

## First Point of Contact Screening

**Patient Name** \_\_\_\_\_  
Please print full legal name

**Date** \_\_\_\_\_

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms? YES NO

If yes, please circle the symptoms you have now, or have had, over the past seven days?

- fever
- night sweats
- sneezing or runny nose
- severe headache
- stiff neck
- muscle or joint pain (circle one or both)
- new rashes or open sores on your skin or in your mouth
- redness, swelling, or discharge of your eyes (pink eye)
- unexplained bleeding
- vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? YES NO

If yes, please list where: \_\_\_\_\_

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? YES NO

If yes, please list where: \_\_\_\_\_

**Thank you for your help and support in caring for our patients and community.**

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**\*\*TO BE FILLED OUT BY OFFICE STAFF\*\***

Reviewed by: \_\_\_\_\_

Action taken:

- No action taken
- Isolate
- Cough/ hand washing etiquette provided
- Mask provided
- PM/ Lead clinical provided

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*Thank you for trusting us with your healthcare!*

*Revised: 01/11/17*

On behalf of the team here at Mountain Vista OB/GYN & Midwifery we want to welcome you to the practice! We understand you have a variety of choices in your healthcare and we want to thank you for choosing our Practice for your OB/GYN needs!

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Who will be taking care of you today?**

- Amita Kumar, M.D.
- Lori Lindsay, M.D.
- Alex Marcotty, M.D.
- Kenneth Moss, M.D.
- Andrew Ross, M.D.
- Elizabeth Newell, M.D.
- Jennifer Wilson, M.D.
- Lauren Linden, CNM
- Shana Martin, CNM
- Mary Wilterdink, CNM
- Joan Girard, NP
- Shelbie Paul, NP
- Diane Torres, NP
- Abbie Wegert, NP

**How did you hear about our practice?**

- Referring provider (First and last name) \_\_\_\_\_
- Family/friends
- Healthgrades.com
- Insurance (Physician directory)
- Mountain vista website
- Direct mailer
- Social Media (facebook, blog, twitter) \_\_\_\_\_
- Search engine (specify) \_\_\_\_\_
- Vitals.com
- Yelp.com
- Google places
- Other \_\_\_\_\_
- Received postcard in the mail

To find out more information visit our website at:

<http://www.MountainVistaOBGYNMidwifery.com>

***Thank you for taking the time to let us know how you heard about us.***

## General Consent for Care and Treatment Consent

**TO THE PATIENT:** You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Printed Name of Witness**

\_\_\_\_\_  
**Employee Job Title**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

## Patient Responsibility Policy

**Thank you for choosing Mountain Vista OB/GYN and Midwifery for your OB/GYN needs.**

**In order to achieve our goal in providing and maintaining a good physician-patient relationship we believe it is important to have solid policies in place. The policy below is designed to help provide our patients with high quality, cost-effective and timely health care. We ask that you carefully read and sign the following expectations prior to your visit.**

A 24 hour notice is expected for all appointment cancellations and reschedules.

- o If you **fail** to notify us of a cancellation or reschedule your appointment it will result in a “No-Show/ No-Call”.

Patients with repeat “No-show/ No-Call’s” are subject to review with possible discharge from the practice.

Patients are expected to arrive **15 min. prior to their scheduled appointment time** to accommodate the check-in process.

- o If you **fail** to arrive 15 min. prior to your appointment you may be asked to reschedule.

Upon arrival, please sign in at the front desk and present complete insurance information.

- o Which includes: current health insurance cards and proper picture ID.
- o You will be asked to present both of these items at each visit for proper identification.
- o If you **fail** to provide complete or current insurance information we may not be able to accurately file your claim(s) and you will be responsible for full payment until accurate information is submitted to our office.

Co-payments are expected to be paid at each visit if required by your insurance plan.

It is the patient’s responsibility to know their Healthcare benefits and coverage limitations.

- o Any services determined NOT covered by your insurance plan will be the patient’s responsibility to pay.

A 35 % discount is provided to patients without health care coverage or if we do not participate with their health plan.

**I, the undersigned, have read and understand the Mountain Vista OB/GYN and Midwifery Patient Responsibility Policy above. I agree to comply and accept the terms and responsibility to the policy as outlined above. I agree to pay for all services rendered NOT covered by my insurance plan and to notify the office should there be any changes to my health insurance coverage.**

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient Signature (or Responsible Party)

\_\_\_\_\_  
Date

## Patient Privacy Policy

**In an effort to protect your privacy, our practice standard does not allow sharing of medical information with anyone except the patient or legal guardian or for messages to be left on voice mail unless permission is given. If you would like to grant permission please indicate below.**

**Approved phone numbers for detailed voice mail messages:**

My home phone: \_\_\_\_\_

My cell phone: \_\_\_\_\_

My work phone: \_\_\_\_\_

OTHER: \_\_\_\_\_

My Spouses phone: \_\_\_\_\_

My Spouses Name: \_\_\_\_\_

**I, the undersigned, give permission to the office of *Mountain Vista OB/GYN and Midwifery* to leave a phone message regarding my medical care on the numbers listed above, including the voice mail associated with that number.**

\_\_\_\_\_  
Patient Signature (or Responsible Party)

\_\_\_\_\_  
Date

**Patient Review of Systems**

Name: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

DOB: \_\_\_\_\_

Other Physician/Specialist: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Highest level of school completed:  High school  College  Graduate Degree  other: \_\_\_\_\_

**\*Please answer all questions if applicable. All information will be kept confidential.**

Are you **currently** experiencing any of the following? (Please circle Yes or No)

<u>Constitutional</u>			<u>Resp./Pulmonology</u>			<u>Gynecology</u>			<u>Psychology</u>		
Fatigue	No	Yes	Coughing	No	Yes	Abnormal bleeding	No	Yes	Anxiety	No	Yes
Fever	No	Yes	Shortness of breath	No	Yes	Infertility issues	No	Yes	Changes in appetite	No	Yes
Weight loss	No	Yes	Sleep apnea	No	Yes	Painful intercourse	No	Yes	Depression	No	Yes
Weight gain	No	Yes	Wheezing	No	Yes	Pelvic pain	No	Yes	Insomnia	No	Yes
<u>Skin &amp; Breast</u>			<u>Cardiology</u>			Vaginal discharge	No	Yes	<u>Hem/ Lymph</u>		
Breast discharge	No	Yes	Chest pain	No	Yes	Vaginal itching	No	Yes	Anemia	No	Yes
Lump in breast(s)	No	Yes	Swollen Ankles	No	Yes	<u>Musculoskeletal</u>			Bruising easily	No	Yes
Pain in breast(s)	No	Yes	Heart palpitations	No	Yes	Joint/back pain	No	Yes	Chills	No	Yes
Skin lesions	No	Yes	<u>Gastroenterology</u>			Muscle pain	No	Yes	Night Sweats	No	Yes
Dry skin	No	Yes	Abdominal pain	No	Yes	Muscle weakness	No	Yes	<u>Endocrinology</u>		
<u>HEENT</u>			Blood in stool	No	Yes	<u>Neurology</u>			Hair loss	No	Yes
Change in vision	No	Yes	Constipation/	No	Yes	Balance Issues	No	Yes	Hot flashes	No	Yes
Hearing Loss	No	Yes	Diarrhea	No	Yes	Numbness	No	Yes	Heat/Cold Intolerance	No	Yes
Ringing in ears	No	Yes	Nausea/Vomiting	No	Yes	Seizures	No	Yes			
Congestion	No	Yes	<u>Genital/Urinary</u>			Fainting	No	Yes			
Sore Throat	No	Yes	Blood in urine	No	Yes	Changes in speech	No	Yes			
Headache	No	Yes	Painful urination	No	Yes	Tingling	No	Yes			
			Frequent urination	No	Yes						
			Frequent UTI's	No	Yes						

Last Menstrual Period: \_\_\_\_\_

Medications and Vitamins:

Name	Dose

Allergies to Medications?


Review with patient. Provider Signature \_\_\_\_\_

## New Patient Health History

Name: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

DOB: \_\_\_\_\_

Other Physician/Specialist: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Highest level of school completed:  High school  College  Graduate Degree  other: \_\_\_\_\_

**\*Please answer all questions if applicable. All information will be kept confidential**

**Do you have any allergies?**  No  Yes (please list below)

**Are you currently taking any Prescription or Over-the-counter medications, herbal remedies or vitamins?**  No  Yes (please list below)

Name of Medication	Dose (total mg)	How many times per day?	When do you take it? (Morning, afternoon, night)	Name of prescribing doctor?	How do you take the medication?
					<input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Dermal
					<input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Dermal
					<input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Dermal
					<input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Dermal
					<input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Dermal
					<input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Dermal
					<input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Dermal
					<input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Dermal

**Personal Medical History:** Have you ever had any of the following?

Illness	(Circle Yes or No)	Illness	(Circle Yes of No)
Anemia	No Yes	Eating Disorder	No Yes
Arthritis/joint pain	No Yes	Glaucoma	No Yes
Asthma	No Yes	High Blood Pressure	No Yes
Bowel trouble	No Yes	Kidney Disease	No Yes
Cancer	No Yes	Pneumonia	No Yes
-If yes, type of cancer:		Rheumatic Fever	No Yes
Chronic Lung Disease	No Yes	Seizures/epilepsy	No Yes
High Cholesterol	No Yes	Stroke	No Yes
Heart Disease	No Yes	Thyroid Disease	No Yes
Depression/anxiety	No Yes	Tuberculosis	No Yes
Diabetes	No Yes	Other: _____	No Yes
DVT's/Clotting Disorder	No Yes	Other: _____	No Yes

GYN History		Sexual History	
Date of your last Pap?		Are you sexually active?	No Yes
Have you ever had an abnormal Pap?	No Yes	-If yes, is your partner: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both	
-If yes, when?		Lifetime sexual partners: #	
-Treatment?		How many sexual partners in the last year?	
Age when periods began?		Do you have a history of sexual abuse/ assault?	No Yes
Date last period began: / /		Do you have a history of sexually transmitted infections?	No Yes
Number of days between periods:		- If yes, what?	
How would you describe your flow? <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy			
How many days do your periods last?		<b>Contraceptive History</b> <input type="checkbox"/> N/A	
Do you have any problems with your periods?	No Yes	Current method of contraception: (check box below)	
-If yes, what?		<input type="checkbox"/> None <input type="checkbox"/> Natural Family Planning <input type="checkbox"/> Condoms <input type="checkbox"/> Diaphragm <input type="checkbox"/> Nexplanon <input type="checkbox"/> Depo-Provera <input type="checkbox"/> IUD <input type="checkbox"/> Permanent Sterilization <input type="checkbox"/> Pills <input type="checkbox"/> Nuva Ring <input type="checkbox"/> Other, which? _____	
<b>GYN History: (ONLY For women 40 yrs and older)</b>		How long have you been using this method? _____	
If you are <u>not</u> having menstrual periods, is it due to:		Are you having problems with this method?	
<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Pregnancy <input type="checkbox"/> Menopause <input type="checkbox"/> Other: _____		No Yes	
If Menopausal, do you experience any of the following:		-If yes, explain:	
<input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats <input type="checkbox"/> Insomnia <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> other: _____		Do you want contraceptives now?	
		No Yes	

Are you taking hormones?	No	Yes	-If yes, which method?
-If yes, what type:			
Do you experience any involuntary urine leakage?	No	Yes	
Have you had a colorectal cancer screening?	No	Yes	
-If yes, when was your last?			
Have you ever had a Mammogram?	No	Yes	
-If yes, when was your last?			
-Where?			

**OB/ Pregnancy History**  None Total number of Pregnancies: \_\_\_\_\_ Total number of Living children: \_\_\_\_\_  
 # Miscarriages: \_\_\_\_\_ # Live births: \_\_\_\_\_ # Abortions: \_\_\_\_\_ # Still births: \_\_\_\_\_ # Ectopic: \_\_\_\_\_ # C-sections: \_\_\_\_\_  
 (List pregnancies below)

Birth year	Sex	Wt. of Baby	Hrs in labor	Wks. gestation	Vag. / C/S	Anesthesia used	Complications

**Surgeries/Hospitalizations** (Please list any surgeries or hospitalizations below, if not leave blank)

Date	Surgery/Hospitalization	Date	Surgery/Hospitalization

**Family History** Has anyone in your family ever had any of the following?

Illness	(Circle Yes or No)		If yes, who? (which maternal or paternal family member)	Illness	(Circle Yes or No)		If yes, who? (which maternal or paternal family member)
	No	Yes			No	Yes	
Anemia	No	Yes		Eating Disorder	No	Yes	
Arthritis/joint pain	No	Yes		Glaucoma	No	Yes	
Asthma	No	Yes		High Blood Pressure	No	Yes	
Bowel trouble	No	Yes		Kidney Disease	No	Yes	
Cancer	No	Yes		Pneumonia	No	Yes	
-If yes, type of cancer:				Rheumatic Fever	No	Yes	
Chronic Lung Disease	No	Yes		Seizures/epilepsy	No	Yes	
High Cholesterol	No	Yes		Stroke	No	Yes	
Heart Disease	No	Yes		Thyroid Disease	No	Yes	
Depression/anxiety	No	Yes		Tuberculosis	No	Yes	
Diabetes	No	Yes		Other: _____	No	Yes	
DVT's/Clotting Disorder	No	Yes		Other: _____	No	Yes	

**Social History**

Do you drink alcohol?	
-If yes, # drinks/day: _____ # drinks/week: _____	
Have you ever smoked cigarettes? <input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	
-Packs/day: _____ -# of years: _____	
Do you exercise regularly?	No Yes
- If yes, #/week: _____ type: _____	
Do you use recreational drugs?	No Yes
-If yes, what type: _____	
Do you drink caffeine?	No Yes
- If yes, # drinks/wk? _____	
Are you on a special diet?	No Yes
If yes, what? _____	

### Mountain Vista OB/GYN and Midwifery

Our practice is now on EMR and would like to web-enable you to our patient portal. You would be able to obtain your records online, see your lab/test results and send/receive secure messages to/from your provider. Do you consent to be web-enabled? YES \_\_\_\_\_ NO \_\_\_\_\_

\*E-Mail Address: \_\_\_\_\_

**PATIENT INFORMATION** (Please Print)

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Previous Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex:  F – Female  M – Male  Transgender

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell No. \_\_\_\_\_ SSN: \_\_\_\_\_

\*E-Mail Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Employment Status:**  1 - Full-Time  2 - Part-Time  3 - Not Employed  4 - Self-Employed  5 – Retired  6 - Active Military

**Student Status:**  F - Full-Time Student  P - Part-Time Student  N – Not a Student

**Marital Status:**  Married  Single  Divorced  Widowed  Legally Separated Partner

**Race:**  American Indian or Alaska Native  Asian Native  Hawaiian or Other Pacific Islander  Black or African American  White  Declined

**Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino  Declined

**Language:**  English  Spanish  Indian  Japanese  Chinese  Korean  French  German  Russian  Other \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ Phone: \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_

Emergency Contact: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION – ONLY IF PATIENT IS A MINOR (Or Power of Attorney relationship)**

**Check here if information is same as patient**  Responsible Party (If minor):  Another Patient  Guarantor

Responsible Party Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

DOB: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell No: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber ID (Policy Number): \_\_\_\_\_ Group ID: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Patient Relationship to Policy holder: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION (If Medicare, please provide reason)** (provide your insurance card to the front desk at check-in)

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber ID (Policy Number): \_\_\_\_\_ Group ID: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Patient Relationship to Policy holder: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

**Medicare Secondary reason:**  Working Aged Beneficiary/Spouse  Disabled Beneficiary under age  Other liability

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

**Patient (or Responsible Party) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_