Horizon View Medical Center

Phone # 702 641-8500   Fax # 702 641-8502

PATIENT REGISTRATION

(Please Print Clearly)

Patient's Name:____
First Name   MI   Last Name

Social Security Number:____

Date of Birth:____Male:__________Female:_________________

Single:___________Married:__________Widowed:__________Divorced:_____________

Street Address:____

City/State:____Zip Code:_______________________

Home Phone Number: (_______)________-_________ Cell Phone Number: (________)__________-_________

Email Address:____

Mother/Guardian Name: ____

Phone Number: (____________)_____________-_________________

Social Security Number:______________________________Date of Birth:_________________________________

Father/Guardian Name:____

Phone Number: (____________)______________-__________________

Social Security Number:______________________________Date of Birth:_________________________________

In Case of Emergency, please contact (a person not living with you) -

Name:____

Home Phone Number: (_______)________-_________ Cell Phone Number: (________)__________-_________

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Relationship to Patient:____

Referring Physician Name:____

Referring Physician Phone Number: (__________)_______________-________________

PLEASE PRESENT INSURANCE CARDS & PHOTO ID FOR COPYING.
PLEASE COMPLETE THE REQUESTED INFORMATION BELOW.

Insurance Company #1:____

Phone Number: (__________)_______________-________________

Primary Insured's Name:____

Date of Birth:____

Policy #:_______________________________________Group #:____

Relationship:____

Insurance Company #2:____

Phone Number: (__________)_______________-________________

Primary Insured's Name:____

Date of Birth:____

Policy #:_______________________________________Group #:____

Relationship:____

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You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If you physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

Complaints
You may complain to the Secretary of Health and Human services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for **filing a complaint**.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to the protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (702) 641-8500.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:____

Signature:____**Date**:_________________________

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HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination and management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician practice. These activities include, but are not limited to, quality assessment activities, employee
review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers Compensation, Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

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ATTENTION PATIENTS

IT IS THE RESPONSIBILITY OF THE PATIENT/INSURED TO KNOW WHETHER THE DOCTOR YOU ARE SEEING FOR MEDICAL SERVICES IS A PROVIDER ON YOUR INSURANCE AND TO PROVIDE A REFERRAL (IF NECESSARY) UPON ARRIVAL.

IF NOT, YOUR APPOINTMENT WILL BE RESCHEDULED.

YOU AS THE INSURED, ARE RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE OR DEDUCTABLE AT THE TIME OF SERVICE.

IF OUR OFFICE IS NOTIFIED BY YOUR INSURANCE COMPANY FOR INELIGIBILITY OF BENEFITS, OR THAT YOU ARE NO LONGER INSURED, **YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL**. YOU AS THE PATIENT ARE ALSO RESPONSIBLE TO PAY IN FULL ANY MONEY TOWARDS YOUR DEDUCTIBLE.

SIGNED:____DATE:______________________

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- I hereby authorize the payment of medical benefits to Horizon View Medical Center, for services rendered.
- I understand that I am financially responsible for any services not covered by my insurance carrier.
- I hereby authorize Horizon View Medical Center to release any medical information necessary to complete and process my insurance claims.

Please check which provider:

________I authorize **Rola J. Saad, M.D.** Pediatric Endo. to treat me and use my personal health information for healthcare operations.

(Or)

________I authorize **Trisha Briones, C.P.N.P. A.P.N.** Pediatric Endo. to treat me and use my personal health information for healthcare operations.

Signature:____Date:______________________________
(Patient or Insured's signature, if patient is a Minor must have responsible party sign.)

*How did you hear about us?____
____
____
____

Name:______________________________ Date of Birth:__________________Date:_________________

PEDIATRIC ENDOCRINOLOGY QUESTIONNAIRE

Physician who referred you to our office/Ei medico que le refirio: ________________________

Pediatrician or Family Doctor Name /Pediatra o Medico Primario: ________________________________

Pediatrician Phone Number:____

Address and Group Name/El nombre de grupo ____

Pharmacy/Farmacia: ____

Pharmacy Phone Number/Farmacia y numero de telefono:___________________________________

Pharmacy Fax Number/Farmacia numero de fax:____

Pharmacy Address/Farmacia direccion:____

PROBLEM/PROBLEMA: What medical problem(s) can we help you with/ Le con que problemas medicos podemos ayudar nosotros?

____

____

____

MEDICATIONS/MEDICINAS: (Current and recent/ La corriente y reciente)

Drug Name/ Nombre de la Medicina	Strength/Dosis (e.g. 50mg)	Frequency/Frecuencia	Refill? Y/N

Do You Exercise/ Hace ejercicio? Yes/Si ________ No ________

Type?Typo? ____ Duration/ Duracion? _____________________

Minutes/ Minutos?______________________________Times Per Week? Veces por semana?______________

How many hours do you spend watching TV/playing video games/Cuantas horas pasas viendo la television/jugar juegos de video?____

Calories eaten/Calorias consumidas por dia? Too Many/Demasiado___________Too Few/Muy pocos______

What grade is your child in/ En que grado esta su nino/nina?________________________________

How are your child's grades/Como son sus grados de su nino/nina?________________________________

Name:________________________________ Date of Birth:___________________Date:__________________

Have there been any problems with any of the following/
Tenga cualquier problema con cualquiera del siguiente:

	Yes/Si	No		Yes/Si	No
Recent illness/ Enfermedad reciente			Chest pain/El dolor de pacho		
Recent hospitalization/Hospitalization reciente			Breathing problems/Problemas de respire		
Recent surgery/Cirudia reciente			Heart problems/Problemas de Corazon		
Recent injury/Lesion reciente			Muscle or joint pain/Musculo o dolor conjunto		
Recent ER visit? Visita a la sala de emergencia reciente			Limping/Cojeando		
Energy/Activity/La energia o la actividad			Unusual thirtiness/Bebe mas que normal		
Sleep/El sueno			Frequent urination/Frecuente miccion		
Mood/El humor			Painful urination/miccion dolorosa		
Heat or cold intolerance/Calor o frio intolerencia			Bed wetting/Cama que moja		
Hearing or ear problems/Oyendo o los problemasde oreja			Kidney infections/Infecciones de rinon		
Vision or eye problems/Los problemas de la vision o el ojo			Nausea/Vomiting/Nausea o Vomita		
Sore throat/Dolor de garganta			Diarrhea/Diarrhea		
Neck swelling/Hanchaxon del cuello			Constipation/Estrenimiento		
Headaches/Los Dolores de cabeza			Anemia/Anemia		
Dizziness/Mareo			Bleeding or bruising/Sangrado o Moretoes		
Poor coordination/Coordination pobre			Smoking cigarettes/Fumar cigarrillos		
Seizures/Convulsiones			Drinking alcohol/Beber alcohol		
Numbness or tingling/Entumecimiento o hormigueo			Drug use/El Uso de Drogas		
Change in appetite/El cambio en el apetito			Age of onset ot puberty/Edad de inicio de la pibertad: _______________		
Skin problems/Los problemas de piel			**For girls only/Solo para mujeres:**		
Birth marks/Las marcas del nacimiento			Vaginal bleeding/Sangrado vaginal		
Hair loss/Perdida de cabello			Vaginal discharge/Secrecion vaginal		
Recent weight loss/ La perdida de peso			Irregular periods/Periodos irregulares		
Recent weight gain/ El aumento de peso			Age of first menstruation/Edad de mesntruacion primera: _______________		

If yes, please explain/Si si, explique por favor:

____

____

____

____

____

Name:______________________________ Date of Birth:__________________Date:_________________

INITIAL HISTORY

BIRTH HISTORY / HISTORIA DE NACIMIENTO:

Any complications during pregnancy, the labor or delivery/ Hubo alguna complicaciones Durante de la embarazo o durante el parto?

____

____

How many months was the pregnancy/Cuanto meses eran el embarazo? ____________________________

What was the birth weight/Que era el peso del nacimiento?____

Length/La longitude____

Was the birth/Fue el parto Vaginal__________________ C-Section/Cesarea ________________

MILESTONES OF DEVELOPMENT/ LOS METOS DEL DESARROLLO:

Do you have any concerns about your child's development/ Tiene usted cualquiera concierne acerca de su desarrollo de nino?

____

____

Are you concerned about emotional or nervous problems/ Esta usted preocupado acerca de problemas emocionales o nerviosos?

HEALTH HISTORY/ LA HISTORIA DE LA SALUD:

	Yes/ Si	No	If yes, please explain/ En caso si, expligue por favor:
Allergies/Alergias			
Past illnesses/Las enfermedades pasadas			
Injuries/Las heridas			
Hospital stays/El hospital permanence			
Operations/Las operaciones			
Blood tests/Examenes de Sangre			
X-rays/Radiografias			

If yes, please explain/Si si, explique por favor:

____

____

____

Name:_______________________________ Date of Birth:__________________Date:_________________

FAMILY HISTORY/ HISTORIA DE LA FAMILIA:

Family member's age, sex, height, weight, and age of first menstrual period or beginning of puberty/ Miembro de la familia edad, sexo, altura, peso, y la edad del periodo primero menstrual y empezando de la pubertad:

	Age/Edad	Height/Altura	Weight/Peso	Puberty/Pubertad
Father/Padre				
Mother/Madre				
Sibling/Hermano M/F				
Sibling/Hermano M/F				
Sibling/Hermano M/F				
Sibling/Hermano M/F				
Sibling/Hermano M/F				

Does anyone in the family have/Cualquiera en la familia tiene el siguiente?

	Yes/Si	No	If yes, who is it/Si si quien es?
Diabetes/La diabetes			
Thyroid problems/Los problemas de tiroides			
Too short/Demasiado corto			
Too tall/Demasiado alto			
Late puberty/La pubertad temprana			
Cancer/El cancer			
Heart problems/Los problemas de corazon			
High blood pressure/La tension alta			
Nervous problems/Los problemas nerviosos			
Other health problems/Otros problemas de salud			

Please list the family members and any other few people who live at home with the patient/ Liste por favor los miembros de la familia y a cualquier otras personas que viven en el hogar con el paciente.

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Horizon View Medical Center

702.641.8500

We're Looking Beyond The Horizon

ADDRESS: **6850 North Durango Drive, Suite #301, Las Vegas, Nevada 89149**
Phone: 702-641-8500 • Fax: 702-641-8502