloration of fingers?
- ☐ Abnormal EKG or cardiogram?
- ☐ History of heart murmur?
- ☐ Thrombophlebitis or inflammation of veins in legs?

GASTROINTESTINAL
- ☐ Trouble with appetite?
- ☐ Weight gain or loss of 10 lbs. or more without trying?
- ☐ Nausea or vomiting?
- ☐ Vomited blood or other abnormal material?
- ☐ Heart burn or pain in stomach or abdomen?
- ☐ History of ulcers?
- ☐ History of liver disease or yellow jaundice?
- ☐ Gray, black tarry or bloody stool?
- ☐ Recent change in bowel habits?
- ☐ Unusual Stools?
- ☐ Burning , itching or pain in rectal area?
- ☐ Three or more bowel movements per day?
- ☐ problems with liver, intestines, spleen or gallbladder?

GENITOURINARY
- ☐ Bladder or urinating problems in the past year?
- ☐ Pain or burning when urinating?
- ☐ Urinate two or more times a night?
- ☐ History of sugar or glucose in urine?
- ☐ Bladder control problems?
- ☐ History of kidney or bladder infection?
- ☐ Passed a kidney stone?
- ☐ History of kidney disease?

BONES / JOINTS
- ☐ Painful joints?
- ☐ Swollen joints?
- ☐ Loss of muscle strength?
- ☐ Lump pr swelling in muscle or on bone?
- ☐ Back or neck pain?

ENDOCRINE
- ☐ Thirsty all the time?
- ☐ Cold most of the time?
- ☐ Warm most of the time?
- ☐ Unusually tired or sluggish?
- ☐ Unusually jumpy or nervous?
- ☐ History of thyroid or goiter?

NEUROLOGY
- ☐ Problems with moving, controlling or shaking of body parts?
- ☐ Numbness, tingling or prickly sensation in any part of the body?
- ☐ Trouble keeping balance?
- ☐ Any decrease in size or strength of any muscles?

GENERAL
- ☐ Skin problems?_____
- ☐ Changing moles?
- ☐ Bruise or bleed easily?
- ☐ Recurrent fevers or chills?
- ☐ Depressed frequently?
- ☐ Difficulty sleeping?
- ☐ Tendency to worry a lot?
- ☐ Lose temper often or have a violent temper?
- ☐ Feeling stressed?
- ☐ If married, marriage problems?
- ☐ Problems with sex?
- ☐ Have you ever considered or attempted suicide?
- ☐ Ever seen or would like to see a psychiatrist?

TO BE ANSWERED BY WOMEN ONLY
- ☐ Lumps, sores or infections in breast?
- ☐ Menstrual periods? Date of last period_____
- ☐ Menopause?
- ☐ Bleeding or spotting between menstrual period?
- ☐ Pelvic exam or pap smear within the last year?
- ☐ History of venereal disease?
- ☐ Itching in vaginal area?
- ☐ Discharge from vaginal area?

  Number of pregnancies_____

  Number of babies given birth to_____
- ☐ Any miscarriages, stillbirths, or abortions?
- ☐ Pregnant now?

TO BE ANSWERED BY MEN ONLY
- ☐ Any problems with prostate gland?
- ☐ Any problems starting urine stream?
- ☐ Any decrease in size or force of stream?
- ☐ Any discharge from penis?
- ☐ Rupture or hernia?
- ☐ Any other problems with scrotum, testes, or penis?

_____

Ralston Family Physicians - Patient Medical History

Date_____

Patient Name_____ Date of Birth _____

Age_____ HT_____ WT_____ Marital Status: Single Married Seperated Divorced Widowed

Main Concern Today _____

_____

Allergies: (List all medications and other items which cause allergies)

_____

Medications: (List all current medications- Prescription and Nonprescription)

_____

Immunizations - Indicate Date

Tetanus _____ Hep B _____ Other _____

Flu Shot _____ Pumovax _____

Hep A _____ TB skin Test _____

Social History:

Tobacco Use	Y / N	Number of packs per day _____ Number of Years _____
Alcohol Use	Y / N	Number of drink per week _____
Drug Use	Y / N	If yes, what? _____

Family History:

	Age if living	Health condition	Cause of Death / Age
Father			
Mother			
Brother			
Sister			
Children			

Please check any you have been diagnosed with:

- ☐ Allergies - Hayfever
- ☐ Anemia
- ☐ Angina Of Heart Disease
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Infections
- ☐ Bronchitis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema / COPD
- ☐ Gallbladder Disease
- ☐ Gastoesophageal Reflux
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Joint Disease
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Meningitis
- ☐ Migraines - Headaches
- ☐ Mononucleosis
- ☐ Nervous Breakdown
- ☐ Pancreatitis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinusitis
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other

Surgery : (Please Check if any of the following pertain to you and explain)

- ☐ Any Surgeries_____
- ☐ Blood Transfusions _____
- ☐ Major illiness or injury requiring hospitalization _____

PATIENT RESPONSIBILITIES
VERIFICATION OF UNDERSTANDING AND AKNOWLEDGEMENT

IT IS THE RESPONSIBILITY OF THE PATIENT TO:

1. Provide a copy of any and all medical insurance card and valid ID.
2. Provide this office with complete personal information requested on this form and notify this office of any changes including address, phone, employment and insurance.
3. Pay co-pays, deductibles and/or percentages due at the time of services.
4. Comply with the medical advice, instructions and plan of care given to you by your physician.
5. Allow 48 to 72 business hours to refill prescriptions.
6. Maintain a respectful tone and demeanor to the physician and staff.
7. Respect the privacy of all the other patients in this office and anyone in the waiting area.
8. Read the notice issued to me of Privacy Practices, and uses and disclosures for treatment, payment and health care operations.
9. Reimbursement is due in full within 30 days of our submitting the claim to the insurance company. If your insurance company does not respond or delays payment for any reason beyond 30 days, as required by Nevada State Law, the patient and /or guarantor is responsible for the balance due.
10. If Ralston Family Physicians is not contracted with your insurance plan it is your responsibility to pay for all charges occurred at the time of service. We will courtesy bill your insurance for you and a refund can be requested when the insurance pays on the charges. _____int.
11. If you do not have insurance you are required to pay for services prior to being seen. _____ int.
12. **NO NEW PATIENTS REQUIRING LONG TERM NARCOTICS OR PAIN MANAGEMENT!** _____int.
13. Know the benefits and providers allowed by your insurance network.
    Please note the following that your insurance requires you to use:

    Hospital_____ Lab_____

BY SIGNING THIS FORM I AGREE, UNDERSTAND AND WILL FOLLOW THE PRIVACY PRACTICES, AND AGREE TO THE PATIENT RESPONSIBILITIES.

SIGNATURE_____ **DATE**_____

PRINT NAME_____

Ralston Family Physicians

☐ Donald Farrimond, M.D. ☐ Thomas O'Gara, M.D. ☐ Shannon Zambonl, M.D. ☐ Z. Baumgardner

Patient Information

Registration Date:

Name (Last, First, Middle)	Social Security Number	Date of Birth

Address (Street, City, State, Zip)	Phone Number

Mailing Address	E-Mail	Cell Phone

Status: Child Single Married Separated Sex: Male / Female

Employer Information

Name	Phone Number

Address (Street, City, State, Zip)	

Parent or Spouse Information

Name (Last, First, Middle)	Social Security Number	Date of Birth

Employer (Name and Address)	Phone Number

In Case Of Emergency

Name	How Related?

Address (Street, City, State, Zip)	Phone Number

Insurance Information

Insurance plan Name	Phone

Address (Street, City, State, Zip)		

Name of Insured	DOB	Social Security Number

Insurance ID#	Group #	Effective Date

Advanced Directive / Living Will

Do you have an Advanced Directive? Yes / No

If NO would you like to obtain one with Ralston Family Physicians? Yes / No