Patient Registration *(please print clearly)*

Last Name: ______________________ First: ______________ Middle: ____________

Preferred Name: ____________________ Date of Birth: __________ Birth Sex: ☐ Male ☐ Female

SSN: ____________ Driver License #: ____________ Preferred Language: ______________

I identify as: ☐ Female ☐ Female-to-Male Transgender ☐ Non-Conforming
☐ Male ☐ Male-to-Female Transgender
☐ Other: ________________________ ☐ Decline to answer

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ African American
☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Address: ______________________ City: ____________ State: ______ Zip: _______

Mailing Address: ______________________ City: ____________ State: ______ Zip: _______

Primary Phone: ______________ ☐ Home ☐ Work ☐ Cell Email: __________________

Secondary Phone: _____________ ☐ Home ☐ Work ☐ Cell

Preferred Pharmacy: __________________ Appointment Reminders OK? ☐ Yes ☐ No

Ok to leave message on: Home? ☐ Yes ☐ No Work? ☐ Yes ☐ No Cell? ☐ Yes ☐ No

Emergency Contact: __________________ Phone: ____________ Relationship: __________

Emergency Contact: __________________ Phone: ____________ Relationship: __________

Employer: ________________________ Phone: ____________ Occupation: __________

PRIMARY INSURANCE INFORMATION

Policy Holder: _____________ DOB: __________ SSN: __________ Relationship: __________

Primary Insurance: __________________ Policy #: ____________ Group #: ____________

SECONDARY INSURANCE INFORMATION

Policy Holder: _____________ DOB: __________ SSN: __________ Relationship: __________

Secondary Insurance: ________________ Policy #: ____________ Group #: ____________

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Mountainview to provide my insurance companies with all information necessary to process insurance claims and assign payments to Mountainview all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. I have read and understood all of the above.

Signature: ____ Date: ______________

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Authorization for Communication of Protected Health Information to Family and Friends

Patient Name ______________________ Date of Birth ______________

Home Phone Number ______________________ Cell Phone Number ______________________

Address ______________________ City ______________ State ______ Zip ______

I, ______________________________, authorize Mountainview to discuss/share my protected health information with the following individual(s):

Name	Relationship	Phone Number

Type of information to be shared or disclosed:

- ☐ Appointment Information
- ☐ Medical Information
- ☐ Prescription Information
- ☐ Mental Health Information
- ☐ Lab/Imaging Results
- ☐ Any Information

☐ **I do not authorize** Mountainview to share my protected health information with any individuals.

I authorize Mountainview to leave detailed messages about my medical and health information on the following:

- ☐ Cell Phone Voicemail
- ☐ Home Phone Voicemail

Signature: ______________________________________ Date: ______________

(This authorization shall remain in effect until revoked by the patient or for 1 year. You may request a new form at any time. Submitting a new form will replace the existing form.)

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Medical Record Release

I hereby authorize:

Name of disclosing party

Address

City State Zip

To disclose to:

Name of recipient

Address

City State Zip

RECORDS AND INFORMATION FOR THE PAST TWO (2) YEARS PERTAINING TO:

Patient name (list other names used) SSN Date of Birth

Address Phone number

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here ______________ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

- ☐ Medical information ________ (initials)
- ☐ Psychiatric information — Signature ________ Date ________
- ☐ Drug/Alcohol Information — Signature ________ Date ________
- ☐ Results of HIV Test — Signature ________ Date ________
- ☐ Genetic Records — Signature ________ Date ________
- ☐ Other Health Information ________ (initials and specify below)
- ☐ Specify the records to be disclosed: ________________

This authorization ☐ **does** / ☐ **does not** discontinue my care through Mountainview.

The recipient may use the health information authorized on this form for the following purposes:

____

Signature Date If signed by other than patient, indicate relationship

(A copy of this authorization is as valid as the original. Patient has a right of receive a copy of this authorization.)

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Health History

Name ____ Date ____________

Date of birth ____________ Referred by ______________________________

Are you under the care of any other physician/provider? ☐ Yes ☐ No

Please list other health care providers ______________________________

SOCIAL HISTORY

Women Only

First menstrual cycle (age) ____________ Present form of birth control ____________

Date of last menstrual cycle ____________ # of pregnancies ________ Full-term ________ Live births ________

Date of last mammogram ____________ Date of last pap smear ____________

Men Only

Date of last prostate exam ____________ Date of last PSA test ____________

Date of last colonoscopy ____________ Date of last Dexa Scan ____________

LIFESTYLE

Exercise

What do you do? ____________________ How long? ____________ How often? ____________

Can you walk a block or climb a flight of stairs without getting short of breath? ☐ Yes ☐ No

Tobacco Use

Do you currently use any forms of tobacco? (please specify what type) ____________________

If yes, how frequently is your usage? ____________________ Are you interested in quitting? ☐ Yes ☐ No

If no, do you have a history of tobacco use? ☐ Yes ☐ No

Alcohol

How many drinking days do you have per week? ________ On average, how many drinks per drinking day? ________

Have you had more than 4 drinks a day in the past 3 months? ☐ Yes ☐ No

Are you or others concerned about your drinking? ☐ Yes ☐ No

Falls

Have you fallen in the past year? ☐ Yes ☐ No

Do you have problems with walking or balance? ☐ Yes ☐ No

Safety

Are you in a relationship that makes you feel unsafe or have been hurt? ☐ Yes ☐ No

Do you regularly wear a seatbelt? ☐ Yes ☐ No

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Health History *(continued)*

HIV Testing

Would you like HIV testing? ☐ Yes ☐ No (If yes, please tell the nurse). HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

Caffeine

How much caffeine do you consume per day? (e.g. coffee, tea, chocolate, soda) ______________________________

Birth Control

Method (if applicable): ____

Sleep

Do you stop breathing during sleep or have concerns about sleep apnea? ☐ Yes ☐ No

Depression Screen

Recently, have you been bothered by little interest or pleasure in doing things, or feeling down, hopeless, or depressed? ☐ Yes ☐ No

Medications

Medications *(please list all)*	Dose *(Mg., pill, etc.)*	Times Per Week

(If you need more room to list additional medications, please write them on a blank sheet of paper with the required information)

Do you have any trouble taking any of your medications? ☐ Yes ☐ No

Allergies

Allergies *(environmental, food, drug)*	Reaction *(symptoms)*	Severity

(If you need more room to list additional allergies, please write them on a blank sheet of paper with the required information)

Bladder Control

Do you lose control of your urine to the point you would like to know how to treat it? ☐ Yes ☐ No

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Health History *(continued)*

PAST MEDICAL HISTORY (check all that apply)

☐ Cancer (type and location) ______________________
☐ Coronary artery disease
☐ Diabetes Type I
☐ Diabetes Type II
☐ Heart infections/inflammation
☐ Heart malformations
☐ Heart muscle disorders
☐ Heart rhythm
☐ High blood pressure
☐ Hypothyroidism
☐ Psychiatric condition
☐ Other ______________________

Diabetic Patients

Date of last foot exam ____________ Date of last eye exam ____________

Date of last A1c ____________ Date of last cholesterol panel ____________

PREVIOUS SURGERIES

	Type	Year	Surgeon	City
1				
2				
3				
4				

FAMILY HISTORY

Father (if living) Age ________ Health ______________________

Mother (if living) Age ________ Health ______________________

Father (if living) Age of Death ________ Cause ______________________

Mother (if living) Age of Death ________ Cause ______________________

Children

of Children ________ # living ________ # deceased ________ Ages of each ______________________

Serious illnesses of children

FAMILY MEDICAL HISTORY (Please check and note relationship. If grandparent, please specify paternal.)

☐ Cancer (type and location) ______________________
☐ Coronary artery disease
☐ Diabetes Type I
☐ Diabetes Type II
☐ Heart infections/inflammation
☐ Heart malformations
☐ Heart muscle disorders
☐ Heart rhythm
☐ High blood pressure
☐ Hypothyroidism
☐ Psychiatric condition
☐ Other ______________________

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Review of Symptoms

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

Constitutional Symptoms
- ☐ Fever
- ☐ Weight loss
- ☐ Extreme fatigue

Eyes
- ☐ Double vision
- ☐ Sudden loss of vision

Ears, Nose, Mouth, and Throat
- ☐ Sore throat
- ☐ Runny nose
- ☐ Ear pain

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools

Genitourinary
- ☐ Irregular menses
- ☐ Bloody urine
- ☐ Vaginal bleeding after menopause
- ☐ Frequent or painful urination
- ☐ Impotence

Skin
- ☐ Rash
- ☐ Changing Mole

Sleep
- ☐ Snoring
- ☐ Difficulty sleeping

Neurological
- ☐ Headache
- ☐ Persistent weakness on one side of the body
- ☐ Falling

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle weakness

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts

Endocrine
- ☐ Excessive thirst
- ☐ Cold or heat intolerance
- ☐ Breast mass

Hematologic
- ☐ Unusual bruising or bleeding
- ☐ Enlarged lymph nodes

Allergic
- ☐ Hay fever

IF YOU HAVE ONE OF THE FOLLOWING CONDITIONS PLEASE ANSWER:

Diabetes
Any problems with medications? ☐ Yes ☐ No Home glucose readings: ______________________________

High Blood Pressure
Any problems with medications? ☐ Yes ☐ No Home blood pressure readings: ______________________________

High Cholesterol
Any problems with medications? ☐ Yes ☐ No

Depression
Any problems with medications? ☐ Yes ☐ No Any suicidal thoughts? ______________________________

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Review of Symptoms *(continued)*

Please identify any issues on this form which are new or that you specifically want to address:

If you need help between appointments, please call our office at (541) 471-2701.

Our goal is to see you the day you call in or the next day. It is helpful if you call first thing in the morning. One of our nurses will help you decide if you need to be seen and if any tests are needed prior to your appointment.

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