FOUNTAIN MEDICAL ASSOCIATES INTAKE FORMS

How did you hear about us? ____

PATIENT INFORMATION: PLEASE PRINT

First Name: _____________________Middle_____ _______Last Name: _______________________

Date of Birth: _______________ ___ Sex: Male: ____ Female: ____ Age: ____

Social Security # _______-______-_________ Marital Status: _________

Address: ___________________________________City: ____________________ State: _________

Zip Code: ________ Home Phone: _______________________Cell Phone: _____________________

Work Phone: _____________________

Employer: __________________________

Personal Email Addresss____

Emergency Contact: ______________________Phone No.___________________Relationship:________

PRIMARY INSURANCE INFORMATION:

Insurance Company: __________________________ Member ID: ____________________

Group # ______________ Claims Mailing Address: _______________________ City: ________________

State: ____ Zip Code: __________ Name of Insured: ________________________________

Relationship to Patient: ________________________ Insured's Date of Birth: ___________

Social Security # ____-_____-______ Insurance Phone Number: _______________

SECONDARY INSURANCE INFORMATION:

Insurance Company: ____________________ _____ Member ID: _________________

Group # ________________ Name of Insured: _____________________

Relationship to Patient: ________________________ Insured's Date of Birth: ___________

Social Security # ____-_____-_____ Insurance Phone Number________________

MEDICAL HISTORY Date____________ ___ Office Use: Reviewed-MA /Staff Initials______

PATIENT'S QUESTIONAIRE; PLEASE ANSWER AS ACCURATELY AS YOU CAN

What is the Level of Your Health? Excellent _____ Good _____ Fair _____ Poor _____

Chief Complaint

Please list your most concerning health care problems at this time and duration of problem

1. ____

2. ____

3. ____

Past Medical History:

Please list any serious medical conditions for which you have been treated / hospitalized in the past:

Problem Dates

1. ________________________________ 6. ________________________________

2. _______________________________ 7. ________________________________

3. ________________________________8. ________________________________

4. ________________________________9. ________________________________

5. _______________________________ 10. ________________________________

Past Surgical History:

Please list any Surgical Procedures you have had and the approximate dates:

1. ________________________________ 6. ________________________________

2. _______________________________ 7. ________________________________

3. ________________________________8. ________________________________

4. ________________________________9. ________________________________

5. _______________________________ 10. ________________________________

Medications:

List all of the Prescription Medicines or Over the Counter Drugs including herbs you are now taking and doses:

1. ________________________________ 6. ________________________________

2. _______________________________ 7. ________________________________

3. ________________________________8. ________________________________

4. ________________________________9. ________________________________

5. _______________________________ 10. ________________________________

Allergies:

Please list any medications to which you are allergic:

____

____

Please list any foods that you are allergic or sensitive:

____

____

Family History:

Please list health disorder or condition that tend to run in your family and list what relative (father, grandmother, etc.)

1. ________________________________ 6. ________________________________

2. _______________________________ 7. ________________________________

3. ________________________________8. ________________________________

4. ________________________________9. ________________________________

5. _______________________________ 10. ________________________________

Social History:

Please check beside any of the following you have used in the past or currently:

______ Alcohol (beer, wine or spirits)

______ Illegal Drugs

______ Tobacco (cigarettes, cigar, pipe)

______ Tobacco (chewing)

______ Coffee

IMMUNIZATION HISTORY:

Tell Us: Yes or No and Date of Last Shot

Chicken Pox or Vaccination? _____ Date: _________ Hepatitis B Vaccination? _____ Date: ________
Influenza Vaccination? _______ Date: ____________Pneumonia Vaccination? _______ Date: _________
Rubella Vaccination or Blood Titer Test? ____ Date: _______Tetanus Vaccine? _______ Date: ________

Shingles Vaccination? ______Date: ________

REVIEW OF SYSTEMS: Check Yes if you currently have any of the following conditions

NEURO

NO YES

_____ _____ Headaches

_____ _____ Seizures

_____ _____ Dizziness

_____ _____ motion sickness/head spinning /Vertigo

_____ _____ Balance / Gait Problem

_____ _____ Tingling or Numbness

_____ _____ Fainting spells/Passing out

_____ _____ Sensitive to light

_____ _____ Sensitive to Noise

_____ _____ Weakness

_____ _____ Tremors/Shakings

_____ _____ Memory problems

_____ _____ Confusion

NECK

NO YES

_____ _____ Neck Injury

_____ _____ Neck Pain

_____ _____ Thyroid Problem

_____ _____ Swollen glands

REVIEW OF SYSTEMS: Check Yes if you currently have any of the following conditions

HEENT

NO YES

_____ _____ Hair Loss

_____ _____ Head Injury

_____ _____ Hearing Problem

_____ _____ Ringing in Ear

_____ _____ Ear Infections

_____ _____ Discharge from Ear

_____ _____ Retina Problems

_____ _____ Wear Glasses

_____ _____ Glaucoma

_____ _____ Cataracts

_____ _____ Eye Pain

_____ _____ Red eye

_____ _____ Sinus infections

_____ _____ Nose Allergy

_____ _____ Loss of Smell

_____ _____ Frequent cavities

_____ _____ Teeth problems

_____ _____ Gum problems

_____ _____ Loss of taste

_____ _____ Sore throats

_____ _____ Swallowing problem

_____ _____ Loss of voice

REVIEW OF SYSTEMS: Check Yes if you currently have any of the following conditions

Genitourinary:

NO YES

____ ____ Frequent Urination

____ ____ Painful Urination

____ ____ Difficulty urinating

____ ____ Waking to Urinate

____ ____ Incontinence

____ ____ Blood in Urine

Male

____ ____ Erection problems

____ ____ Discharge from Penis

____ ____ Testicle pain or swelling

____ ____ Infertility

Female

____ ____ Vaginal discharge

____ ____ Painful Intercourse

____ ____ Vaginal itching

____ ____ Heavy periods

____ ____ Irregular periods

____ ____ Long lasting periods

____ ____ Bleeding between periods

____ ____ Pelvic pain

____ ____ Excessive flushing

___ ____ Menopause

Age menstruation began: __________

How frequent are periods: every ______ days How long do Periods usually last? ________ days

REVIEW OF SYSTEMS: Check Yes if you currently have any of the following conditions

Gastrointestinal:

NO YES

____ ____ Abdominal pain

____ ____ Heartburn

____ ____ Nausea

____ ____ Vomiting

____ ____ Indigestion

____ ____ Bloating

____ ____ Diarrhea

____ ____ Constipation

____ ____ Blood in Stool

____ ____ Anal pain

____ ____ Rectal Itching

____ ____ Abdominal swelling

Skin:

NO YES

____ ____ Ulcers

____ ____ Rashes

____ ____ Itching

____ ____ Warts

____ ____ Hives

____ ____ Boils / Abscesses

____ ____ Acne

____ ____ Skin cancer

REVIEW OF SYSTEMS: Check Yes if you currently have any of the following conditions

Musculoskeletal:

NO YES

____ ____ Muscle pain

____ ____ Joint pain

____ ____ Bone pain

____ ____ Broken Bones

____ ____ Recurrent falls

____ ____ Weakness in arms/legs

Mental Health

NO Yes

____ ____ Difficulty Concentrating

____ ____ Impulsive

____ ____ Restlessness

____ ____ Nervousness / Anxiety

____ ____ Loss of interest

____ ____ Irritability

____ ____ Anger problems

____ ____ Mood Swings

____ ____ Depression / Sadness

____ ____ Hallucinations

____ ____ Feelings of Euphoria

____ ____ Difficulty falling asleep

____ ____ Nightmares

____ ____ Waking frequently

____ ____ Waking too early

REVIEW OF SYSTEMS: Check Yes if you currently have any of the following conditions

Respiratory:

NO YES

_____ _____ Ribs pain

_____ _____ Hemoptysis (coughing blood)

_____ _____ Persistent Cough

_____ _____ Wheezing

_____ _____ Phlegm (frequent)

_____ _____ Short of Breath

_____ _____ Fluid in Chest

_____ _____ Stops breathing during sleep

Cardiovascular:

NO YES

_____ _____ High blood pressure

_____ _____ Low blood pressure

_____ _____ Heart Valve Problems

_____ _____ Chest Pain

_____ _____ Chest Tightness

_____ _____ Palpitations

_____ _____ Irregular Heartbeat

_____ _____ Ankle or leg swelling

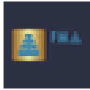
Please list any other specific problems that you have: ____

____

AUTHORIZATION TO TREAT (PLEASE SIGN & DATE)

I hereby authorize medical treatment for the above patient. I fully acknowledge that all office visits are on a cash basis and will be paid in full at the time of visit, unless otherwise contracted by my insurance. I further understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to Fountain Medical Associates and /or its providers, for any fees not covered by insurance. I also understand there might be a charge of $25.00 for a No-Shows or Cancellation without a 24-hour notice except for medical emergency situation.

Patient/Authorized Signature: _______________________________ Date: ___/___/___



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____ Date of Birth: ____________________
Date of Request ______________________________ Social Security # ________ ______ _________
Address: __________________________ _________________________ ____ ____________________

RECEIVE RECORDS FROM: Physician /Facility
Name:____Specialty_____________________ Phone #
_____________________________ Fax # ________________________________ Address:
______________________ ____

RELEASE RECORDS TO: FOUNTAIN MEDICAL ASSOCIATES Internal Medicine / Osuoha Chima M.D. 3599 S. Eastern Avenue, Las Vegas, NV 89169 Fax# 702-522-1653 Phone# 702-522-0701

Please send a copy of my medical records: to
____

SELECT ALL THAT APPLY: Chart/Progress Notes /H&P____ Lab Reports ____ X-ray Reports____
Discharge Summary ___ All Records____ Other: ________________________________

Purpose of releasing medical information: _____________________________________

Date(s) Requested _____________

I understand that my express consent is required to release any health information relating to testing, diagnosis, and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42C.F.R. Part 2) prohibits anyone from making any further disclosure of these records without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Patient / Authorized Signature: ___________ __________________ Date: ___/___/_______

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS

I hereby authorize Fountain Medical Associates providers and staff to disclose my protected health information to the following Family, Friends, and/or Caregivers:

Name: _________________________ Relationship: ____________ Phone # _________________
Name: _________________________ Relationship: ____________ Phone # _________________
Name: _________________________ Relationship: ____________ Phone # _________________

*I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department.

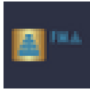
*I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment or payment of healthcare operations as cited in the Notice of Privacy Practices.

*I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not to sign this form to assure treatment.

*Unless, otherwise revoked or specified below, this authorization will remain indefinitely. I would like this authorization to expire on____________________________

Patient Signature: ____________________________ ____________Date: ___/___/_______

Guardian / Authorized Signature: ____________________________Date: ___/___/_______



RETREIVING YOUR OWN MEDICAL RECORDS

If you chose to retrieve your medical records, how would you prefer them? Please number in priority order with (1) being the most preferred and (5) being the least preferred.

(a) Patient Portal (___)

(b) Paper Copied Records (___)

(c) Emailed to secure /HIPPA compliant e-mail (___) (depends how large file is) Secure E-Mail address: ___________________________

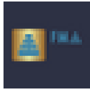
(d) Regular Mail (___)

Mailing address: ___________________ ___________City: ______________ State: ___Zip Code: ____________

(e) I prefer to pick up my records (__) Contact Phone # _____________________

Note: All Medical Records request must be in writing and signed by Patient or Authorized Individual with Power of Attorney. There might be an administrative fee for processing release of large volume of medical records billed directly to Patient or Representative.

Patient/Authorized Signature: _____________________________ Date: ___/___/_______



PATIENT PORTAL ACCESS

Patient Name: _______________________________ Date of Birth: ___________________

Our Patient Portal is now up and running. Please indicate if you would like access to the patient portal. The patient portal allows you to have access to some of your medical information and be proactive in your healthcare. Our staff can assist you with setting up this portal.

1) I would like access to the Patient Portal Yes / No (circle one)

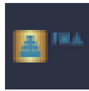
2) If NO, please circle one (a) Refuse to participate (b) Does not have e-mail account (c) Will not disclose d) No interest in the Patient Portal e) Other ___________________

Patient/Authorized Signature: ___________________________ Date: ___/___/_______

NOTICE OF PRIVACY PRACTICES

I, ____________________________, Date of Birth____________________ acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the practices use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Patient/Authorized Signature: ____________________________ Date: ___/___/_______



FOUNTAIN MEDICAL ASSOCIATES

Chima Osuoha MD. MPH.

Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner.

You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I want an office visit, not a telehealth visit?

You can still schedule an office visit if allowed by your physician office, local or state mandates and public health guidelines.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit. But until the office opens for all appointments, you will get an office visit only for one of the reasons listed above.
- If you decide you do not want to use telehealth again:
    - call 702-522-0701 and say you want to stop, **OR**
    - sign into your patient portal and [send us a secured message OR follow instructions to unsubscribe.]
    - It will be as if you never signed this form.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?

No. Only sign this document if you want to use telehealth.

Do not sign this form until you start your first telehealth visit. Your provider will discuss it with you.

What does it mean if I sign this document?

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You want a telehealth visit.

If you sign this document, we will give you a copy.

Your name (please print) Date

Your signature