HILLSIDEHEALTH

Date: _____

PATIENT INFORMATION

Patient Last Name	Patient First Name	Patient Middle Name	
Date of Birth	Social Security #	Cell Phone	Home Phone
Address	City	State	Zip
Occupation	Employer		Business Phone
Employer Address	City	State	Zip
Driver License #	Email Address		

Ethnicity ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Multiracial ☐ Other

Emergency Contact Information (Full Name/Relationship to the Patient)	Phone (REQUIRED)

What Influenced Your Decision to Come to Our Practice?

☐ Newspaper/magazine ad ☐ Clinic website ☐ Mailer ☐ Insurance plan ☐ Friend/family ☐ Yellow page book ☐ Other: _____

☐ Radio or TV ad ☐ Facebook/social media ☐ Seminar/talk ☐ Physician referral ☐ Hospital website or referral line ☐ Online search

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES)

Primary Insurance Company	Co-Pay Amount	Policyholder Name	Policyholder DOB	Patient Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other: _____
Insurance Company Address			Effective Date	Phone
Policy #	Group #		Group Name	
2nd Insurance Company	Co-Pay Amount	Policyholder Name	Policyholder DOB	Patient Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other: _____
Insurance Company Address			Effective Date	Phone
Policy #	Group #		Group Name	

The Health Insurance Portability Accountability Act (HIPAA) of 1996 was created with the sole purpose and goal of protecting patients' medical records and financial information. Please authorize below who you would like Hillside Health to release your medical and financial information to. This will allow us to better protect your private information. Please be specific when designating your choices.

I authorize the staff of Hillside Health to release any FINANCIAL INFORMA-TION to the following people:

_____

_____

_____

I authorize the staff of Hillside Health to release any MEDICAL INFORMA-TION to the following people:

_____

_____

_____

I authorize the staff of Hillside Health to leave laboratory or radiology tests results on my voicemail at the following telephone numbers:

HOME: _____

CELL: _____

OTHER: _____

Patient Name: Last, First, MI	Date of Birth: mm/dd/yyyy

I make the following consents, understandings, and agreements on my own behalf. In partial consideration of health care services to be provided by the Hillside Health (HH) and its affiliates.

CONSENT FOR SERVICES: I hereby give consent to the Facility, its Contractors, Physicians, and Employees to provide health care services to me as the Patient and to administer physician orders for my benefit for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty involved in the health care services for which this consent is given.

ASSIGNMENT OF BENEFITS: Any and all benefits from insurance companies and other third-party payers that are payable to me, the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to the HH for the exclusive purpose of paying for charges associated with the health care services provided to me. I understand and intend that all insurance companies and other third-party payers will pay benefits directly to the HH for services rendered to me and that the HH is authorized to bill in connection with health care services provided.

RELEASE OF INFORMATION: The HH is required by law to make and keep records of the Patient's medical treatment. The HH safeguards those records and it uses and discloses such records and information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Hillside Health's Notice of Privacy Practices, which may be amended from time to time. I understand that I may ask to see a copy of the current notice at any time.

MEDICARE/MEDICAID/TRICARE PATIENT'S CERTIFICATION: I certify that the information given by me in applying for payment under the titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or other information about me to release to the Social Security Ad-ministration, other intermediaries or carriers, or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its service.

FINANCIAL RESPONSIBILITY: I, the undersigned, jointly and severally agree to pay for all the health care services rendered to me, the Patient including but not limited to any amounts not paid by any insurance company or other third-party payor (excluding contract discounts). I remain responsible for all copayments, deductibles, co-insurance, and / or non-covered services regardless of amount paid by insurance or third-party payor. I understand and agree than any amounts not paid within 30 days of the date of the bill or statement for payment shall accrue interest at the rate of 1.5 % per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, I jointly and severally agree to pay all costs of collections and reasonable attorney's fees in connection with the collection process. As a courtesy to our personal pay patients, a discount is extended for specified services. The largest discount is available when services are paid in full on the date of service. Please ask about any discounts that may be available.

I sign this document as the Patient to execute this document and to accept and agree to its terms. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing above. I understand that I am entitled to request and obtain a copy of this document, as well as a copy of my billing rights according to the Fair Credit and Billing act. This document will remain in effect unless revoked in writing.

SIGNATURE:_____ DATE:_____

HILLSIDEHEALTH

Name: _____ **Date of Birth:** _____

Patient Intake Paperwork

Preferred Pharmacy: _____ Zip Code: _____

Medications:

Current Medications Dose Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Previous unsuccessful medication treatments:

_____
_____

Blood Thinners?: _____

Allergies:

Drug Allergies: _____
_____
_____
_____
_____

May include but not limited to: Codeine, Contrast Dye, Penicillin, Sulfa, Fentanyl. Specify reaction(s)

Food Allergies: _____
_____
_____
_____
_____

Do you have a known latex allergy? Yes / No

Medical History:

Current conditions/diagnosis's:

_____
_____
_____
_____
_____
_____
_____

Previously treated conditions/ diagnosis's:

_____
_____
_____
_____
_____

Family History:

Specify relationship(s) and list what conditions.

_____
_____
_____
_____
_____

Please indicate if any conditions were fatal.

May include but not limited to: Alzheimers, Diabetes, Migraines, Heart Disease(s), mental illness(s) Cancer, High Blood Pressure

Surgical History:

List past surgery type and date to best of abilities

_____
_____
_____
_____
_____

HILLSIDEHEALTH

Name: _____ **Date of Birth:** _____

Review of Symptoms: Select all symptoms you are experiencing

Constitutional
O Fever O Weight loss/gain O Chills
O Malaise

EENMT
O Dry eyes O Vision change O Ear pain
O Difficulty Hearing O Frequent nosebleeds
O Sore throat O Sinus problems O Snoring
O Dry mouth O Bleeding gums

Cardiovascular
O Chest pain O Palpitations O Hypertension
O Shortness of breath O Swelling of legs

Respiratory
O Cough O Wheezing O Coughing blood

Gastrointestinal
O Abdominal Pain O Blood in stool O GERD
O Black/tarry Stool O Dyspepsia O Vomiting
O Frequent diarrhea O Constipation

Genitourinary
O Loss of control O Increase in frequency
O Blood in urine O Difficulty with urinating

Musculoskeletal
O Aches O Spine pain O Arthritis O Swelling
O Joint pain O Weakness O Cramps O Gout
O Atrophy/Loss of muscle O Restricted motion

Integumentary
O Discoloration O Rash O Itching O Dry skin
O Abnormal mole O Open wound O Bruising
O Excessive sweating O Growth O Lump

Neurologic
O Loss of consciousness O Frequent headaches
O Migraines O Weakness O Seizures O Tremors
O Dizziness O Difficulty walking O Paralysis

Psychiatric
O Mood swings O Anxiety O Issues with sleep
O Depression O Anger O Memory loss
O Panic attacks O Hallucinations

Endocrine
O Fatigue O Increased thirst O Hair loss/growth
O Cold intolerance

Hematologic/Lymphatic
O Swollen glands O Easy bruising O Anemia
O Excessive bleeding O Phlebitis

Allergic/Immunologic
O Runny nose O Sinus pressure O Itching
O Frequent sneezing O Hives

Social History

Do you drink? Yes / No Servings weekly: _____ (of) Beer _____ Wine _____ Liquor _____
Do you smoke? Never / Current / Former How much: _____ Method of consumption: _____
Any illicit drug use? Yes / No What is your level of caffeine intake? _____
Family history of substance Abuse? None / Alcohol / Illicit drugs / Prescription drug
Personal history of substance Abuse? None / Alcohol / Illicit drugs / Prescription drug
Have you been diagnosed with? Attention Deficit Disorder (ADD) / Depression / Schizophrenia Disorder/ Obsessive Compulsive Disorder (OCD) / Bipolar Disorder / NA
How many times a week do you get exercise? _____ Do you follow any specific diet? _____
Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night?
O Not at all O Only a little O Too some extent O Rather much O Very much
Do you use your seat belt or car seat routinely? Yes / No

Patient Health Questionnaire In the past two weeks have you felt?

As if you had little interest or pleasure in doing things
O Not at all O Several days O More than half the days O Nearly every day
Felt down, depressed or hopeless?
O Not at all O Several days O More than half the days O Nearly every day

HILLSIDEHEALTH

Name: _____ **Date of Birth:** _____

Gynecological History:

What was the date of your last pap smear?

_____

Have you ever received an abnormal pap?

_____

What was the date of your last mammogram?

_____

What was the date of your last menstrual period?

_____

Are your menstrual cycles typically monthly?

_____

How long do they normally last?

_____

How would you describe your flow rate?

_____

Obstetrics History:

How many total pregnancies have you had?

_____

How many total living pregnancies?

_____

Any multiple births? Yes / No

Would you like this provider to be in charge of your medication management?

Yes / No

Screening:

When was your last bone density (DEXA) scan?

_____

When was your last colonoscopy?

_____

Specialty Care:

Any current specialist treatment?

_____

_____

_____

_____

Additional Patient Comments:

_____

HILLSIDEHEALTH

MEDICAL RELEASE FORM

Patients Name: _____ DOB: _____

Phone Number: (___)-___-_____

Please release my medical records from:

Name of Provider/Facility: _____

Phone Number: (___)-___-_____ FAX:(___)-___-_____

Name of Provider/Facility: _____

Phone Number: (___)-___-_____ FAX:(___)-___-_____

Name of Provider/Facility: _____

Phone Number: (___)-___-_____ FAX:(___)-___-_____

Sent to:

Hillside Health

1841 E. Riverside Dr. Suite 201

St. George, UT 84790

Phone (435)-256-8890 Fax: (833)-907-2388

Patient's Signature: _____ **Date:** _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE:

FOR OFFICE USE ONLY:

Progress notes	Radiology Reports	Procedure notes/ reports
Clinic notes	Lab Results	Physician Orders
History/Physical	Pathology Reports	Mammogram Report
Discharge notes	Pap Smear Results	**ALL RECORDS**
Colonoscopy report	Prescriptions	
Consultations	EKG/ECG/EMG	
Operative Reports	Psych Evaluation	

Notes from the last ____ Office visits