Health Center
at Touro University Nevada

Name: _____ DOB: _____

Circle any you may have or have had:

Arthritis	Drug Abuse	Miscarriages
Asthma	Alcohol Abuse	Pneumonia
Bleeding Tendency	Heart Disease	Scoliosis
Blood Transfusions	Hepatitis (B,C)	Skin Disease
Cancer	High Cholesterol	Stroke
Cataract	HIV	Tuberculosis
COPD	Hypertension	Ulcers
Diabetes	Kidney Disease	Sexually Transmitted
Blood Clot	Mental Illness (Depression/Anxiety	Disease
Thyroid Disease	Osteoporosis	

Explain any circled items or add any other problems you may have had.

_____

_____

_____

_____

FAMILY HISTORY: *(List any diseases by family member (i.e. hypertension, diabetes, heart attack, stroke or cancer)*

Relative / Relationship **Illness/Medical Condition**

Mother_____

_____

Father_____

_____

CURRENT MEDICATIONS: *(prescription and over the counter)*

Name **Strength** **Frequency**

_____

_____

_____

_____

_____

_____

If you have any further medications, please list them on the back of this form.

ALLERGIES (*Medications, foods, etc. and list the reaction*)

_____

_____

_____

_____

Name: _____ DOB: _____

SURGICAL HISTORY

Year	Operation	Reason for Surgery	Hospital/Location

SOCIAL HISTORY

Do you smoke?_____ How much per day?_____ How many years?_____
Do you drink alcohol? _____ Do you use any narcotics or addicting medications?_____
Do you use caffeine (coffee, soda, tea?)_____
What is your marital status? Single Married Divorced Separated Widowed Partner
What is your occupation?
Are you in danger either from yourself or someone else? ____ Yes ____ No

PREVENTIVE CARE

When was the last time you had each of the following? (circle if it was normal or abnormal)

Pap Smear? _____ Normal /Abnormal
Mammogram? _____ Normal /Abnormal
Bone Density Scan?_____ Normal /Abnormal
Colonoscopy?_____ Normal /Abnormal
Cholesterol check?_____ Normal /Abnormal
Prostate exam?_____ Normal /Abnormal
EKG?_____ Normal /Abnormal
Chest Xray?_____ Normal /Abnormal

IMMUNIZATIONS

Tetanus shot? ____Yes ____No _____Date
Pneumonia? ____Yes ____No _____Date
Flu? ____Yes ____No _____Date
Shingles? ____Yes ____No _____Date

PREGNANCY HISTORY

How many pregnancy's?_____
How many were? Live Birth_____ Miscarriage_____
Termination_____ Tubal_____

Please list all other physician's names, address, phone number and fax number that you currently see.

_____
_____
_____
_____

Name_____ Date_____

Review of Systems: Are you currently having any problems related to the following systems? Check Yes or No

General

Feeling well	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No
Weight gain	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No
Fever	☐ Yes ☐ No

Integumentary (skin)

New or changing moles	☐ Yes ☐ No
Itching	☐ Yes ☐ No
Rash	☐ Yes ☐ No

HEENT

Eye pain	☐ Yes ☐ No
Change in vision	☐ Yes ☐ No
Change in hearing	☐ Yes ☐ No
Ear pain	☐ Yes ☐ No
Runny nose	☐ Yes ☐ No
Difficulty swallowing	☐ Yes ☐ No

Respiratory

Cough	☐ Yes ☐ No
Snoring	☐ Yes ☐ No
Difficulty breathing	☐ Yes ☐ No

Breast

Breast mass	☐ Yes ☐ No
Breast pain	☐ Yes ☐ No
Nipple discharge	☐ Yes ☐ No

Cardiovascular

Chest pain	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No
Swelling in legs	☐ Yes ☐ No

Gastrointestinal

Abdominal pain	☐ Yes ☐ No
Black or bloody stool	☐ Yes ☐ No
Constipation	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No
Heartburn/indigestion	☐ Yes ☐ No
Nausea	☐ Yes ☐ No
Vomiting	☐ Yes ☐ No

Genitourinary-Female

Change in urination	☐ Yes ☐ No
Menstrual irregularities	☐ Yes ☐ No
Awaken at night to urinate	☐ Yes ☐ No
Painful urination	☐ Yes ☐ No
Strong/sudden urge to urinate	☐ Yes ☐ No
Vaginal discharge	☐ Yes ☐ No
Vaginal bleeding	☐ Yes ☐ No

Genitourinary-Male

Change in urination	☐ Yes ☐ No
Impotence	☐ Yes ☐ No
Urine loss/leakage	☐ Yes ☐ No
Awaken at night to urinate	☐ Yes ☐ No
Difficulty emptying bladder completely	☐ Yes ☐ No

Musculoskeletal

Back pain	☐ Yes ☐ No
Joint pain	☐ Yes ☐ No
Have you given up any activity due to pain?	☐ Yes ☐ No

Neurological

Numbness/tingling	☐ Yes ☐ No
Difficulty speaking	☐ Yes ☐ No
Headaches	☐ Yes ☐ No

Psychological

Difficulty with sleep	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Depression	☐ Yes ☐ No

Endocrine

Excessive thirst	☐ Yes ☐ No
Heat intolerance	☐ Yes ☐ No
Cold intolerance	☐ Yes ☐ No

Hematology

Easy Bruising/	☐ Yes ☐ No
Nosebleeds (Epistaxis)	☐ Yes ☐ No

Touro Health Center

PATIENT INFORMATION

Name:	Home Tel:
Address One:	Work Tel:
APT #:	Cell #:
City:	Sex: F
State: NV Zip:	DOB:
Usual Provider:	SS#:
Referring Physician:	Employer:
Referring Physician Address:	Email:
Ste:	Marital Status:
City:	Relation to Guarantor:
State: Zip:	Race:
Referring Physician Phone:	Ethnicity:
Primary Care Doctor:	Language:
Primary Care Doctor Address:	How Did You Hear About Us:
Ste:	TUN:
City:	
State: Zip:	
Primary Care Doctor Phone:	

GUARANTOR INFORMATION

Name:	Home Phone#:
Address One:	Work Phone#:
Address Two:	Cell Phone#:
City:	Sex: F
State: NV Zip:	DOB:
	SS#:
	Employer:
	Relationship to Patient:

Emergency Contact

Emergency Contact Name:	Emergency Contact Home Tel:
Emergency Contact Address:	Emergency Contact Work Tel:
APT #:	Emergency Contact Cell:
City:	Relation To Patient:
State: Zip:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Sub DOB: Sub Sex: M F	Sub DOB: Sub Sex: M F

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider, Touro University when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, Touro University to release any information necessary for my course of treatment.

_____ _____

Signature (patient or parent if minor) Date

Health Center
at Touro University Nevada

General Consent to Treat / Patient Authorization / Acknowledgement of Benefits Release

The following are the conditions for services provided by Touro University Nevada Health Center for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/We voluntarily consent to medical treatment and diagnostic procedures provided by Touro University Nevada Health Center and its associated physicians, clinicians, and other personnel. I/We consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/We am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning, and further medical treatment. To include information referring to psychiatric care, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/We also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law. I/We fully understand that, as part of a teaching institution, information may be collected from the patient encounter or chart in order to collect data. I/We understand that personal health information may be used or disclosed for the purposes of carrying out treatment, evaluating the quality of services proved and any administrative operations related to treatment or payment. I/We understand that I/we have the right to restrict how the personal health information is to be used and disclosed for treatment, payment and administrative operations if I/we submit a written request. I/We understand that each request will be considered for restriction on a case-by-case basis.

ASSIGNMENT OF INSURANCE BENEFITS

I/We guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Touro University Nevada Health Center. I/We understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/We understand that Touro University Nevada Health Center can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/We have provided all necessary information for proper assignment of Medicare benefits.

ROUTINE PHYSICAL APPOINTMENTS

I understand a routine physical appointment cannot be accompanied with any health complaints or abnormalities. I understand that if any complaints or abnormalities are addressed with the physician the visit may not be billed as a routine physical and I may be responsible for all copays, deductibles or co-insurance costs associated with the visit.

_____*Initials*

LAB DISCLAIMER

It may be necessary to perform or request lab work (cultures, pap smears, biopsies, lab work, etc.). Our office may send you directly to the Lab of your choice. Our office may send out a specimen to a Lab of the Physician's choice, but will consider your insurance carrier. Each test may have more than one fee depending on the complexity. Your insurance carrier may not cover certain tests. It is your responsibility to know your benefits. We cannot change any coding (CPT Procedure Codes or ICD-9 Diagnosis Codes) to conform to your plan's coverage or benefits.

Below check the Laboratory that is contracted with your insurance.

_____ Lab Corp
_____ Quest
_____ CPL
_____ Other _____.

_____ *Initials*

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION

I understand that Nevada Worker's Compensation law provides that written information pertaining directly to a worker's compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the NV Code NRS616C.050. I/We authorize Touro University Nevada Patient Clinic to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.

CONTROLLED SUBSTANCE PRESCRPTIONS

Touro University Nevada Patient Clinic reserves the right not to prescribe narcotic medications. If you take narcotic medications for pain control on a regular basis, you must see a pain management physician. No narcotic prescriptions will be given for new patients on the initial visit until a complete work up has been performed and old records have been received. Controlled substance medications (narcotics, anti-anxiety, sleeping mediations, etc.) are very useful, but have high potential for misuse and abuse. These drugs are closely controlled by local, state, and federal government. They are intended to relieve pain, to improve function and/or ability to work, not simply to feel good. If you are prescribed such medications to help manage pain, you are responsible for the controlled substance medication. If the prescription is lost, misplaced, stolen, or use up medication sooner than prescribed, it will not be replaced. You cannot request nor accept substance medication from any other physician or individual while you are receiving this medication from your doctor. Prescription Refills of controlled substance cannot be called in to the pharmacy. They must be hand written and you must attend your scheduled appointment. You will be informed by your doctor about any side effects, including normal psychological effects of tolerance and dependence.

INFORMATION RELEASE

Other Person(s) authorized to discuss any medical information (including appointments, billing and insurance):

Full Name	Phone Number	Relationship

CONFIDENTIAL COMMUNICATION

You may request to receive confidential communications of Protected Health Information (PHI), i.e. Lab results, x-ray results, referral/prior authorization, prescription refills, in the method you prefer. ***Please select all that apply.***

I authorize Touro University health center to leave PHI messages at the following:

- ☐ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN A CALL
- ☐ Home Voicemail ( ) _____
- ☐ Cell Voicemail ( ) _____
- ☐ Work Voicemail ( ) _____
- ☐ Patient Portal Web Message (email address required) _____

MEDICAL STUDENTS

You have the opportunity to assist future healthcare professionals by allowing them to participate with your physician in your appointment(s). **Please indicate below your preference to participate.**

- ☐ I will allow a medical student to participate in my appointment(s)
- ☐ I will not allow a medical student to participate in my appointment(s)

_____ *Initial*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/We have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time.

Signature of Patient, Parent, Guardian or Legal Representative	Print name of Patient, Parent, Guardian or Legal Representative / Relationship to patient	Date
Signature of Witness	**Please print name of Witness / Relationship to Patient**	**Date**

Health Center
at Touro University Nevada

Welcome to our Practice

Our Mission

The mission of Touro University Nevada Health Center is to provide quality patient care in a compassionate, timely and confidential manner, emphasizing holistic, osteopathic principles, preventative health care, patient education and shared decision making.

Appointments

Appointments for the clinic are scheduled Monday thru Thursday (8am – 5:00pm) and Fridays (8am – 3:00pm). Appointments are scheduled according to the treating physician. ***New patients*** *must arrive* ***45 minutes*** *prior to their scheduled appointment to fill out the proper paperwork or they will be rescheduled.* ***Existing Patients*** *must arrive 30* ***minutes*** *prior to their scheduled appointment and must not be late or they may be rescheduled. Any special appointment times are to be given directly from the doctor.*

Referrals

If a referral is required, we will complete the necessary paperwork and submit to your health plan for authorization. It has been our experience that each health plan varies in its response timeliness.

Financial Policy

Our physicians are providers with traditional insurance health plans. If you have any questions about whether any of our physicians are participants in your health plan, please call or directly speak with our office staff and your insurance company. Co-payments/Deductibles are due at the time of service.

Emergency / Non-Emergency Care

If you believe you have an emergency, please call 911. Your health plan may require that any non-emergency health care received outside of our office also receive prior authorization from your health plan and your physician. If authorization is not obtained, you may be financially responsible for the services rendered.

Billing

Insurance is billed as a courtesy to the patient. Please direct all billing inquiries and account questions to (702)777-3197. Patients without insurance are required to pay for services in full at the time of service. A minimum of $125 will be collected at check-in. If the total amount of the visit is more than $125, the balance is due at checkout. If the total amount is less than $125, the balance is refundable at checkout. Power of Attorney verification is expected at the first visit. Any medical records or test results requested by another physician's office may be sent by fax/mail at no charge. Patients requesting medical records/test results will be charged $.60 per page. Payment is expected prior to the release of records.

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