PATIENT INFORMATION SHEET

Patient Name: _____Jr. / Sr. / III
(Last) (First) (MI)
Marital Status: S M D W O Sex: M or F
Address (Mailing): _____
City: _____State: _____ Zip: _____
Physical Address (If Different): _____
Date of Birth: _____ Social Security #: _____ Email: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
Employer: _____ Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____
Whom may we contact in case of emergency: _____
Relationship: _____Phone: _____
Are there other members of the immediate family who have already been to this office? Y or N
If so, list their names:
_____

INSURANCE INFORMATION

Primary Insurance
Subscriber (whose job provides plan?):
_____
(Last) (First) (MI)
Subscriber's Date of Birth: _____Sex: M or F
Subscriber's Social Security #: _____
Insurance Company: _____ ID #: _____
Group#: _____
Second Insurance? Y or N
Subscriber's Date of Birth: _____ Sex: M or F
Subscriber's Social Security #: _____
Insurance Company: _____ ID #: _____
Group #: _____
If there is a third plan, please put information on back. Is this related to a Motor Vehicle Accident or Worker's Comp? _____

AUTHORIZATION TO PAY INSURANCE BENEFITS/CONSENT FOR TREATMENT

If required, I hereby authorize payment directly to the physician responsible for my care. I understand that I am financially responsible to my physician for all fees incurred and for fees not covered by this authorization. I authorize the release of my medical information to my third party payor in order to obtain payment. I hereby authorize the physician to release any medical information required for my examination or treatment. I understand that payment is expected at rendering of services unless other arrangements have been made. I hereby also consent to medical treatment for my present condition or injury, and for any illness or injury incurred at any time after the date noted below. I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I understand that even if I have some type of insurance coverage, I am responsible for payment of services.

_____
Signature of Responsible Party (relationship) Date

Print name

HEALTH HISTORY

Check symptoms you currently have or have had in the past year

General

_Chills
_Depression
_Nervousness
_Dizziness/Fainting
_Fever
_ Forgetfulness
_Headache
_Loss of Sleep
_Loss of weight
_Numbness
_Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:
_Arms _Hips
_Back _Legs
_Feet _Neck
_Hands _ Shoulders

Gastrointestinal

_Appetite Poor
_Bloating
_Bowel Discharge
_Constipation
_Diarrhea
_ Excessive Thirst
_ Gas
_Hemorrhoids
_Indigestion
_Nausea
_Rectal Bleeding
_ Stomach Pain
_ Vomiting Blood

Eye, Ear, Nose Throat

_Bleeding Gum
_Blurred Vision
_ Crossed Eyes
_Difficulty swallowing
_Double vision
_ Earache/Ear Discharge
_Hay Fever
_ Hoarseness
_ Loss of Hearing
_Nosebleeds
_Persistent cough
_Ringing in Ears
_Sinus Problems
_ Vision-flashes/halos

Men Only

_ Erection Difficulties
_ Lump in Testicles
_ Penis Discharge
_ Sore on penis
_Other

Women Only

_ Abnormal Pap Smear
_Bleeding between periods
_Breast Lump
_Extreme menstrual pain
_Hot Flashes
_Nipple discharge
_Painful Intercourse
_ Vaginal Discharge
Date of Last Period
Date of Last Pap smear
Have you had a Mammogram?
Are you Pregnant?
Number of Children

Genital-Urinary

_ Blood in urine
_Frequent urination
_Lack of bladder control
_Painful Urination

Cardiovascular

_Chest pain
_High/Low Rapid heartbeat
_Irregular/ Rapid Heartbeat
_Poor Circulation
_Swelling of ankles
_ Varicose Veins

Skin

_Bruise easily
_Hives
_Itching/Rash
_Change in Moles
_ Scars
_Sore that won't heal

Check condition you have or have in the past..

AIDS	Chicken Pox	HIV Positive	Polio	High Blood Pressure
Appendicitis	Diabetes	Kidney Disease	Prostate Problem	
Arthritis	Emphysema	Liver Disease	Rheumatic Fever	
Asthma	Epilepsy	Measles	Scarlet Fever	
Bleeding Disorders	Glaucoma	Migraine Headaches	Stroke	
Breast Lump	Heart Disease	Multiple Sclerosis	Thyroid Problem	
Cancer	Hepatitis	Mumps	Tuberculosis	
Cataracts	Herpes	Pacemaker	Ulcers	
Chemical Dependency	High Cholesterol	Pneumonia	Venereal Disease	

MEDICATIONS

List medications you are currently taking-

_____

ALLERGIES TO MEDICATIONS

_____

HEALTH HABITS

__CAFFEINE_____ __ STREET DRUGS_____
__TOBACCO_____ __ STRESS_____
__ HEAVY_____
__ HAZARDOUS SUBSTANCES_____
__OTHER_____

To the best of my knowledge, the about information is complete and correct. I understand that it is my responsibility to inform my doctor it I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or personal Representative Date

Print name of Patient, Parent, Guardian or personal Representative Date

Step Mountain Medical Family Practice
2332 West 12600 South, Suite 2C
Riverton, UT 84065

Kirt Larson, MSN, FNP-C
Jane Ricks, MD

AUTHORIZATION FOR TREATMENT FORM

Medical care is a patient care/service provided in response to a wide range of medical care/service needs of patients of all ages regardless of gender, color, race, creed, national origin, or disability, five days a week.

The purpose of medical care is to treat disease, injury, and disability by examination, testing, and use of procedures in the aid of diagnosis or treatment; to obtain information needed in diagnosing, and examination of patient; to prevent or minimize residual physical and mental disability; to aid patient in achieving their maximum potential within their capabilities; and to accelerate convalescence and reduce the length of functional recovery.

You are not expected to experience any increase in your current level of pain or discomfort. You are expected to cooperate fully with the examination and stop any test or treatment before any increase in your current level of pain or discomfort. Because of the nature of services provided you may be asked to disrobe or partially disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request the presence of another person of the same gender.

There are certain inherent risks with medical treatment. There is also a possibility that you could experience a new injury, but this risk is small and you will be able to control any procedure by stopping if you feel any increase in pain or discomfort. You will also be able to stop treatment if you feel any discomfort in any other part of your body. The treating medical practitioner will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure, which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. The clinic reserves the right to restrict visitors and outside communication at any time during your medical treatment sessions to ensure you receive the maximum therapeutic value from treatment. The law requires all staff members to report any evidence of abuse, neglect, and/or exploitation of patients. Should you observe any abuse, neglect, or exploitation by an individual in the clinic you are encouraged to report it immediately. Should you wish to file a complaint or grievance for any reason, you will be provided, in written form, with the names and addresses of appropriate individuals and protective agencies, and, if necessary, be given appropriate privacy to complete your communication with those individual agencies.

Based on the above information, I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of care services as it is established. I agree to pay a $10.00 surcharge fee if I do not pay my co-pay at the time of service. In addition, I understand that there will be 1.5% monthly interest charge to all balances left outstanding after 30 days of receiving my first invoice. In case of default or non-payment, I agree to pay all collection fees (approx 33.3%) and interest associated with the collection of monies owed. I also will pay all legal fees of collection, with or without pursuit, including attorney fees and court costs. I acknowledge that I have read and received copies of the Authorization for Treatment and Patient's Rights and Responsibilities, and authorize release of medical information to appropriate third parties.

NOTICE: For your personal safety, do not use or tamper with any equipment without a staff member present.

_____ ____/____/____
Patient's Signature Date

_____ ____/____/____
Parent or Guardian if Patient is under 18 Date

Step Mountain Medical Family Practice
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Riverton, UT 84065
Kirt Larson, MSN, FNP-C
Jane Ricks, MD

Notification and Acknowledgement of Notice of Privacy Practices Regarding Protected Practices Regarding Protected Health Information

Our Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information about you. As a patient you have a right to a copy of that Notice from:

Step Mountain Medical Family Practice
2332 West 12600 South
Riverton, UT 84065
801-446-2760

We reserve the right to change the Notice, and if we do, you may obtain a copy of the revised Notice from the same location noted above.

Please acknowledge your receipt of this notification by signing and dating it below.

Thank you.

_____ _____
Signature (Patient or Legal Representative) Date

_____
Printed Patient Name

STEP MOUNTAIN MEDICAL
2332 WEST 126000 SOUTH SUITE 2C
RIVERTON, UTAH 84065
(801) 446-2760

RELEASE OF INFORMATION

This form allows Step Mountain Medical to release information such as

___Labs ___ Billing __Office notes __Medical History
Please select what information you would like to have released to person(s);

Example: Family, Caregivers, Parents, etc.

Any person over the age 18 is required to have this form filled out and signed in order to release information. If not completed there will be no information released. By signing this form you understand that the information that you have selected can be released to the person who is authorized to have this information. If this release of information changes due to the patient decision of not having this information released to any one or group listed above, there must be written and signed notification from the patient that this is no longer valid. Phone calls will not be honored to void Release of Information, as we require to have written notification to be able to void the Release of Information.

Patient Signature Date