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| --- | --- |
| Rowena Achin, MD | ☐ |
| Don Pepito, MD | ☐ |
| Danilo Duenas, MD  Yoyen Espartero | ☐  ☐ |



**INTERNAL MEDICINE**

**7373 Peak Dr. Suite 130 Las Vegas, NV 89128 | Phone: 725.780.4351 | Fax: 725.780.4339**

**PATIENT REGISTRATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name: | First Name: | | Date of Birth: | Sex: |
| Address: | | | | |
| Home Phone: | Cell Phone: | | Work Phone: | |
| Social Security Number: | | Email: (Do we have permission to email you? Yes or No) | | |
| Occupation: | | Employer: | | |
| Insured Name: | | Relationship to Patient: | | |
| Insurance Carrier: | Insurance ID#: | | Insurance Group#: | |
| Secondary Insured Name: | | Relationship to Patient: | | |
| Secondary Insurance Carrier: | Insurance ID#: | | Insurance Group#: | |
| Emergency Contact’s Name: | | Relationship to Patient: | | |
| Home Phone: | Cell Phone: | | Work Phone: | |
| Preferred Pharmacy Name: | | Pharmacy Address: | | |

|  |
| --- |
| **Please place your initials next to the statements below indicating you have read and understand them:**  \_\_\_\_ I authorize the insurance listed above to pay directly to Hope Medical Clinic. I will pay for all such charges that  may be denied by the insurance company(ies) above mentioned.  \_\_\_\_ I hereby consent to treatment rendered by Hope Medical Clinic which could include in office procedures and  injections.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient’s Signature Date |

|  |  |  |
| --- | --- | --- |
| Rowena Achin, MD | ☐ | **New Patient Health & History Form** |
| Don Pepito, MD | ☐ |
| Danilo Duenas, MD | ☐ | Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 Yoyen Espartero ☐

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Last Name | First Name | Date of Birth |

**Past Medical History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| High Blood pressure | Diabetes | Stroke | | Anxiety |
| High Cholesterol | Colon Disease | COPD/Emphysema | | Depression |
| Hypothyroid | Peptic Disease/GERD | Asthma | | Cancer/Type\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Anemia | Heart Disease | Allergies | | Skin Disease |
| Hepatitis | Seizure Disorder | Arthritis | | Kidney Disease/Stones |
|  | | | | |
| **Allergies to Medications** | | | **Reaction** | |
|  | | |  | |
| Latex Allergy?  Yes  No | | | | |

|  |  |
| --- | --- |
| **Medication Name/ Strength** | **How many times a day?** |
|  |  |
|  |  |
|  |  |
|  |  |
|  | |
| **Previous Surgeries/Procedures** | **Date** |
|  |  |
|  |  |
|  |  |
|  | |
| **Hospitalizations** | **Date** |
|  |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **Family History** |  | **Significant Diseases** |
| Father | Alive?  Yes  No/Age of death \_\_\_\_\_\_ |  |
| Mother | Alive?  Yes  No/Age of death \_\_\_\_\_\_ |  |
| Siblings | Alive?  Yes  No #\_\_\_\_ Brother #\_\_\_\_ Sister |  |
| Children | Alive?  Yes  No #\_\_\_\_ Son #\_\_\_\_Daughter |  |

**Social History**

|  |  |
| --- | --- |
| Do you live:  Alone with Spouse with Family  Other | |
| Marital Status:  Married Single Widowed  Divorced | |
| Tobacco use: | Current smoker/ #\_\_\_\_\_cigaretted per day / week / month (please circle one)  Former Smoker  Nonsmoker  E-Cigarette  Chewing Tobacco |
| Alcohol use: | I do not drink  Socially  Everyday / I drink # \_\_\_\_\_\_\_ beer / wine / liquor (please circle one) |



**Reason for your visit:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you currently have any of the following symptoms today? -OR- ☐ None**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| General  ☐ Change in appetite | ☐ Fever | ☐ Night Sweats | ☐ Weight gain |  |  |
| Ophthalmologic  ☐ Blurred Vision | ☐ Eye pain | ☐ Itching and redness |  |  |  |
| ENT  ☐ Decreased Hearing | ☐ Nosebleed | ☐ Snoring | ☐ Swollen glands |  |  |
| Endocrine  ☐ Cold intolerance | ☐ Excessive thirst | ☐ Heat intolerance | ☐ Weight loss |  |  |
| Respiratory  ☐Cough | ☐ Shortness of breath | ☐ Wheezing |  |  |  |
| Cardiovascular  ☐ Chest pain | ☐ Fluid accumulation in  the legs | ☐ Irregular heartbeat | ☐ Palpitations |  |  |
| Gastrointestinal  ☐Abdominal Pain | ☐ Blood in stool | ☐ Constipation | ☐ Diarrhea | ☐ Nausea | ☐ Vomiting |
| Genitourinary  ☐ Blood in urine | ☐ Difficulty urinating | ☐ Frequent urination | ☐ Painful urination |  |  |
| Musculoskeletal  ☐ Back/Neck problems | ☐ Painful joints | ☐ Weakness |  |  |  |
| Skin  ☐ Dry Skin | ☐ Itching | ☐ Rash |  |  |  |
| Neurologic  ☐ Dizziness | ☐ Headache | ☐ Memory loss | ☐ Tingling/Numbness |  |  |
| Psychological  ☐ Anxiety | ☐ Depressed mood |  |  |  |  |

**Preventive Medicine**

|  |  |  |  |
| --- | --- | --- | --- |
| Female | Date/Name of Doctor | Male | Date/Name of Doctor |
| Last menstrual period? |  | Last colonoscopy? |  |
| Last mammogram? |  | Last PSA? |  |
| Last pap smear? |  |  |  |
| Last bone density test? |  |  |  |
| Last colonoscopy |  |  |  |

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### CONTACT INFORMATION

Cell Phone:

May we leave a message? YES / NO (circle one)

Home Phone:

May we leave a message? YES / NO (circle one)

Work Phone:

May we leave a message? YES / NO (circle one)

Other #'s:

May we leave a message? YES / NO (circle one)

##### I give Dr. Rowena Achin/Dr. Don Pepito and the staff, my permission to discuss my condition, treatment, and diagnosis with the following individuals.

Name: Phone: Relationship:

Name: Phone: Relationship:

Name: Phone: Relationship:

Patient's Name (PRINT) Patient's Signature/Date



**FINANCIAL POLICY**

We are committed to providing you with the best possible care. In order to achieve this goal, we need to ensure your understanding of our payment policy.

Claims for insurance companies with which Dr. Rowena Achin and Dr. Don Pepito participates, are submitted electronically. For those insurance companies with whom we do not participate, we are pleased to provide you with an itemized bill, that you can submit for reimbursement.

All co-pays and coinsurance amounts are due at the time of service and, cannot be waived. All patient balances as determined by your insurance company, are due and payable within 30 days of our invoice. All balances over 30 days are automatically forwarded to our billing company. *All balances over 60 days are automatically referred to a collection agency and assessed a $100 collection fee.* Please pay your balance promptly. If you have financial difficulties, please notify us as soon as possible to avoid this eventuality.

**FEES**

1. **Payment for services is due at the time services are rendered.** We accept cash, checks, MasterCard, Visa and American Express. To ensure a stress-free visit, *please verify that Dr. Achin and Dr. Pepito participate with your insurance plan*. It is not possible to keep up with all plans available today.
2. Returned, unpaid checks will be added to your account with a $35.00 charge fee.
3. There will be a $25 cancellation/no-show fee if you are unable to make your appointment without giving at least24 hour notice.

**I have read HOPE MEDICAL CLINIC Financial Policy.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature/Policy Holder Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Policy Holder if other than patient Witness