Deni Llovet, FNP & Kinsey Fisher, FNP
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(406) 214-2040

PATIENT INFORMATION Today's Date: ______________

Last Name: ______________________ First Name: ______________________

Preferred name (if different than first name): ______________________

Physical Address: ______________________ City: ______________

State: ________ Zip Code: ______________ E-mail: ______________________

Mailing Address: ____

Cell Phone: ______________ Home Phone: ______________

Employer: ______________ Occupation: ______________ Highest Level of Education: ________

SSN: ______________________ Birthdate: ______________ Age: ________

Sex: M F Marital Status: S M W D Spouse: ______________

Gender Identity: ____________ Sexual orientation: ____________ Decline to answer: ______

Emergency Conact: ______________________ Phone: ______________

Pharmacy: ______________________ Race: ______________

If patient is a minor, parent/guardian name: ______________________

Insurance Name: ____________ Subscriber ID: ____________ Subscriber Name: ____________

Secondary Insurance: ____________ Subscriber ID: ____________ Subscriber Name: ____________

AUTHORIZATION:

○ All of the above information is true to my knowledge. I authorize treatment of the patient named above.

○ 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 RCWH.

○ I understand that payment may be made in the form of cash, check, or credit card.

○ I understand that there is a $25 charge for returned checks which, with the charge of the previuos visit will be collected by cash or credit prior to being seen at the next appointment and that only cash or credit will be used for any subsequent appointments.

○ I understand that there is a $25 missed appointment fee if I do not call to cancel or reset my appointment 24 hours before I am scheduled.

○ I understand that if I do not pay my bill and my accounts has to be prepared for collections I will be charged an additional $25 fee.

○ I authorize River City Whole Health to leave a message on the phone number(s) I have provided.

○ I am aware of my privacy and confidentiality rights under HIPAA.

○ I have read and understand the above statements and agree to abide by these policies.

Patient/Parent Signature: ______________________________ Date: ______________

Date ______________________

Name ______________________

Date of Birth ______________________

Signature of Parent or Guardian:

____

Sex ☐ Male ☐ Female

Milestones	Age
Rolling Over	
Sitting Up	
Walked	
Talked	

Social History		
Smoke Exposure	YES	NO
Pet Exposure	YES	NO
City Water (Fluorinated)	YES	NO
Day Care	YES	NO

Sports

Football	Volleyball	Basketball
Hockey	Baseball	Softball
Soccer	Gymnastics	

Current Medications

(include prescription and over the counter drugs, birth control, herbal medications, and vitamins)

Medication	Dosage/How Often
1.	
2.	
3.	

Allergies	Reaction

Are Immunizations up to date? YES NO

(Please provide our office with a copy)

Social History for adolescents

DRUG/ALCOHOL USE	YES	NO
Do you or have you ever smoked?		
If yes, how many cigarettes a day?		
If former smoker, when did you quit?		
If former smoker, how long did you smoke?		
Do you drink alcohol?		
Average Use Per Week:		
Do you use illegal drugs?		
If yes, what type(s)?		
How much and how often?		
If no, have you used illegal drugs in the past? (Please indicate type/how much/how often)		
Do you drink caffeine?		
If yes, how much per day?		
Do you exercise?		

If yes, what activity?		
How many days per week?		
Time/duration (minutes)?		
Are you sexually active		
Do you have a history of sexually transmitted diseases?		

Check if the PATIENT has had or currently has any of the following

Past Medical History

Anemia		Eczema	
Anesthesia Problems		Eye Disease	
Asthma		Frequent Colds	
Anxiety		Heart Disease	
Back Pain		Joint Pain	
Bleeding Disorders		Kidney Disease	
Blood Clots		Murmur	
Blood Transfusions		Physical Abuse	
Broken Bones		Pneumonia	
Cancer		Reflux	
Type:		Seasonal Allergies	
Chicken Pox		Sexual Abuse	
Colic		Thyroid Disease	
Depression		Tonsillitis	
Diabetes			
Ear Infections			

Comments on Past Medical History

____

____

Hospitalizations

Date (mm/year) Reason

____ / ____ ______________

____ / ____ ______________

____ / ____ ______________

Birth and Development

Full Term YES NO

Delivery Vaginal C-Section Complicated

Pregnancy Problems (please explain)

____

____

Birth Weight ______________

Discharge Weight ______________

Jaundice YES NO

:

Gynecologic History (Females Only)

Age at first period ______________

Other menstrual history ______________

____

Past Surgical History

Please check the box if Patient has had the surgery and then indicate the year if you know it.

SURGERY	Y	YEAR
Appendix		
Back Surgery		
Ears		
Eyes		
Foot		
Hernia repair		
Joint		
Tonsils		
Wisdom teeth		

Other Surgical History

Surgery Year

____

____

Testing

	DATE	NORMAL RESULTS	
Lead		Yes ☐	No ☐
TB		Yes ☐	No ☐
Hearing		Yes ☐	No ☐
Eye exam		Yes ☐	No ☐
Dental exam		Yes ☐	No ☐

Family History

Family Member	Age if Living	Age Deceased	Cause of Death
Mother			
Father			
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Sibling			

Use the key to indicate if any of your family members currently have or have had any of the conditions/diseases listed.
M=Mother F=Father S=Sibling

DISEASE/COND.	M	F	S	S	S
Alcoholism					
AIDS					
Alzheimer's					
Anemia					
Anesthesia Problems					
Anxiety					
Asthma					
Bleeding Disorders					
Blood Clots					
Cancer					
Type:					
Depression					
Diabetes					
Emphysema					
Glaucoma					
Heart Disease					
Hemorrhoids					
High Cholesterol					
High Blood Pressure					
Kidney Disease					
Migraines					
Osteoporosis					
Seizures					
Stroke					
Thyroid Disease					
Tuberculosis (TB)					

Use the key to indicate if any of your family members currently have or have had any of the conditions/diseases listed.

GMM=Maternal grandmother
GFM=Maternal grandfather
GMP=Paternal grandmother
GFP=Paternal grandfather

DISEASE/COND.	GMM	GFM	GMP	GFP
Alcoholism				
AIDS				
Alzheimer's				
Anemia				
Anesthesia Problems				
Anxiety				
Asthma				
Bleeding Disorders				
Blood Clots				
Cancer				
Type:				
Depression				
Diabetes				
Emphysema				
Glaucoma				
Heart Disease				
Hemorrhoids				
High Cholesterol				
High Blood Pressure				
Kidney Disease				
Migraines				
Osteoporosis				
Seizures				
Stroke				
Thyroid Disease				
Tuberculosis (TB)				

Additional Comments on Family History: ____________