New Patient Registration Form

Alpine Healthcare

First Name	Middle Name	Last Name		
Address		City	State	Zip
Sex	Marital Status	Date of Birth	Social Security Number	
Mobile Phone	Home Phone	Email		
Referred By:	Previous Primary Care Provider	Pharmacy Name		
Pharmacy Phone	Pharmacy Address or Cross streets			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone		
Employer/School Address		City	State	Zip

Emergency Contact Information

Name	Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan		
Plan Number	Group Number	Insured's Employer		
Insured's Name		Relation to Patient	Insured's Phone	
Insured's Address		City	State	Zip
Insured's Social		Insured's Date of Birth		

Secondary Health Insurance

Insurance Company		Plan		
Plan Number	Group Number	Insured's Employer		
Insured's Name		Relation to Patient	Insured's Phone	
Insured's Address		City	State	Zip
Insured's Social		Insured's Date of Birth		

Patient Name: _____

Gender____ Date of birth: _____ Age: _____

Reason for Visit

_____

_____

_____

Current Medications:

Name	Dosage	Frequency

Allergies

Do you have any allergies?

Name	Reaction

Preventative Exams:

Last Colonoscopy: _____

Last Flu shot: _____ Pneumonia shot: _____

For Women only:

Last Pap smear: _____ Mammogram: _____

Last Menstrual Period: _____

Birth control method: _____

Past Medical History

- ◯ Alcoholism
- ◯ Allergies
- ◯ Anemia
- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ AIDS/HIV
- ◯ Back problems
- ◯ Bleeding issues
- ◯ Blood disease
- ◯ Blood transfusion
- ◯ Cancer
- ◯ Diabetes
- ◯ Depression
- ◯ Ear problems
- ◯ Eating disorder
- ◯ Epilepsy
- ◯ Glaucoma
- ◯ Gout
- ◯ Heart Disease
- ◯ Heart Attack
- ◯ Hepatitis
- ◯ High blood pressure
- ◯ High cholesterol
- ◯ Joint disorder
- ◯ Kidney disorder
- ◯ Liver disorder
- ◯ Lung disease
- ◯ Measles
- ◯ Migraines
- ◯ Osteoporosis
- ◯ Pneumonia
- ◯ Stroke
- ◯ Skin disorder
- ◯ STDs
- ◯ Substance abuse
- ◯ Thyroid disorder
- ◯ Tuberculosis
- ◯ Others: _____ _____ _____

Hospitalizations and Surgeries

Reason	Date

Social History

Are you sexually active? ◯ Yes ◯ No

# of partners in the last year? _____

Do you want to be checked for STDs? ◯ Yes ◯ No

Have you ever smoked? ◯ Yes ◯ No

# of years? _____ # packs/day _____

Do you smoke now? ◯ Yes ◯ No #pack/day _____

Do you use recreational drugs? ◯ Yes ◯ No

Types? _____ # times/week _____

Family History

Mom	
Dad	
Siblings	
Grandparents	
Others:	

How much alcohol do you drink per week? _____

How much caffeine do you drink per day? _____

How often do you exercise in a week? _____

Who do you live with at home? _____

Other Medical Providers

What other providers or physicians do you see and what for?

Name	Reason

Other additional information:

Responsible Party

Billing Name	Phone	Relation to Patient		
Address		City	State	Zip

I certify that I am the patient or duly authorized to complete this form. I understand that even though I have insurance coverage, I am responsible for any balances, co-pays or deductibles due on my account at the time of service.

NO SHOW POLICY: I understand that I need to call 24-hr ahead of my scheduled appointment to cancel or reschedule. Failure to do so may result to either $25.00 charge for no show, delay in next available appointment or be discharged from care and will need to find a new primary care provider.

FORMS: There is a $25.00 to $35.00 charge for forms that need to be completed by our office. For example, FMLA (Family Medical Leave Act), Work Clearance forms, Physical exam forms and others. Payment is due before forms are completed.

_____ _____

Signature of Patient or Authorized Guardian Date Today

Prescriptions and Refill Requests

Please call your preferred pharmacy for all refills. They will contact us with all the information we need to process your request. Also, please allow 3 working days not including weekends or holidays for all new prescriptions and refills.

If requesting on the phone, please leave a detailed message including your complete name, date of birth, medication name, dosage, pharmacy information and best number to call you back.
Please make sure that is your responsibility as the patient to make sure you call ahead of time for prescription refills.

_____ _____

Signature of Patient or Authorized Guardian Date Today

Laboratory Notification

Our office utilizes several laboratories for blood test, pap smears and urine specimens.
If your insurance required you to utilize a *particular laboratory*, you will need to inform our staff every time you come in to our office.

It is your responsibility as a patient to be knowledgeable of your benefits. If you are unsure whether your insurance company requires you to use a specific laboratory, please contact them directly for that information.

Please note, it is our company's policy to discuss all test results including lab work, x-ray, ultrasound, CT scan, MRIs, etc. in the office during your visit with the provider.

_____ _____

Signature of Patient or Authorized Guardian Date Today

Alpine Healthcare
3061 S. Maryland Pkwy., Ste 104 Las Vegas NV 89109
Ph: (702) 438-5555 Fax: (702) 438-6666

HIPPA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

Obtain payment from designated third-party payers.

Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information available in office. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Authorized Guardian Date Today

Alpine Healthcare
3061 S. Maryland Pkwy., Ste 104 Las Vegas NV 89109
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Controlled Substance Contract

The purpose of this contract is to prevent misunderstandings about certain medications you may be prescribed that is controlled (This includes controlled medications schedule I-V; for example, pain medications, benzodiazepines, sleep medications, stimulants, etc.). This is to help both you and your provider to comply with the state and federal regulations regarding controlled pharmaceuticals. This contract is essential to the trust and confidence necessary in the provider/patient relationship and treatment rendered.

Please read, initial and sign.

1. I understand that if I break this contract, my provider may stop prescribing me controlled medications. _____
2. I will communicate fully with my provider about my pain, anxiety and sleep issues and the effect this has on my daily life as well as how well the prescribed medication is helping to relieve my symptoms. _____
3. I will not use any illegal substance including marijuana (unless I have a medical marijuana license), Cocaine, Meth, etc. _____
4. I agree to use my medication only as the provider has prescribed it. _____
5. I agree to bring all my unused pain, anxiety or any controlled medication with me to each provider's visit. _____
6. I will not share, trade or sell my medications with anyone. _____
7. I will not attempt to obtain any controlled medications from any other provider and I understand a Prescription Monitoring Report can be accessed at anytime by my provider and pharmacy to confirm this. _____
8. I will safeguard my controlled medications from loss or theft and I understand loss of stolen pain medications will not be replaced. _____
9. I agree to submit to a random blood or urine drug test, if requested by my provider, to determine my compliance with this contract. _____
10. I agree to use the same pharmacy for all my controlled medication refills. _____
11. I understand that the pharmacy has the right to hold my prescription until its validity can be verified and that the pharmacist has the right to refuse to fill my prescription at anytime. _____
12. I authorize the provider and the pharmacy to cooperate fully with any city, sale or other diversion of my controlled medications. _____
13. I authorize Alpine Healthcare to provide a copy of this signed agreement to my pharmacy upon request. _____
14. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. _____
15. I agree to follow all of these guidelines as they have been fully explained to me. _____
16. I agree that all of my questions and concerns have been addressed adequately and a copy of this signed contract will be provided to me. _____

This contract was entered into on _____ day of _____, _____.

_____
Patient Name Printed

_____
Signature of Patient or Authorized Guardian

Stacey Cadaval, DNP
Provider

Stacey Cadaval DNP
_____
Provider Signature

Alpine Healthcare
3061 S. Maryland Pkwy., Ste 104 Las Vegas NV 89109
Ph: (702) 438-5555 Fax: (702) 438-6666

Patient Health Questionnaire (PHQ2)

Patient Name: _____ **Date Today:** _____

Over the past 2 weeks, have you been bothered by any of the following problems?		
1. Little interest or pleasure in doing things	Yes	No
2. Feeling down, depressed or hopeless	Yes	No

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Authorization to Disclose Health Information to Family Members and Friends

Patient Name _____ Date of Birth____/____/____

I, _____ hereby authorize Alpine Healthcare to release my Protected Health Information to_____

_____
either in person, telephone or in writing.

Protected Health Information ("PHI") may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I am not required to sign this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

_____ _____

Patient Signature or Responsible Party Date

Alpine Healthcare

Stacey Cadaval, DNP
3061 S. Maryland Pkwy., Ste 104 Las Vegas NV 89109
Ph: (702) 438-5555 Fax: (702) 438-6666

MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: _____

I hereby authorize:

_____

_____

to disclose the following medical records:

☐ Discharge summary (date): _____

☐ All test results (labs, imaging, stress test, ekg, etc)

☐ 3-4 most recent office visits

☐ All available medical record

☐ Other _____

To the office: ALPINE HEALTHCARE
Phone: (702) 438-5555
Fax: (702) 438-6666

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric or HIV testing results and information relating to my health. This authorization shall expire after the fulfillment of this request. This authorization may be revoked by me at anytime expect to the extent that action has been taken in compliance upon it. The revoke authorization form must be completed and submitted to the HIM services department. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

_____ _____

Signature of patient or responsible party Date

Alpine Healthcare

INFORMED CONSENT FOR THE PRESCRIPTION OF CONTROLLED SUBSTANCES

Patient:_____ Provider: _____

Medications:_____

In accordance with Nevada law AB 474, prior to giving me Controlled Substance prescription, my provider is required to obtain my written informed consent.

My provider has explained to me that these medications may include opioids and/or other drugs that can be used to treat pain, anxiety, insomnia, attention deficit disorder, depression and other conditions. I understand that these medications have known risks and side effects, and can be harmful if taken without medical supervision. I further understand that taking these medications can lead to tolerance, physical dependence, and/or developing an addictive disorder. Stopping the medication abruptly may lead to withdrawal symptoms and/or psychological dependence or addiction that is an abnormal psychological craving of the medication to the point of becoming a danger to oneself or others.

I understand that the most common side effects that can occur with the use of these medications include but are not limited to:

-Constipation	-Depression
-Nausea/vomiting	-Impaired Judgment and/or reasoning
-Excessive drowsiness or sleepiness	-Respiratory Depression
-Itching	-Impotence
-Urinary retention	-Tolerance to medications
-Low blood pressure	-Physical or psychological dependence
-Irregular heart rate	-Addiction
-Inability to sleep	-Death

I further understand that it may be dangerous for me to operate a motor vehicle or other machinery while taking these medications.

The risks, benefits and alternative treatments, including their risks and benefits have been explained to me. I understand that not every possible risk and benefit is listed on this form and that this consent includes the most common side effects or reactions. I acknowledge that I have been warned about the dangers of overdose and/or combining the prescribed medications with other drugs or alcohol may cause serious illness or death.

INFORMED CONSENT FOR THE PRESCRIPTION OF CONTROLLED SUBSTANCES

For Female patients in child bearing age
I understand that there are unknown side effects of the prescribed medications that could harm an unborn child. If I am not pregnant, I will use appropriate contraception (birth control) during the course of my treatment. If I become pregnant or am uncertain, I will notify my provider immediately.

For Minors
I have been informed of the risks that my child may abuse, misuse or divert these controlled substance medications. I have been informed of the ways to detect such misuse.

In addition I have been informed of

- Proper use of storage and disposal of these medications
- How refills will be addressed
- If the medication is an opioid, I understand that I can get the medication to counteract its effects (an opioid antagonist) without a prescription

The goal of this treatment is for the management of my current medical condition. I understand that my treatment plan will be tailored for me. I further understand that I may withdraw from this treatment plan and discontinue medication use at any time. I understand that prior to doing so I need to inform my provider since there may be a medical risk associated with abrupt termination of these medications.

I have been given an opportunity to ask questions about my condition and treatment and the risks and benefits of the prescribed controlled substance(s).

I authorize and direct my provider to prescribe controlled substance(s). I understand in order to initiate or continue treatment with controlled substances I must agree to the condition set forth above.

_____ _____ _____
Signature of Parent/Authorized Representative Date Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the prescribed medications to the patient or patient's legal representative. I have answered all questions fully and I believe the patient/legal representative fully understands that I have explained.

_____ _____ _____
Provider Signature Date Time

Patient's Name

Controlled Substance Questionnaire	YES	NO	N/A
N/A means not applicable.			
Have you ever used a controlled substance in a way other than prescribed?	____	____	____
Have you ever diverted a controlled substance to another person?	____	____	____
Have you ever taken a controlled substance that did not have the desired effect?	____	____	____
Are you currently using any drugs, including alcohol or marijuana?	____	____	____
Are you using any drugs that may negatively interact with a controlled substance?	____	____	____
Are you using any drugs that were not prescribed by a practitioner that is treating you?	____	____	____
Have you ever attempted to obtain an early refill of a controlled substance?	____	____	____
Have you ever made a claim that a controlled substance was lost or stolen?	____	____	____
Have you ever been questioned about your pharmacy report or PMP report?	____	____	____
Have you ever had blood or urine tests that indicate inappropriate usage of meds?	____	____	____
Have you ever been accused of inappropriate behavior or intoxication?	____	____	____
Have you ever increased the dose or frequency of meds without telling your provider?	____	____	____
Have you ever had difficulty with stopping the use of a controlled substance?	____	____	____
Have you ever demanded to be prescribed a controlled substance?	____	____	____
Have you ever refused to cooperate with any medical testing or examinations?	____	____	____
Have you ever had a history of substance abuse of any kind?	____	____	____
Has there been any change in your health that might affect your medications?	____	____	____
Have you misused or become addicted to a drug, or failed to comply with instructions?	____	____	____
Are there any other factors that your practitioner should consider before prescribing?	____	____	____

_____	_____	_____
Patient's Signature	Patient's Printed Name	Date
_____	_____	_____
Parent/Legal Guardian	Parent/Legal Guardian	Date

PRESCRIPTION OPIOID MISUSE INDEX

1. Do you ever use MORE of your medication, that is, take a higher dosage, than is prescribed for you? Yes No

2. Do you ever use your medication MORE OFTEN, that is, shorten the time between dosages? Yes No

3. Do you ever feel high or get a buzz after using your pain medication? Yes No

4. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain? Yes No

5. Have you ever gone to multiple physicians including emergency room doctors, seeking more of your pain medication? Yes No

6. Do you ever need early refills for your pain medication? Yes No