DESERT EDGE MEDICAL

1664 S Dixie Drive Suite D102, St. George, UT 84770
PHONE: (435) 656-2995 FAX: (435) 656-3237

NEW PATIENT FORM

PATIENT INFORMATION

Patient Name: _____ **Sex:** ☐ M ☐ F ☐ Other

Mailing Address: _____ **Date of Birth:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Preferred Communication: ☐ Home ☐ Cell **(Required) Social Security #:** _____

Reason for visiting the doctor today: _____

_____

Referring and/or Primary Care Physician: _____

1. RACE (Please check one)

☐ American Indian/Alaska Native ☐ Asian ☐ Pacific Islander ☐ More than one race
☐ Black/African American ☐ Native Hawaiian ☐ White/Caucasian ☐ Decline

2. ETHNICITY (Please check one)

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline

EMERGENCY CONTACT

Name: _____ **Phone #:** _____ **Relationship:** _____

Name: _____ **Phone #:** _____ **Relationship:** _____

INSURANCE INFORMATION *Complete if insurance is under **SPOUSE, PARENT** or **DIFFERENT NAME**

Name: _____ **Relationship to Patient:** _____

Mailing Address: _____

Primary Phone: _____ **Date of Birth:** _____ **Social Sec #:** _____

OFFICE USE ONLY: Scanned____Entered____

HIPAA/RELEASE OF INFORMATION

Under the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are not allowed to give this information to anyone without the patient's expressed written consent. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

1. Should you ever need a copy of any and/or all of you medical records please print below **authorizing** Desert Edge Medical to release your medical information to YOU.

   _____ Date of Birth: _____
   (Print Patient Name)

2. If you wish to have any and/or all of your medical records released to someone other than yourself (e.g., family member, another physician, attorney) please indicate their name and relationship to you below.

I **authorize** Desert Edge Medical to **release** my medical and/or financial information (as indicated below) to the following individuals:

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____
4. _____ Relationship to Patient: _____

By **signing** below, I agree the information above is correct.

_____ _____
Signature of patient or patient's representative Date

_____
Signature of patient or patient's representative

ALLERGIES

Have you had an allergic reaction to any of the following? ☐ Adhesive Tape ☐ Anesthesia
☐ Aspirin ☐ Latex ☐ Iodine/Shellfish/Contrast Dye ☐ Penicillin ☐ Sulta Drugs
☐ Codeine ☐ Morphine ☐ Other: _____ ☐ No Known Drug Allergies

FAMILY HISTORY

Is there a history of any of the following in your immediate family? ☐ N/A

M - Mother **F -** Father **S -** Sister **B -** Brother ☐ Adopted, family history unknown

	M	F	S	B		M	F	S	B		M	F	S	B
Anesthesia Problems	☐	☐	☐	☐	Headache/Migraine	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	Cardiovascular Problems	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	Hypertension	☐	☐	☐	☐	Stroke (CVA)	☐	☐	☐	☐
Cancer (Type): _____	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	Liver Disease	☐	☐	☐	☐	Other:	☐	☐	☐	☐
Diabetes (Type): _____	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐	Other:	☐	☐	☐	☐

Please check the appropriate answer: (Circle Brother or Sister if applicable)

Mother:	**Father:**	**Brother/Sister:**	**Brother/Sister:**	**Brother/Sister:**
☐ Living	☐ Living	☐ Living	☐ Living	☐ Living
☐ Deceased	☐ Deceased	☐ Deceased	☐ Deceased	☐ Deceased

SOCIAL HISTORY

Occupation:
☐ Full-Time: _____
☐ Part-Time: _____
☐ Retired
☐ Disabled
☐ Unemployment
☐ Student

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Domestic Partner
☐ Separated

Do You?
SMOKE: ☐ Yes ☐ No ☐ Former
How many years? _____
How many packs per day? _____
CHEW: ☐ Yes ☐ No ☐ Former
How many years? _____
ALCOHOL: ☐ Never ☐ Weekly ☐ Seldom

Have you ever abused alcohol? ☐ Yes ☐ No
Have you ever used any illicit substances? ☐ Yes ☐ No Type: _____
Have you ever been addicted to or misused prescription drugs? ☐ Yes ☐ No Type: _____

MEDICAL HISTORY: Do you have a history of any of the following?

Have you had an allergic reaction to any of the following? ☐ Anemia ☐ Anxiety ☐ Arthritis
☐ Asthma ☐ COPD ☐ Chest Pain ☐ Cancer (Type): _____ ☐ Congestive Heart Failure
☐ Coronary Artery Disease ☐ Depression ☐ Fibromyalgia ☐ Heart Disease ☐ Hypertension
☐ Diabetes (Type): _____ **Last A1C:** _____ ☐ Headaches (Type): _____
☐ Hepatitis ☐ Hyper/Hypo-Thyroidism ☐ Infection Problems: _____ ☐ HIV or AIDS
☐ Kidney Failure ☐ Liver Disease ☐ Neuropathy ☐ Osteoporosis ☐ Seasonal Allergies
☐ Shortness of breath ☐ Other: _____ ☐ None of the problems listed

OTHER PROVIDERS

Please list Specialists and any other providers you may also be seeing or have seen in the past. ☐ N/A

PROVIDER NAME	SPECIALTY

SURGICAL HISTORY

Please list all previous surgeries. ☐ N/A

TYPE OF SURGERY	RIGHT OR LEFT	YEAR/DATE	DOCTOR &/OR LOCATION

CURRENT MEDICATIONS

Please list all prescriptions, OTC, herbal, and/or vitamin (nutritional supplements you are currently taking. ☐ N/A

PREFERRED PHARMACY: _____

NAME OF MEDICATION	DOSAGE (mg, mcg, mL)	FREQUENCY

_____ _____

Signature of patient or patient's legal representative: Date:

_____ _____

If signed by legal representative, relationship to patient: Signature of witness (Office):

REVIEW OF SYMPTOMS

GENERAL
- ☐ Change in Appetite
- ☐ Chills
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

SKIN
- ☐ Dry Skin
- ☐ Excessive Sweating
- ☐ Hives
- ☐ Jaundice
- ☐ Loss of Hairs
- ☐ Mole Changes
- ☐ Rash
- ☐ Ulcers
- ☐ Warts

HEAD
- ☐ Head Injury

EYES
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Changes in Vision
- ☐ Color Blindness
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Glasses or Contacts
- ☐ Glaucoma
- ☐ Night Blindness

EARS
- ☐ Deafness
- ☐ Dizziness
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Hearing Aids

NOSE & SINUSES
- ☐ Facial Pressure
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nasal Irritation
- ☐ Nose Bleeds
- ☐ Postnasal Drip
- ☐ Sinus Headache
- ☐ Sinus Pain
- ☐ Sinus Problem

MOUTH & THROAT
- ☐ Bleeding Gums
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Metallic Taste
- ☐ Wears Dentures

NECK
- ☐ Enlarged Thyroid
- ☐ Neck Mass
- ☐ Neck Pain
- ☐ Stiffness
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chest Pain
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Snoring
- ☐ Tuberculosis
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Edema
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Murmur
- ☐ Palpitations

HEMATOLOGIC
- ☐ Anemia
- ☐ Easy Bruising

GENITOURINARY
- ☐ Incontinence
- ☐ Frequency
- ☐ Kidney Stones
- ☐ Nocturia
- ☐ Urgency

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallstones
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Indigestion
- ☐ Nausea

MUSCULOSKELITAL
- ☐ Arthritis
- ☐ Back Pain
- ☐ Gout
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Stiffness

NEUROLOGIC
- ☐ Abnormal Gait
- ☐ Clumsiness
- ☐ Disorientation
- ☐ Dizziness
- ☐ Headache
  - ☐ Migraine
  - ☐ Sinus
  - ☐ Tension
- ☐ Involuntary Movements
- ☐ Memory Loss
- ☐ Numbness
- ☐ Seizure
- ☐ Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Binging
- ☐ Depression
- ☐ Insomnia
- ☐ Irritability
- ☐ Purging

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Excessive Hunger
- ☐ Foot Ulcers
- ☐ Heat Intolerance
- ☐ Unusual Hair Loss

☐ N/A

REVIEW OF PREVENTATIVE SERVICES

****Please check each item that has been done and enter the date (Mo./Yr.) when it was last done.**

Flu Shot

- ☐ Done: _____
- ☐ Have not received

COVID-19 Vaccine

- ☐ 1st Shot Done: _____
- ☐ 2nd Shot Done: _____
- ☐ Booster Done: _____
- ☐ Have not received

Bone Density Scan

- ☐ Done: _____
- ☐ Have not received

Colonoscopy

- ☐ Done: _____
- ☐ Have not received

AAA Screening (Abdominal Aortic Aneurysm)

- ☐ Done: _____
- ☐ Have not received

Eye Exam

- ☐ Done: _____
- ☐ Have not received

Tetanus Shot

**Medicare does NOT cover

- ☐ Done: _____
- ☐ Have not received

Zoster-Shingles

- ☐ Done: _____
- ☐ Have not received

Pneumonia Shot

- ☐ Prevnar 13: _____
- ☐ Pneumonia 23: _____
- ☐ Have not received

WOMEN ONLY:

Mammogram

- ☐ Done: _____
- ☐ Have not received

Pap Smear

- ☐ Done: _____
- ☐ Have not received

MEN ONLY:

PSA

- ☐ Done: _____
- ☐ Have not received

Prostate Exam

- ☐ Done: _____
- ☐ Have not received

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OFFICE & FINANCIAL POLICY AGREEMENT

Thank you for choosing Desert Edge Medical for your medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this Financial Agreement. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care. Except as indicated below, payment is required at the time services are provided unless other arrangements have been made in advanced. We accept cash, personal in-state checks, VISA, MasterCard, Discover, and American Express credit cards. There is a $40.00 service charge for returned checks.

As a courtesy to other patients, we request you arrive on time. If you arrive more than 15 minutes late, you may be asked to reschedule. Same day sick appointments are available, but still needs to be scheduled. For after hours/ weekend emergencies, please call the office first. A message will guide you to the Doctor-On-Call.

***PLEASE INITIAL NEXT TO THE FOLLOWING PARAGRAPHS AFTER YOU HAVE READ AND REVIEWED THEM**

_____ **Insurance:** We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. **You are responsible for any charges not covered by your plan.**

Proof of Insurance: All patients must complete and/or update our Patient Information Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. **Please notify us of any changes in insurance coverage prior to time of service.** Insurance denials for termination of coverage will be automatically billed to you.

_____ **Co-payments and deductibles:** All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required copayments, co-insurances, deductible and non-covered services.

_____ **Claim submission:** We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. We are not a party to your insurance contract.

_____ **Collections:** Any unpaid account balance after 90 days may be assigned to a collections agency. If sent to collections, you will be responsible to pay all attorney fees, court costs, filing fees, including a collection fee up to 40% which will be added to the outstanding balance with or without suit.

_____ **Out-Of-Network Care:** Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, your out-of-pocket expense will be greater. As a courtesy to our out-of-network patients, we will file your insurance claim if you desired, and offer a 10% reduction from our usual fees. It is the responsibility of the insured to make sure we are in network with your plan.

_____ **Missed Appointments:** Missed appointments are not only a cost for us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24 hour notice of cancellation to avoid a $25.00 cancellation fee. It is your responsibility to remember your appointment. Excessive missed appointments may result in termination of care.

Additional Services, Charges and Patient Responsibility: Some of the following administrative services require payment. The services that do require payment may be billed directly to you with payment being your responsibility as they are not covered by insurance. All such administrative fees must be paid prior to scheduling future appointments.

Referrals: If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, etc., it is your responsibility to inform the office of this requirement prior to referral. We require 72 hours notice to facilitate a referral request and cannot issue retroactive referrals.

Prescription Refills: New prescriptions will not be issued without first seeing your Physician. Prescriptions for acute or chronic conditions are written with the appropriate number of refills to complete the course of treatment or to last until your next appointment. All prescription requests are taken only during regular office hours and filled within 48 hours.

Prior Authorizations (prescriptions): We will honor prior authorization requests from the patient, but the patient is responsible for contacting their insurance company to have them forward to the prior authorization form to our office. Any request for a forced change in your medication by your insurance company will require an office visit. The patient will need to ask their insurance plan what "alternative medications" are covered and then provide a list to their Physician Once submitted, if a prior authorization is then denied by the insurance, an appointment will need to be scheduled to discuss other medication options. Please note that appeals will not be submitted once a prior authorization is denied.

_____ **Request for medical records:** In accordance to HIPAA's Privacy Policy, Desert Edge Medical requires written requests for the release of medical records. The administrative fee associated with retrieving and copying medical records is based on whether they printed or electronically **faxed. Please take this into consideration when requesting copies of your medical records. To print medical records, Starting fee for the first 40 pages is $0.50 per page. Additional pages will be $0.25 per page. There will be a service fee of $15 added on top of page count fee. Payment is due prior to the printing of records. (If you want records mailed, there will be a mailing fee added. This will be determined based off of cost for postage.)**

I AUTHORIZE DESERT EDGE MEDICAL CO TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY MEDICAL TREATMENT, AND ASSIGN TO THIS PRACTICE ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME AND/OR MY DEPENDENTS. However, regardless of insurance coverage, I agree that it is my responsibility to pay all amounts owing as set forth herein. In the event any amount is referred to a third party debt collection agency, I agree that in addition to any other amount allowed for by law, (such as interest, court costs, reasonable lawyer's fees, etc) I will also be responsible for a collection fee of up to 40% of the principal amount owing as allowed by Utah code annotated sec. 12-1-11. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amount are incurred today or after today.

I have read, understand and agree to comply with the terms of your Office & Financial Policy.

Patient's Name: _____ Signature: _____

Date: _____ (Office) Witness: _____