DATA (Participant Complete)

Patient First Name:	DOB:	Age:	Sex:	Phone:
Patient Last Name:				
Have you been fasting? ☐ No ☐ Yes	If so, how long? _____ hours			
Do you have elevated Cholesterol Levels? ☐ No ☐ Yes	Last time checked?			
Do you have thyroid problems? ☐ No ☐ Yes				
Do you have any present illness? ☐ No ☐ Yes				

MEDICAL HISTORY (Participant Complete)

PATIENT HISTORY			FAMILY HISTORY		
Endocrine (Thyroid) Disorder	☐ No	☐ Yes	Hypertension	☐ No	☐ Yes
Cancer	☐ No	☐ Yes	Heart Disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Kidney Disorders	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	Cancer ☐ No ☐ Yes	Diabetes ☐ No	☐ Yes
Lung Disease	☐ No	☐ Yes	Arthritis	☐ Yes	☐ No
Liver Disease	☐ No	☐ Yes	Other ☐ No	☐ Yes	
History of Bleeding	☐ No	☐ Yes	**SOCIAL HISTORY**		
Aids / HIV	☐ No	☐ Yes	History of Smoking?		
Tuberculosis	☐ No	☐ Yes			
Pneumonia	☐ No	☐ Yes	Alcohol	☐ No	☐ Yes
Asthma	☐ No	☐ Yes			
Hypertension	☐ No	☐ Yes	Within Normal Growth and Development?	☐ No	☐ Yes
Kidney / Bladder	☐ No	☐ Yes	Immunizations Up to Date?	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes	Other	☐ No	☐ Yes
Stomach / Bowel	☐ No	☐ Yes			
Other	☐ No	☐ Yes			

Allergies ☐ No ☐ Yes

Current Medications ☐ No ☐ Yes

DATA (Participant Complete)

			VITAL SIGNS	Vitals Collected By: ___
HEENT:	☐ WNL	☐ ABN		
HEART:	☐ WNL	☐ ABN	BP: ___ HR: ___	Temp: ___
LUNGS:	☐ WNL	☐ ABN	WT: ___ HT: ___ BMI: ___	Body Fat%: ___
RESPIRATORY:	☐ WNL	☐ ABN	**COMMENTS**	
OTHER:				

LABS

☐ Venipuncture	236415	Additional Labs:	Collection
☐ GHP (CBC, CMP, TSH)	280050	_____	Date _____
☐ Hga1c	283036	_____	Time _____
☐ Lipid Panel	280061	_____	Initial _____
☐ PSA	284153		Labs Ordered:
☐ CBC	285025	Flu Vaccine (V04.81)	_____
☐ CMP	280053	☐ Vaccine 290732	_____
☐ TSH	284443	☐ Administration 2G0009	_____

VISIT

☐ H&P 18-39 New	299385	☐ H&P 65+ NEW	299387
☐ H&P 18-39 EST	299395	☐ H&P 65+ EST	299394
☐ H&P 40-64 NEW	299386	☐ H&P Medicare NEW	2G0438
☐ H&P 40-64 EST	299396	☐ H&P Medicare EST	2G0439

Physician Signature _____ M.D./N.P./P.A. Date: _____

Mountain View Hospital
Preventative Services

OFFICE USE ONLY
☐ Cash: $_____
☐ Flu ONLY ☐ Check:$: _____ Ck#: ____

Office: 208-542-7111
Fax: 208-542-7091

-Patient Registration Form-

Please complete each field of this form in its entirety, unless otherwise noted.

Date: _____

Last Name: _____ **First Name:** _____ **M.I.**_____

D.O.B: ____/____/____ **Age:** _____ **Sex:** _____ **Home Phone:** _____ **Cell Phone:** _____

☐ Married ☐ Divorced ☐ Single ☐ Widowed Smoker: ☐ Yes ☐ No

Address: _____|_____|_____|_____|_____
Street City State Zip Code County

Email Address: _____ **Your clinic conformation will be sent to this email**
Username: _____ **Please provide a username you would like to use for this account**
Password: _____ **Must be a combo of upper and lower case letters, numbers, and/or special characters. Example: Abc12$

Although you are registering hard copy, your patient information will be entered on our Website.

PLEASE DO NOT USE THE SAME EMAIL AND PASSWORD AS SPOUSE

Will you be attending the clinic for a flu vaccine *ONLY*? ☐**YES** (do not complete H&P Form) ☐**NO** ☐**N/A**

Primary Care Physician Name: _____

-Employment Information-

Employer: _____ **Occupation**: _____ **Employment Type:** FT PT Not Employed
(PleaseCircle)

-Insurance/Payment Information-

Insurance Company: _____ **Member ID:** _____

Insurance Contact Number (on back of your card): _____ **Are you the policy holder?** ☐ Yes ☐ No

Policy Holder's Name: _____ **Policy Holder's DOB:** _____

Relation to Patient: _____

I will be paying ***CASH*** For: ☐ Wellness Screening ☐ Flu Vaccine **Please See Your Company's Posters for Pricing**
(If you do not wish you wish to bill your insurance, please indicate cash pay services requested.)

-Clinic Attending-

Please *Check* the clinic date you wish to attend and indicate the time you will be arriving.
Time Arriving: _____

☐ 10/9 Linden Park	☐ 10/17 Taylorview	☐ 10/30 Temple View
☐ 10/10 Eagle Rock	☐ 10/18 T. Bunker	☐ 10/31 Administration
☐ 10/10 Transportation	☐ 10/23 Dora Erickson	
☐ 10/11 IFHS	☐ 10/24 Fox Hollow	
☐ 10/16 Skyline	☐ 10/25 Long Fellow	

Rev. 1/2017

CONDITION OF ADMISSION
ON-SITE TESTING
MOUNTAIN VIEW HOSPITAL

CONDITIONS OF ADMISSION--ON SITE TESTING SERVICES ONLY

1. **MEDICAL CONSENT:** I, the undersigned, consent to the services which may be performed during this visit or on an outpatient basis, including treatment, and which may include but are not limited to laboratory procedures, radiology procedures, diagnostic procedures, testing, medical, or pathology, emergency procedures, or hospital services rendered to me under the general and special instructions of a provider. If the patient takes any medications or other substances without orders from the provider, the patient hereby releases the hospital, clinic and physician from liability for any reactions that may occur. By signing this form, and on behalf of your heirs, executors, administrators and assigns, you agree to release Mountain View Hospital and/or the institution where this screening is conducted and their respective officers, directors, employees, agents, servants and subcontractors from any liability, claim or damage for any injury suffered as a result of undergoing the aforementioned testing, for any liability, or damage suffered as a result of inaccurate or erroneous outcomes, actions, or inactions taken as a result of this test.

2. **I authorize MVH to transfer myself to another health care facility should my provider determine it necessary. In addition, I also consent to the release of my medical records to such facility.**
3. **RELEASE OF INFORMATION:** I acknowledge that Mountain View Hospital (MVH) will use my information for the purpose of treatment, payment, and health care operations. I authorize MVH and any provider involved in my care to release medical information and supporting documentation of same as compiled in my medical records during the admission or outpatient visit to any organization which is or may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses and technicians at the hospital, clinic, home health agencies, ambulance companies, and such other health care agencies involved in my care during and after transfer or discharge from the hospital/clinic. I further acknowledge that my medical records, photographs, negatives and or prints will be utilized in the hospital's utilization review, performance improvement, peer review and other similar processes and studies. I also acknowledge that my medical records photographs, negatives and or prints may also be made available to governmental agencies as required by law. Information contained in my medical records may be extracted and complied for research purposes and the aggregated results (without individually identifying me) may be released to the public. I acknowledge that patient medical records at the hospital may be stored electronically and made available through computer networks to hospital personnel, physicians involved in my care and their offices. I acknowledge that my religious preference may be released to local religious organizations.

4. **FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS:** In consideration of clinic care and services rendered, I hereby authorize payment directly to the above named hospital for hospital/clinic insurance benefits otherwise payable to me, but not to exceed the hospital's regular charges. In addition, I authorize payment of Medicare/Medicaid/Insurance benefits to any contracted provider; this includes, but is not limited to laboratory procedures, radiology procedures, and anesthesia, pathology, or hospital/clinic services rendered to me under the general and special instructions of my provider during this encounter. In the event that my insurance policy was cancelled or inactive, I understand that I am financially responsible for charges. In the event that this account is not paid according to the terms of the hospital's credit policy, I agree to pay interest at the rate of 18% APR and/or costs of collection, not to exceed reasonable legal fees and court costs.

5. **ORGAN DONATION:** I understand that I have the right to donate any of my organs or tissues for transplantation and that I may do so by completing an anatomical gift form. If I have signed an organ donor card I agree to supply a copy of the card to the hospital.

6. **MOUNTAIN VIEW HOSPITAL IS A PHYSICIAN OWNED HOSPITAL:** Upon request a list of ownership will be provided to you.

I herby certify and state that I have read, and that I fully and completely understand the Conditions of Admissions and Authorization for Medical Treatment, and that I have signed the Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

_____
Signature

_____
Print Name

_____
Date

Questions: Please Contact Our Office Monday-Thursday 8:30am-3:00pm OR email: kanderson1@mvhospital.net

Please send registration information to our office by Noon the day prior to the clinic in which you are attending.