



PATIENT REGISTRATION INFORMATION

Patient's Name (Last)	Patient's Name (First)	DOB:	Social Security#:
Mailing Address:			Apt. #:
City:	State:	Zip:	
Marital Status:	Single	Married	Widowed
		Divorced	Separated
Phone# (Home):	Phone# (Cell.):	E-Mail:	
Employer:	Employer Phone#:		
Pharmacy Name and Phone# Main Cross Street: REQUIRED			
Emergency Contact:	Relationship:	Phone#:	

INSURANCE COVERAGE

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins. Co. Name:	Ins. Co. Name:
ID #:	ID #:
Group #:	Group #:
Subscriber's Name:	Subscriber's Name:
Relationship to Patient: Self Spouse Parent	Relationship to Patient: Self Spouse Parent
Address:	Address:
Employer:	Employer:
Subscriber's Soc. Sec. #: DOB:	Subscriber's Soc. Sec. #: DOB:

CONSENT TO TREAT

I consent to my medical or surgical treatment as determined necessary by the Neighborhood Primary Care health care provider.

Signature of Patient/Gardian/POA: _____

Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign any and all insurance benefits payable to me, which are applicable to the patient account, but not to exceed the outstanding balance on my account. Should this account have to be turned over for collection, I agree to pay all reasonable attorney fees, court costs, and/or collection fees necessary to collect the past due balance on this account. I understand that Neighborhood Primary Care will bill my insurance as a courtesy to me. I will notify Neighborhood Primary Care in writing of any change in insurance information or coverage. If payment is not received within 45 days from the date of the bill, I understand that I am financially responsible for all services rendered to aforementioned patient by

Signature of Patient/Gardian/POA: _____

Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received a copy of Neighborhood Primary Care 's Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Signature of Patient/Gardian/POA: _____

Date: _____



and/or actions toward the staff.

Phone: 702-659-9090 | Fax: 888.288.5030 | Email: admin@ncchousecalls.com
3830 E Flamingo Road Ste., 201 Las Vegas, Nevada 89121

OFFICE POLICIES

- Please refrain from using abusive language and/ or actions toward staff.
- Please refrain from using your cell phone at the time of your visit.
- Please supervise your children at all times while in the clinic.
- Patient privacy is maintained in a manner that all patients are treated individually in their designated rooms with the doors closed.
- Forms such as FMLA, disability, and Motor Vehicles must be presented at the time of visit.
- Your health care provider will determine the number of refills you will be allowed for your prescription medication(s). Narcotics and controlled substances are not allowed refills.
- Requests for referrals will be processed as follows:
Stat referrals: processed within 24 hours
Routine referrals: processed within 72 hours.
- Your medical information is stored securely within our facility. It is readily available to your health care provider. Copies may be obtained for 60 cents per page by contacting our office.
- Service animals are allowed within the facility and are the responsibility of the owner. Animals shall remain on leashes at all times.
- It is the responsibility of the patient/guardian/ POA to update pertinent information that may assist in medical treatment and/or billing purposes. This includes address, phone number, insurance information, changes in medications, etc.

BILLING & FINANCIAL POLICIES:

- Current photo ID and insurance card(s) are required in order to be seen.
- Insurances will be verified, and claims submitted on behalf of the patient.
- Patients will be informed of co-pays and deductibles which are due prior to care being provided.
- Worker's compensation claims must be identified at the initial visit with a completed C-4 form.
- Patients will be given receipts for all payments received at the time of their visit.
- There is a fee of \$75.00 for the completion of documents and forms (FMLA, disability, OMV, etc.)
- There is a \$25.00 fee for returned checks.
- The initial charge for uninsured patients is \$150.00. This does not include lab work, injections, x-rays, etc. Follow-up visits will also be provided at a cost of \$100.00, not including lab work, injections, x-rays, etc.
- Payment assistance may be provided if necessary. The front office supervisor, or members of the front office staff, will gladly assist you should you require financial assistance.
- Delinquent accounts will be turned over to a collections agency if no payment has been received after 90 days.
- There will be a charge of \$25.00 added to your account for every appointment missed without 24 hour prior notification. 3 no showed appointments will be allowed before being discharged as a patient.

I have read and understand the above Office Policies as well as the Billing & Financial Policies.

Signature of Patient/Gardian/POA: _____

Date: _____



PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

First Name: _____

Last Name: _____

Current problems (Reason for Today's Visit): _____

When did symptoms occur (if applicable)? _____

Review of Systems (Check all that Apply)

- | | | | | |
|-----------------------------|--|---|--|---|
| General: | <input type="checkbox"/> Chills | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Change |
| Eyes: | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Light Sensitivity | |
| Ear/Nose/Throat: | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Pain | <input type="checkbox"/> Congestion | <input type="checkbox"/> Bloody Nose |
| | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Hoarseness | | |
| Heart: | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Skipped Beats | <input type="checkbox"/> Flip Flop Beats | <input type="checkbox"/> Racing Heart |
| Lungs: | <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Coughing up Blood | |
| Stomach/Intestinal: | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| | <input type="checkbox"/> Stool Changes | | | |
| Genital/Urinary: | <input type="checkbox"/> Pain w/ Urination | <input type="checkbox"/> Genital Lesio | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Erectile Dysfunction |
| | <input type="checkbox"/> Increased Urinary Frequency | <input type="checkbox"/> Changes in Urine Streamn | | |
| BoneJoint/Muscle: | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Extremity Pain |
| Skin: | <input type="checkbox"/> Atypical Moles | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Itching Skin | <input type="checkbox"/> Rash |
| Brain/Nerves: Blood: | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Tingling/Numbness | <input type="checkbox"/> Weakness |
| | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Lymph Node Swelling | |
| Mood: | <input type="checkbox"/> Anxietys | <input type="checkbox"/> Depression | <input type="checkbox"/> Trouble Sleeping | |

Other: _____

Allergies

Allergy

Reaction

1. _____
2. _____
3. _____
4. _____

- _____
- _____
- _____
- _____

First Name: _____

Last Name: _____

Medications

	Drug Name	Strength	Frequency Taken
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Personal History (Check all that Apply)

Common

- Diabetes
- Blood Pressure
- Cholesterol
- Kidney Diseases
- Liver Disease

Blood

- Anemia
- Bleeding Disorder
- Clot (DVT/PE)
- Clotting Disorder

Gastro

- Heartburn
- Crohns
- Colitis
- IBS

Heart

- Attack (MI)
- Arrhythmia
- Heart Disease
- Failure (CHF)

Thyroid

- Hypo(low)
- Hyper(high)
- Hashimoto's

Bone

- Gout
- Osteoarthritis
- Osteoporosis
- Rheumatoid (FM)
- Lupus

Neurology

- Paralysis
- Seizures
- Stroke
- MS

Lung

- Asthma
- COPD
- Emphysema
- TB

Mood

- Anxiety
- Depression
- OCD
- Bipolar
- ADHD

Cancer

- Bladder
- Lung
- Brain
- Ovarian
- Breast
- Prostate
- Colon
- Uterus

Family History (Check all that Apply)

Common

- Diabetes
- Blood Pressure
- Cholesterol
- Kidney Diseases
- Liver Disease

Blood

- Anemia
- Bleeding Disorder
- Clot (DVT/PE)
- Clotting Disorder

Gastro

- Heartburn
- Crohns
- Colitis
- IBS

Heart

- Attack (MI)
- Arrhythmia
- Heart Disease
- Failure (CHF)

Thyroid

- Hypo(low)
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Cancer

- Bladder
- Lung
- Brain
- Ovarian
- Breast
- Prostate
- Colon
- Uterus

First Name: _____

Last Name: _____

Surgical History

	Surgery	Reason	Year
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Social History

Smoking Tobacco: Never Current Smoker Past Smoker(Quit date): _____

Chewing Tobacco: Never Current User Past User(Quit date): _____

Alcohol: Never Current Drinker Past Drinker(Quit date): _____

Drug Use: Never Current User of: _____ Past User (Quit date): _____

Sexual History

Sexual Preference: Men Women Both Neither

Pregnancies: Number of times pregnant _____ Number of live births _____

Birth Control: Abstinent Condoms Hysterectomy Vasectomy
Medication Tubal Litigation Menopause Other _____

Last Menstrual Period: _____

Signature of Patient/Gardian/POA: _____

Date: _____



NEIGHBORHOOD
Primary Care

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