RIVER CITY FAMILY HEALTH
Deni Llovet, FNP
742 Kensington Street, Missoula, MT 59801
Ph: (406) 541-8090 Fax: (406) 541-8093
www.rivercityfamilyhealth.com

Do you have insurance? **YES** **NO**
Have you been seen in this office before? **YES** **NO** Referred by____________________________
Current Dentist______________________
PATIENT INFORMATION
Last Name_______________________________ First Name _______________________________ Middle _____
I prefer to be called ______________________
Street Address ____ Mailing Address_______________________
City ______________________ State ___ Zip ________ Email ____
Home Phone ______________________ Cell Phone ______________________
Employer ______________________ Occupation____________________ Work Phone _____________________
Date of Birth ____/____/_______ Age ____ Social Security # ____-____-_______
Sex **M F** Marital Status **S M W D** Spouse's Name______________________
If patient is a minor, Parent/Guardian Name______________________
In case of emergency, friend or relative not living with you _________________ Phone _____________________
Pharmacy Preference ______________________
ARE YOU ALLERGIC TO ANY MEDICATIONS?
____
____
____
____
____

AUTHORIZATION:
- All of the above information is true to my knowledge.
- I authorize this office to release to my insurance company, third party, medical facility or attorney any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.
- I understand that payment of charges is due in full at the time of service unless I have insurance coverage. I understand that failure to pay may result in dismissal from the practice.
- I understand that payment may be made in the form of cash, check, money order, or credit card.
- I understand that there is a $25 charge for returned checks which, with the charge of the previous visit, will be collected by cash or credit card prior to being seen at the next appointment and that only cash or credit card will be used for any subsequent appointments.
- I authorize River City Family Health to leave a message with my family or on my answering machine reminding me about my upcoming appointment.
- I have read and understand the above statements and agree to abide by these policies.
- I am aware of my privacy and confidentiality rights under HIPPA.

PATIENT/PARENT SIGNATURE____DATE_____________

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Name____ Date ____________

Occupation________________________________ Last 4 digits of Social Security Number XXX-XX-________

Date of Birth _______/_________/_________ Age ______

Drug Allergies

____

____

Current Meds

____

____

____

____

Women ONLY:

Pregnant? ☐ Yes ☐ No

Planning Pregnancy? ☐ Yes ☐ No

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Hospitalizations or Surgeries

Reason	Date	Reason	Date

Medical History

☐ Allergies/Hay Fever	☐ Frequent infections	☐ Osteoporosis
☐ Anemia	☐ Gallbladder disease	☐ Peripheral vascular disease
☐ Anxiety	☐ GI Disorder	☐ Pneumonia
☐ Arthritis	☐ Gout	☐ Polio
☐ Asthma	☐ Headache	☐ Prostate disease
☐ Bowel Irregularity	☐ Heart Murmur	☐ Rheumatic Fever
☐ Bronchitis	☐ Heart Palpitations	☐ Rubella
☐ Chest Pain	☐ Hepatitis	☐ Scarlet Fever
☐ Chronic Rashes	☐ Incontinence	☐ Sexual/mentrual Disfunction

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- ☐ Depression
- ☐ Lactose Intolerance
- ☐ Shortness of Breath
- ☐ Diphtheria
- ☐ Measles
- ☐ Tetanus
- ☐ Dizziness/Fainting
- ☐ Mumps
- ☐ Ulcer
- ☐ Fatigue
- ☐ Nervousness
- ☐ Venereal Disease/ STD

Habits

☐Smoke: Packs Daily ____
How Long? ____
Interested in stopping? ____
☐Exercise routine: ____

☐Coffee: Cups Daily ____
Other Caffeine ____
☐Alcohol: Type ____
Amount ____
☐Diet: Salt Intake ____
Fat Intake ____

☐Sleep: Difficulty falling asleep ____
Continuity disturbances ____
Snoring ____
Early morning awakening ____
Daytime drowsiness ____
Hours per night ____

Hepatitis C risk factor

- ☐ Blood transfusion prior to 1992
- ☐ Contact with blood/bodily fluid
- ☐ Shared razor/toothbrush
- ☐ IV Drug use (1+ times)
- ☐ Tattoos
- ☐ Body piercing

Name____ Date _____________________

Date of Birth _______/_________/_________ Age ______ Last 4 digits of Social Security Number XXX-XX-________

____Date:____________