NEIGHBORHOOD
Primary Care

Phone: 702-659-9090| Fax: 888.288.5030 | Email: admin@ncchousecalls.com
2050 Mariner Dr. Ste., 120, Las Vegas NV 89128

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:
Relationshio to Patient: ☐ Self ☐ Spouse ☐ Parent	Relationshio 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: _____

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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 raferrals: 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.

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

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: _____

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