NEW PATIENT QUESTIONNAIRE

Please fill out the following questionnaire. Completion of this form will allow us to have more time to discuss any health problems that you might have.

Thank You!

Sincerely,

Brandi E. Guthrey, M.D.

Patient Name_____Date _____

Who was your previous primary care physician? _____

What other doctors have you seen in the past? _____

Pharmacy that you would like your medications sent to: _____

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1. List medications to which you are allergic:

2. List any medicines or vitamins that you currently take:

3. **List the types of surgery that you have had and the dates performed**:

4. **List any problems causing you to be hospitalized in the past (except for surgery and childbirth) along with the dates of these hospitalizations.**

5. Please circle any of the following problems that you may have:

Heart disease	Thyroid disease	Stroke	Lupus
High blood pressure	Tuberculosis	Cancer	Cataracts
Rheumatoid arthritis	Seizures	Anemia	Hepatitis
Kidney disease	Peptic ulcers	Diabetes	Kidney stones
Other_____			

6. **Please circle if any of your family members have the following diseases:**

Heart disease	Thyroid disease	Cancer	Other:
High blood pressure	Tuberculosis	Anemia	
Rheumatoid arthritis	Seizures	Diabetes	
Kidney disease	Stroke	Lupus	

7. **Please circle if you consume any of the following:**

Cigarettes	Coffee	Chewing Tobacco
Cigars	Tea	Beer/ Wine/ Liquor
Pipes	Soda Pop	

8. **Have you had any blood transfusions? Yes _____ No _____**
   If so, when? _____

9. **When was your last Tetanus vaccination? _____**

10. **Have you ever been given the Pneumococcal (Pneumovax) vaccine?**
    Yes _____ No _____

11. **When was your last Flu (influenza) shot? _____**

12. **Do you own or work with animals? Yes _____ No _____**
    If so, what types: _____

13. **Have you traveled to any foreign countries in the last 5 years?**
    Yes_____ No _____
    If so, where? _____

14. **What types of jobs have you done in the past?**

15. **Are you currently taking any Narcotics? If so who prescribes them?**

PLEASE NOTE DR.GUTHREY DOES NOT PRESCRIBE NARCOTICS

Sparks Clinic
A Division of Sparks Regional Medical Center

Patient Registration

Today's Date: _____ Primary Care Physician (PCP): _____

Patient Name: _____
First *Middle* *Last*

Birthdate: _____ Age: _____ Circle One: Male or Female

Social Security Number: _____ Marital Status: Single Married Divorced Widowed

Race: ____ Caucasian ____ Black ____ Hispanic ____ Asian ____ American Indian or Alaskan Native

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address *(if different from mailing address)*: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ Cell: ( ) _____ E-mail: _____

Employer: _____ Work Phone: ( ) _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Birthdate: _____ Age: _____ Circle One: Male or Female

Social Security Number: _____ Marital Status: Single Married Divorced Widowed

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address *(if different from mailing address)*: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ Cell: ( ) _____

Employer: _____

City: _____ State: _____ Zip: _____

Work Phone: ( ) _____

In case of an emergency, list whom we can contact: *(Please list at least one contact outside of your household)*

Contact: _____ Relationship: _____ Phone: ( ) _____

Contact: _____ Relationship: _____ Phone: ( ) _____

Do you have a Living Will? ____ Yes ____ No

Patient Label

Personal Insurance Information

Primary Insurance

Name of Person who carries primary insurance: _____

Social Security Number: _____ Birthdate: _____

Relationship to Patient: _____ Employer: _____

Name of Insurance Company: _____

Insurance ID# (as shown on card): _____

Secondary Insurance

Name of Person who carries secondary insurance: _____

Social Security Number: _____ Birthdate: _____

Relationship to Patient: _____ Employer: _____

Name of Insurance Company: _____

Insurance ID# (as shown on card): _____

I understand that if I do not have my current insurance information with me today, I will be responsible for the charges incurred. I understand that I have 30 days from my visit to supply copies of my current insurance cards and if I fail to do so, my insurance will not be filed and I will be responsible for the charges incurred. I agree that I am financially responsible for all services incurred today. This financial responsibility includes deductible, co-insurance, non-covered services, and all other sums of money that may become patient due.

Notice of Privacy Practice: I acknowledge receipt of Sparks' notice of Privacy Practice.

_____

Patient or Responsible Party Signature *Date*

I understand and consent to any medical or surgical treatment or tests that may be deemed needed as advised by the provider in charge of my care. I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals. This includes all or part of my medical record for this admission and may include information regarding:

- Testing, treatment, hospitalization and/or outpatient care for psychological or psychiatric impairment(s)
- Acquired immunodeficiency syndromes (AIDS) or a human immunodeficiency virus (HIV)
- Sexually transmitted diseases (STDs)
- Certain information related to drug and alcohol conditions

I understand I have a right to object to the use of my health information for directory purposes. I understand I have the right to request as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____

Patient or Responsible Party Signature *Date*