CEDAR RIDGE
FAMILY MEDICINE

NEW PATIENT INFORMATION

****{Please Fill Out Completely and Print Clearly}****

Today's Date ____/____/_____

First Name: _____ **M:** _____ **Last Name:** _____

Mailing Address: _____	**Billing Address (IF DIFFERENT):** _____
_____	_____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____

Cell Phone# (_____) _____-_____ Home Phone# (_____) _____-_____

Work Phone # (_____) _____-_____ Employer _____

Marital Status [ ] Single [ ] Married [ ] Widowed **Date of Birth** _____/_____/_____

Social Security # ___ ___ ___ --___ ___ -- ___ ___ ___ ___ [ ] Male [ ] Female

Race: [ ] White or Caucasian [ ] Hispanic or Latino [ ] Black or African American [ ] American Indian or Alaskan
[ ] Native Hawaiian or other Pacific Islander [ ] Asian [ ] Unknown Other_____

Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Other/Undetermined

Pharmacy of choice _____

E-mail address (for appt. reminders) _____

Primary Insurance _____

Policy Holder _____ DOB ____/____/____

Policy ID# _____ SS # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Secondary Insurance _____

Policy Holder _____ DOB ____/____/____

Policy ID# _____ SS # ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Guarantor (Parent or Guardian responsible for payment, if different from patient. (Must be filled out if you are under 18)

First Name: _____ Last Name: _____

Mailing Address: _____

City: _____ State _____ Zip _____

Home Phone # _____ DOB ____/____/____

Cell Phone # _____ SS # X X X - X X - ___ ___ ___ ___

EMERGENCY CONTACT

Name (Spouse/Parent/Guardian/other) _____

Relationship _____ Phone (_____) _____-_____

Mailing Address (if different) _____

Name of contact not living with you _____

Relationship _____ Phone (_____) _____-_____

Mailing Address _____

See Other Side!! →

CEDAR RIDGE
FAMILY MEDICINE
110 W 1325 N, Suite 200, Cedar City, UT 84721
1760 N Main St Suite 103, Cedar City, UT 84721

It is important that you read and understand the terms of this agreement before you sign.
We will be happy to answer any questions you may have.

Consent to Treatment

- I voluntarily consent and authorize diagnostic, medical and/or surgical treatment that the physician and /or His assistants deem necessary to properly care for me and my family members.

Financial Agreement

- I agree to pay my insurance co-payment, coinsurance, and/or deductible amounts at the time of service.
- I agree to pay for office visits at time of service if I am unable to show valid proof of insurance. I understand that lab tests and other ancillary testing **may be billed separately**.
- I agree to pay for services if ***Cedar Ridge Family Medicine*** is unable to collect from my insurance company within 90 days. I also agree to **pay for any services not covered** by my insurance company.
- I agree to pay Interest of 1 ½% per month on balances over 60 days past due from the date of service.
- I understand that accounts with balances over 90 days past due are referred to a collection agency and that I will be responsible for the original cost of service . . . (plus collection fees up to 50% of the amount billed), and attorney fees or both. I also understand that if my account has been sent to a collection agency, I may only be seen if cash payment is made in advance.

Being Late for or Missing Appointments

- I agree to notify 24 hours in advance if I ever need to cancel or reschedule an appointment. I also understand that in order to be fair to other patients, I may be asked to reschedule if I arrive more than 10 minutes late. I agree to pay a $40 fee the second time I miss an appointment without giving 2 hours advance notice. I also understand that I may no longer be able to be seen as a patient if I miss three appointments.

Assignment of Insurance / Medicare / Medicaid Benefits

- I give permission for ***Cedar Ridge Family Medicine*** to bill my insurance company in my name and for the insurance Benefits to be paid directly to ***Cedar Ridge Family Medicine.***
- I understand that it is my responsibility to understand my insurance coverage, requirements, Deductibles, co-payments, prior authorizations, etc.

Release of Information

I give permission for ***Cedar Ridge Family Medicine*** to disclose my personal medical information to my insurance company, other medical consultants, and facilities that may render care, and in situations that would require my transfer of care to another medical facility.

I also give permission for ***Cedar Ridge Family Medicine*** to disclose my personal medical information to:

[ ] My spouse _____ (Name)

[ ] Other _____ (Name & Relation)

I give permission for ***Cedar Ridge Family Medicine*** to give me my personal medical information via:

[ ] Release of Clinical Notes, labs and Records. (must be checked if med info. is to be released to listed person above)
[ ] Mental Health Reasons (must be checked in order to discuss case with listed person above)
[ ] Home Answering Machine
[ ] Other: _____

I acknowledge that I have been given an opportunity to read Cedar Ridge Family Medicine's Notice of Privacy Practices.

_____
Name of Patient (printed)

_____ _____
Signature of Patient (or representative) Relationship to Patient (if representative)

_____ _____/_____/_____
Signature of Witness Date of Signature

Name (Print) _____

DOB: _____/_____/_____

CEDAR RIDGE
FAMILY MEDICINE

PATIENT HEALTH HISTORY

Welcome to Cedar Ridge Family Medicine. In order for us to provide you with the best possible care we need your health history information. Please fill in your health history information as best as possible.

Please List the Primary Concerns You Have for Your First Visit Today:

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

Last Mammogram	Last PAP	Last Colonoscopy	Last HgA1C (diabetic patients)	Last Lipid/Cholesterol Check
Date: Results:	Date: Results:	Date: Results:	Date: Results:	Date: Results:

Last PSA (Prostate blood test)	Last TSH (Thyroid blood test)	Last PT/INR (Clotting test)	Last Pneumonia Shot	Last Tetanus Shot
Date: Results:	Date: Results:	Date: Results:	Date:	Date:

Last Dexa/Bone Density Scan	Are you up to date on Vaccinations?	Last Flu Shot
Date: Results:	Yes _____ No _____ For children please provide a copy of vaccination card	Date:

Allergies

List any drug or environmental allergies and the type of reaction (hives swelling, etc).

_____

_____

_____

PERSONAL MEDICAL HISTORY

Current/ Past

- [ ] [ ] Alcohol/Drug Abuse
- [ ] [ ] Allergy/Hay Fever
- [ ] [ ] Anemia
- [ ] [ ] Anxiety
- [ ] [ ] Arthritis-Osteoarthritis
- [ ] [ ] Arthritis-Rheumatoid
- [ ] [ ] Asthma
- [ ] [ ] Bladder/Kidney problems
- [ ] [ ] Blood clot (lung or leg)
- [ ] [ ] Blood Transfusion
- [ ] [ ] Breast lump (benign)
- [ ] [ ] Cancer(type)_____
- [ ] [ ] Cataracts
- [ ] [ ] C O P D
- [ ] [ ] Colon Polyps
- [ ] [ ] Coronary Artery Disease
- [ ] [ ] Depression
- [ ] [ ] Diabetes - childhood onset

PERSONAL MEDICAL HX CONT.

- [ ] [ ] Diabetes - adult onset
- [ ] [ ] Diverticulosis/Diverticulitis
- [ ] [ ] Emphysema
- [ ] [ ] Fractures (where)_____
- [ ] [ ] Gallbladder disease
- [ ] [ ] G E R D (Reflux, Heartburn)
- [ ] [ ] Glaucoma
- [ ] [ ] Gout
- [ ] [ ] Gynecological Condition (type)_____
- [ ] [ ] Heart Attack
- [ ] [ ] Hepatitis (type)_____
- [ ] [ ] High Blood Pressure
- [ ] [ ] High Cholesterol
- [ ] [ ] Infertility
- [ ] [ ] Irritable Bowel Syndrome
- [ ] [ ] Kidney Stones
- [ ] [ ] Liver Disease
- [ ] [ ] Migraine Headaches

PERSONAL MEDICAL HX CONT.

- [ ] [ ] Neurological Disorder
- [ ] [ ] Osteoporosis
- [ ] [ ] Pneumonia
- [ ] [ ] Prostate enlargement
- [ ] [ ] P V D (Peripheral Vascular Disease)
- [ ] [ ] Seizure Disorder
- [ ] [ ] Skin Condition (type)_____
- [ ] [ ] Sleep Apnea
- [ ] [ ] Stomach Ulcer
- [ ] [ ] Stroke
- [ ] [ ] Thyroid Disorder
- [ ] [ ] Urinary Tract Infections-recurrent
- [ ] [ ] Varicose Veins/Phlebitis
- [ ] [ ] Other_____
- [ ] [ ] Other_____
- [ ] [ ] Other _____

PAST SURGICAL HISTORY

Year

[ ] Abdominal (type)_____
[ ] Appendix Removal
[ ] Back Surgery
[ ] Biopsy (where)_____
[ ] Breast Surgery
[ ] Bronchoscopy
[ ] Carpal Tunnel
[ ] Cataract Extraction
[ ] Colon Resection
[ ] Coronary Artery Bypass Graft
[ ] Coronary Stent
[ ] Craniotomy
[ ] Gallbladder Removal

PAST SURGICAL HISTORY CONT.

[ ] Gastric Bypass
[ ] Heart Surgery (other than bypass)
[ ] Hemorrhoidectomy
[ ] Hip Replacement
[ ] Hysterectomy (partial or total)
[ ] Knee Arthroscopy
[ ] Knee Replacement
[ ] LEEP (cervix surgery)
[ ] Neck Surgery
[ ] Ovary Ligation ("Tubal")
[ ] Ovary Removal
[ ] Pacemaker
[ ] Prostatectomy or TURP
[ ] Rotator Cuff Repair
[ ] Sinus Surgery

PAST SURGICAL HISTORY CONT.

[ ] Tonsillectomy
[ ] Transplant (what)_____
[ ] Urinary Incontinence surgery
[ ] Vasectomy
[ ] Other _____
[ ] Other _____
[ ] Other _____
[ ] Other _____
[ ] Other _____

FAMILY HISTORY

(Please indicate which relative)

[ ] Alcoholism/Drug Abuse
[ ] Alzheimers
[ ] Anemia
[ ] Anxiety
[ ] Asthma
[ ] Autoimmune Disorder
[ ] Bleeding/Clotting Disor.
[ ] Cancer-Type:

[ ]_____
[ ]_____
[ ]_____
[ ] Coronary Artery Dis.

FAMILY HISTORY CONTINUED

[ ] Depression
[ ] Diabetes (childhood onset)
[ ] Diabetes (adult onset)
[ ] Emphysema/COPD
[ ] Genetic Disorder

[ ] Glaucoma
[ ] Heart Disease
[ ] Hepatitis (type)_____
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Hypothyroidism
[ ] Kidney Disease/Stones
[ ] Macular Degeneration

FAMILY HISTORY CONTINUED

[ ] Migraine Headaches
[ ] Osteoporosis
[ ] Psychiatric Care
[ ] Seizures
[ ] Stroke
[ ] Other_____
[ ] Other_____
[ ] Other_____

SOCIAL HISTORY

[ ] Current Smoker Yr. Start_____
[ ] Former Smoker Yr. Quit_____
[ ] Never Smoked
[ ] Other Tobacco
[ ] Alcohol Use:
Type_____ Frequency_____
[ ] Drug Use: Substance_____
[ ] Regular Exercise

SOCIAL HISTORY CONTINUED

Occupation_____
Employer _____
Marital Status _____
Number of Children _____

List of Current Medications (Dosage and Frequency of Use)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

I agree the information on this Health History form is accurate and correct to the best of my knowledge and that Cedar Ridge Family Medicine will not be held responsible for any health related conditions or allergies that are not reported.

_____ **Patient Signature**

_____ **Today's Date**