Dear New Patient,

Welcome to Queensridge Family Medicine!

We look forward to seeing you at our Summerlin office in the near future!

To ensure your visit goes smoothly, please complete the attached forms and bring them to your first appointment:

- Patient Registration
- Appointment Cancellation and Rescheduling Policy
- Authorization for Release of Medical Records
- Medical History Form

The last form, "Practice Information", contains important information regarding office policies, and is for your private review.

If you are taking any medicines, it would help greatly if you could bring all of your medicines in a bag for your first appointment so we can accurately record dosages and other information.

In addition, please bring any identification and insurance cards, thank you.

We look forward to welcoming you to our friendly family medicine office!

Warm regards,

Queensridge Family Medicine

851 South Rampart Blvd, Suite 110, Las Vegas, NV 89145
Main: (855) 211-3223, Fax: (702) 722-6461
www.QueensridgeFamilyMedicine.com

Queensridge
FAMILY MEDICINE

PATIENT REGISTRATION

Patient Name ____

Home Address ________________________ City ____________ State____ Zip_______

Home Phone ______________ Cell Phone ____________ Fax ________________

Please indicate which telephone number is best to leave personal messages on ________________

Social Security ______________ DOB ______________ Gender: M F

Employer ______________________________ Occupation ______________

Business Phone ____________________ Referred by ____________________

In case of emergency contact ____________________ Phone ______________

Relationship ____________________________

INSURANCE INFORMATION

Name of Primary Insurance ____

Subscriber Name ____________________________ **SAME AS PATIENT CHECK HERE [ ]**

Subscriber ID ____________________ **Group #** ____________________

Insurance Address ____

City ____________ State _______ Zip ________ Phone ________________

Relationship of insured ________________ Social Security _____-____-______ DOB __________

CO-PAY Amount $ ______________

Name of Secondary Insurance ____

Subscriber Name ____________________________ Relationship ______________

Subscriber ID ________________________ **Group #** ________________

Address ________________________________ City ________________

State _________ ZIP __________ Phone ______________

Social Security _______-____-_______ DOB _________________

I certify that the information I have provided is correct. I assign all benefits to Qamar Nevada, Inc. (DBA Queensridge Family Medicine). I authorize release of any information necessary to secure payment for services rendered. I understand that I am financially responsible for all charges that my insurance company may deny as agreed upon with the office.

Signature ______________________________ Date ________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____

Date of Birth: ____

Address: ____

Telephone: ____

Send to/Receive from:

Queensridge Family Medicine
851 S. Rampart Blvd., Suite 110
Las Vegas, NV 89145
Tel.: (855) 211-3223; Fax: (702) 722-6461

Medical records requested:

- o All records
- o Recent progress notes
- o Current medication list
- o Other/Notes

____

Kindly note there may be a waiting period lasting at least two weeks when transferring medical records.

- If the previous doctor requires a fee for this service, this responsibility shall lie with the patient.
- When obtaining or transferring records from our practice, there may be a corresponding charge to cover for copying, postage, and labor. Specific charges will depend on the work involved, and be disclosed prior to starting the process. I hereby authorize release of medical records for the following reason:

Please State Reason ____

____ ____________________

(Signature of patient or representative) **(Date)**

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Appointment Cancellation and Rescheduling Policy

Please note our office policy is that patients cancel or reschedule their appointments with a minimum of 24 hours notice (Friday for Monday appointments).

The following will result in a **Missed Appointment Fee of $30:**

- Cancelling or rescheduling with less than 24 hours notice
- Skipping or no-showing for a scheduled appointment
- Arriving at the office 10 minutes past the mutually agreed time

Missed appointments prevent other sick patients from being seen, disrupts office flow, and creates difficulty in following up with medical conditions.

Once an appointment is made with patient approval, it is the patient's responsibility to remember the appointment date and time. Our office does not provide reminder calls at this time.

Any Missed Appointment Fees are asked to be paid before future appointments can be scheduled. Excessive Missed Appointments may result in dismissal from the practice.

Please let us know if you have any questions. We look forward to serving you.

Thank you,
Queensridge Family Medicine

Patient Name	Signature	Date

MEDICAL HISTORY FORM

Name: ______________________________

DOB: ____________________ **Adopted:** ◻ Y ◻ N

Employer: ______________________________

Occupation: ______________________________

Current Status: ◻ Married ◻ Single ◻ Other
Children Names/Ages:

Please check if you currently have or have had any of the following:

◻ Asthma ◻ Hypertension ◻ Depression ◻ Psychiatric Disorder
◻ Hepatitis B ◻ Seizures ◻ Blood Clots ◻ Bleeding Disorder
◻ Hepatitis C ◻ Heartburn ◻ Diabetes ◻ Heart Disease
◻ Ulcers ◻ Hayfever ◻ Migraines ◻ Elevated Cholesterol
◻ Urinating Difficulties ◻Thyroid Disease ◻ Cancer
◻ Other Please specify: ______________
Comments: ______________________________

Immunizations:

Last Tetanus: __________
Last TB: __________ Positive: ◻ Y ◻ N
Hepatitis A Series: __________
Hepatitis B Series: __________
Flu: __________

Date of Last Preventative:

Colonoscopy: Year ______ Normal?: ◻ Y ◻ N
Pap: Year ______ Normal?: ◻ Y ◻ N
Mammograms: Year ______ Normal?: ◻ Y ◻ N
Dexascan: Year ______ Normal?: ◻ Y ◻ N

Please mark any past surgeries and/or hospitalizations, indicate which by marking an S or H.

Back___(S/H) Sinus___(S/H) Tonsils___(S/H) Bones___(S/H)
Hernia___(S/H) Appendix___(S/H) Vasectomy___(S/H)
Gall Bladder___(S/H) Tubal Ligation___(S/H)
Hysterectomy ___(S/H) Ovaries Removed? (Y/N)
Other/Comments: ______________________________

Medications:
List medications and dose you are currently taking.
Include vitamins and herbal supplements.
Check if no medications. ◻

Allergies:

Preferred Pharmacy? ____________________

Family History: (Blood Relatives Only)

Father: ◻ Alive ◻ Deceased	Present Health or Cause of Death	Age?
Mother: ◻ Alive ◻ Deceased	Present Health or Cause of Death	Age?
Brothers: ___# Alive ___# Deceased	Present Health or Cause of Death	Age?
Sisters: ___# Alive ___# Deceased	Present Health or Cause of Death	Age?

◻ Y ◻ N Tobacco ____________________ (packs/day)
Former Tobacco User ______________ (date quit)
◻ Y ◻ N Alcohol ____________________ (drinks/week)
◻ Y ◻ N Recreational Drugs ______________ (type)
◻ Y ◻ N Exercise ____________________ (times/week)
Sexual Orientation:____________________ (optional)
Religious Preference: __________________ (optional)
Do religious beliefs impact your daily activities? ◻ Y ◻ N
Comments: ______________________________

Please check medical problems ***immediate family members*** have or have had in the past.

Medical Complaints	Mother	Father	Siblings	Comments - **Age?**
Heart Attack	◻	◻	◻	
Diabetes	◻	◻	◻	
Glaucoma	◻	◻	◻	
Cancer (list type)	◻	◻	◻	
Osteoporosis	◻	◻	◻	
Stroke	◻	◻	◻	
High Blood Pressure	◻	◻	◻	
Kidney Disease	◻	◻	◻	
Brain Aneurysm	◻	◻	◻	
Blood Clots	◻	◻	◻	
Colon Polyps	◻	◻	◻	
High Cholesterol	◻	◻	◻	
Thyroid Disease	◻	◻	◻	
Depression	◻	◻	◻	

Females Only:
Current method of Birth Control: ____________
Has your husband had a vasectomy? ◻ Y ◻ N

Total # of Pregnancies: ______
Live Births: ______
Miscarriages/Abortions: ______

Please initial and date any updates made:

______________________________ (sign/date)

______________________________ (sign/date)

______________________________ (sign/date)

______________________________ (sign/date)

Practice Information

Appointments-

- Appointments are scheduled by phone during business hours (Monday to Friday, 9am – 5pm). For urgent issues, we will try to have you seen the same day. We do not offer walk-in visits.
- Appointments must be made for all medical questions and inquiries, and cannot take place over telephone.
- Appointments must be made for the completion of forms, including referrals new to the doctor, family leave forms, disability forms, school physicals, etc.
- Please do not email the office or staff for appointments, refills, referrals, or any medical issues.
- We make every attempt to run on schedule to keep your wait to a minimum. Please understand if we run behind due to other patients' complications before your appointment.
- Please arrive on time for your appointment, and not more than 30 minutes early. Arriving more than 10 minutes late will result in a missed appointment and missed appointment fees.
- Please give the office a minimum 24 hour notice if needing to cancel your appointment. Cancellations with less notice and/or missed appointments will result in missed appointment fees. Excessive missed appointments may result in dismissal from the practice.
- Missed appointment fees are $30 for each missed appointment, and must be paid prior to being seen next.
- It is the patient's responsibility to remember scheduled appointment times, so please enter times into your calendar when scheduling. Our practice does not routinely conduct appointment reminders.

Refills-

- Please have your pharmacy directly fax our office for all refill requests. Pharmacy-requested refill requests are completed at the end of the day.
- Refills cannot be processed after hours, over weekends or holidays due to the office being closed. Please request refills well before running out, during working hours.
- Medications for conditions requiring medical monitoring cannot be excessively refilled without a doctor's visit.
- Please understand that certain medications are not allowed to be refilled by phone. Refills for these medications will require a visit.

Billing-

- All self-pay patient fees and co-pays are required prior to the appointment, and cannot be billed.
- Our office bills your insurance company for services at standard rates. Payment is via negotiated rates that are pre-determined.
- Charges prior to your insurance deductible being met are your responsibility, in which case our office will invoice you directly. Prompt payment is requested, and required prior to further services.

Other Information-

- Our office is closed for lunch daily for approximately one hour.
- Being a new practice, we have limited staff that has many responsibilities. We will return messages left as soon as possible in case we aren't able to immediately take your calls.
- As a courtesy to others, kindly take cell phone calls outside the office.
- Please forward any concerns to our office manager, Samantha Rivera. We will promptly work to resolve any issues you may be dissatisfied with.
- Despite being a busy, growing practice, we strive to maintain a polite, harmonious environment. If we seem overly busy, we promise to give you our full attention at the earliest opportunity!