PATIENT INFORMATION

Please print or write legibly

Full name		Date of birth
Sex M F	Social Security No.	Telephone Number
Adress and Apt/Unit No, City, State, Zip		
Marital Status: single/ married/ divorce/widowed		Race:
E-mail address		Employer
EMERGENCY CONTACT NAME & AND NUMBER		

****Please be advised that we require the social security number of the responsible party if you wish for us to bill your insurance.**

INSURANCE INFORMARTION

	Primary Insurance	Secondary Insurance
Name of Insurance		
Name of Policy Holder		
Policy Holder date of Birth		
Social Security No. of Policy Holder		
Employers Name		

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plan to Caring Health Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this stamen is to be considered as valid as an original.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I understand that I may be billed for any missed appointments not canceled without 24 hours notice. I also understand that my insurance will not pay for missed appointments.

I have received the **Practice Policy** and have read and understood the policy and agree to be bound by the terms and conditions stated there.

I have read the Patient Health Portal Agreement, copies of wich are available at Reception or at www.chclas.com and further understand and consent to the terms thereof.

Please be advised: By signing this form, you agree that the provider may access your medication history from any database available to or her as part of your treatment.

Signature:_____ Date:_____

For any patient under 18 years, a parent or legal guardian must also sign.

Revised 6.28.24

4424 S. Eastern Ave., Las Vegas NV 89119

4418 W. Charleston Blvd., Las Vegas 89102

ACKNOWLEDMENT OF NOTICE OF PRIVACY PARCTICES & PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TERATMENT PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPPA

In signing this form, I understand that as part of my health care, **CARING HEALTH CENTER** originates collects, and maintains paper and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contributed to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. Additional copies are available at www.chclas.com or at the Reception Desk. I understand that I have the right to review the notice prior to signing this consent/disclosure and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that **CARING HEALTH CENTER** is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as a part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email. I further grant **CARING HEALTH CENTER** permission to access my medication history for purposes of my treatment.

In addition, I also give consent to **CARING HEALTH CENTER** to disclose my protected healthcare information to the following person(s), including but not limited to mental health, HIV related information, alcohol and drug abuse information:

Name of Person Permitted Access to your Protected Health Information:_____

Relationship & Phone Number: _____

2nd Name of Person Permitted Access to your Protected Health Information:_____

Relationship & Phone Number:_____

I fully understand and accept the terms of this consent.

X_____

Patient/Legal Guardian Signature Date:_____

Revised 6.28.24

CARING HEALTH CENTER

Name: _____ **DOB: (MM/DD/YEAR):** ___/___/___

PATIENT MEDICAL HISTORY

Do you have any allergies to medications, x-ray dyes or other substances? Yes or Not

If yes, list the names of medication/type of reaction:_____

Do you have any medical device implants? If yes, what type:_____

Are you presently using any devices to assist in walking? (wheelchair/cane/walker)_____

Current Medications	Frequency	Dose

PHARMACY NAME AND ADDRESS: _____

Hospital visits, admissions and operations: INCLUDE DATES AND REASONS/LOCATION	
Date of last colonoscopy?	
For Females: Date of last Mammogram:	
Do you smoke? Yes No	What do you smoke: If yes, how many per day?
Do you drink alcohol? Yes No	If yes, how often?
Do you exercise? Yes No	If yes, how many times per week?
Do you take any narcotics or controlled medications?	If yes, what:
Do you take any illicit drugs or substances?	If yes, what:

Family history. Has any member of your immediate family ever had the following?

Cancer:	Yes No	Type:_____ Relation: Father Mother Sibling Maternal Grandparent Paternal Grandparent Other
Hypertension:	Yes No	Type:_____ Relation: Father Mother Sibling Maternal Grandparent Paternal Grandparent Other
Heart disease:	Yes No	Type:_____ Relation: Father Mother Sibling Maternal Grandparent Paternal Grandparent Other
Diabetes: Type I or II?	Yes No	Type:_____ Relation: Father Mother Sibling Maternal Grandparent Paternal Grandparent Other
Stroke	Yes No	Type:_____ Relation: Father Mother Sibling Maternal Grandparent Paternal Grandparent Other
Bleeding disease:	Yes No	Type:_____ Relation: Father Mother Sibling Maternal Grandparent Paternal Grandparent Other
Other	Yes No	Type:_____ Relation: Father Mother Sibling Maternal Grandparent Paternal Grandparent Other

CARING HEALTH CENTER

Name: _____ **DOB: (MM/DD/YEAR):** ___/___/___

PATIENT MEDICAL HISTORY

Review of Systems. Please circle any **Current Medical Conditions** that you are experiencing:

Constitutional: Chills, Fatigue, Fever/High Temperature, Night Sweats, Unintentional Weight Gain, Unintentional Weight Loss, Lightheadedness or Dizziness.

Eyes: Blurred Vision, Glasses or Contacts, eye Pain, Photophobia, Eye Drainage.

Respiratory: Coughing (acute or chronic), Dyspnea/difficulty breathing, Tuberculosis Exposure/Tuberculosis, Hemoptysis/Coughing Up Blood, Wheezing, Shortness of Breath, Pleuritic pain (sharp or stabbing chest pain).

Cardiovascular: Dizziness, chest pain, claudication/leg pain after walking short distances, palpitations/irregular heartbeat, leg swelling, varicose veins, orthopnea/shortness of breath when laying down, waking up at night gasping for air.\

Neurological: Ataxia/loss of control of bodily movements, fainting, headaches, memory loss, paresthesia/burning or tingling sensation, seizures, tremors, vertigo, weakness, unsteady walk.

Gastrointestinal: Abdominal pain, loss of appetite, acid reflux, anorexia, bloating, dysphagia, difficulty swallowing, tarry block stool, constipation, diarrhea, heartburn, Hematemesis/vomiting blood, hematochezia/defecating blood, hemorrhoids, melena/dark sticky feces with blood, nausea, vomiting, Odynophagia/painful swallowing, change in stool.

Ears/Nose/Throat: Nasal Congestion, pain in ears, hearing problems, tinnitus/ringing in ears, frequent bloody nose, non-healing nasal ulcer, frequently runny nose, Bleeding gums, periodontal disease, snoring, hoarseness, sore/ulcer in mouth, sore throat, sore tongue, thrush, tooth pai.

Hematologic: Easy bruising, excessive bleeding (not menstruation) history of blood transfusion, lymphadenopathy/enlargement of lymph nodes.

Musculoskeletal: Arthralgias/joint pain, back pain, joint stiffness, limb pain, myalgias/muscle aches.

Endocrine System: Enlarged hands/feet, hair loss, heat/cold intolerance, hirsutism/excessive hair growth, infertility, striae/stretch marks, excessive sweating, polydipsia/excessive thirst, polyphagia/excessive hunger, excessive sweating, increased skin pigmentation, hot flashes.

Integumentary: Acne, atypical mole (s), dry skin, fungal nail infection, yellow skin color, pruritis/itchy skin, rash, warts, breast mass, breast skin changes, breast tenderness, nipple discharge.

Genitourinary: urinary incontinence, Urinating at night, Dysuria/ painful urination, Hematuria: blood in the urine, urine stream change, Genital lesions, history of frequent urinary tract infections, Polyuria: excessive or frequent urination, Dyspareunia-painful intercourse, Rape or sexual abuse Impotence, High risk sexual behavior/ Unprotected sex, HIV Risk Factors: shared needles, tattoos.

For Females Only: post-menopausal bleeding, Irregular menstrual cycle, Vaginal itching, Vaginal bleeding outside, of menses, Dysmenorrhea- Menstrual cramps, Menorrhagia: Heavy menses, History of recurrent bacterial vaginosis, vaginal discharge, post-coital vaginal bleeding.

Allergies/Immunologic: Seasonal Allergies, perennial allergies, frequent Upper Respiratory Tract infections, Hives.

Psychiatric/Psychological: anxiety, Crying spells, Depression, feeling stressed, Loss of interest in pleasurable activities, mood swings, personality changes, PMS, Poor concentration, sadness, difficulty sleeping, thoughts of suicide.

OTHER: _____

Past Medical History: Circle or state relevant Past Medical History: High blood pressure, low back problems, gallbladder Disease, persistent cough, chest pain/tightness, hemorrhoids, skin diseases/disorders, kidney stones, heart disease, depression, headaches, thyroid disease, lightheadedness, bronchitis, ulcers, diabetes type I, diabetes type II, cancer, nausea, anemia, constipation, indigestion, palpitations, gout, diarrhea, asthma, arthritis, hepatitis type A, hepatitis type B, hay fever, alcohol abuse, frequent urination, shortness of breath, swollen ankles, tuberculosis, axiety,

OTHER:

_____

_____