

MOUNTAIN VIEW SPECIALITY CLINIC

HIGHWAY 14 EAST/P.O. BOX 1580

MOUNTAIN VIEW, AR 72560

Thank you for visiting our clinic. Please print the following information to help us serve you better.

PATIENT INFORMATION: Reason for Visit: _____ R ___ L ___

Legal Name: _____

Last First Middle Maiden

SS# _____ - _____ - _____ Male ___ Female ___ Date of Birth ____/____/____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Marital Status: _____

Occupation _____ Employer _____

REFERRING PHYSICIAN: Name _____ City _____

FAMILY OR PRIMARY CARE PHYSICIAN (PCP) ___ Same as Referring Physician

Name _____ City _____

INSURANCE: Do you have medical insurance? Yes ___ No ___

If you do not have insurance, how do you plan to pay for services today?: Cash, Check or Credit Card in full today ____ . Workman's Comp ____, Payment Plan ____, Other ____.

If this visit is related to an accident or Worker's Compensation please provide the following:

Type of Accident/Injury: Auto ___ Crime ___ Employment ___ Other ___

Date of Accident/Injury: _____ Place of Accident/Injury: _____

Is this Worker's Comp? Yes ___ No ___ If yes, list contact name _____

Phone # () _____

MEDICAL HISTORY

Have you had or still any of the following:

- | | | | |
|---|----------------|--------------------------------|----------------|
| 1. Bronchitis, Cough, Shortness of breath | [] Yes [] No | Asthma or Hayfever | [] Yes [] No |
| 2. Pneumonia, Tuberculosis, Emphysema | [] Yes [] No | Angina or Other Chest Pain | [] Yes [] No |
| 3. Heart Condition of Any Kind | [] Yes [] No | Heart Surgery or Pacemaker | [] Yes [] No |
| 4. Palpitations, Irregular or Fast Heart Beat | [] Yes [] No | High Blood Pressure | [] Yes [] No |
| 5. Anticoagulants (Coumadin, Aspirin) | [] Yes [] No | Anti-inflammatory Medications | [] Yes [] No |
| 6. Prednisone, Cortisone or other Steroids | [] Yes [] No | Stroke or TIA | [] Yes [] No |
| 7. Seizure, Convulsions, Epilepsy | [] Yes [] No | Glaucoma or Retinal Detachment | [] Yes [] No |
| 8. Diabetes | [] Yes [] No | Kidney or Urinary Disease | [] Yes [] No |
| 9. Jaundice, Hepatitis, Liver Ds | [] Yes [] No | Bleeding Tendency | [] Yes [] No |
| 10. Healing/Wound Problems | [] Yes [] No | Transfusions | [] Yes [] No |
| 11. Illicit Drug Use | [] Yes [] No | Do you smoke/drink alcohol | [] Yes [] No |

Surgery: Yes ___ No ___

Reason

Year

Have you or a close family member ever had problems with anesthesia? Yes ___ No ___

If yes, please describe: _____

Allergies: Yes ___ No ___

List all drugs or substances to which you are allergic and specify the type of reaction: itching, rash, hives, wheezing, swelling, difficulty breathing, etc.

Drug/Substance

Reaction

Medications: Yes ___ No ___ If you have a list, please give it to receptionist!

List all medications which you now take regularly to include diet supplements/vitamins and herbal preparations.

Medication

Strength

Times per day

Remarks _____

Release and Assignment:

1. I authorize the release of any medical information necessary to process my insurance claims.
2. I authorize and request payment of medical benefits directly to my physicians.
3. I agree that this authorization will cover all medical services rendered until revoked by me.
4. I understand that I am responsible for **all insurance deductibles and amounts not otherwise covered by my insurance.**
5. **Payment is expected at time of service unless other arrangements are made.**

By typing your name below you are agreeing to the above conditions.

Typed by Patient or Guardian

Date

Reviewed By: _____

Date: _____