

Frontline Medical Group

3150 N. Tenaya Way, Suite # 400 Las Vegas, NV 89128

Phone #: (702)233-6661 Fax #: (702)233-3055

PATIENT INFORMATION (ACCORDING TO INSURANCE) (PLEASE PRINT)

Last Name		First	Middle	SSN	
Names used other than above		Date of birth	Age	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Street Address		City	State	ZIP Code	Home Phone No. ()
Occupation		Employer	Employer Address		Cell Phone No. ()
Employer Phone No. ()					
How did you hear about our Office				Reason for your Visit	

IN CASE OF EMERGENCY

Name	Relationship	Phone	Address
------	--------------	-------	---------

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD)

Person Responsible for Bill		Date of Birth	Address (if different)		Home Phone No.
Occupation	Employer	Employer Address			Employer Phone No. ()
Primary Insurance:			Insurance Phone Number:		
Policy Holders Name		Date of Birth	Group #	Policy #	
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	Child	<input type="checkbox"/> Other
Secondary Insurance			Insurance Phone Number:		
Policy Holders Name:		Date of Birth	Group #	Policy #	
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

I, hereby, attest that the above information is complete and accurate. I authorize release of information necessary to file a claim with my insurance company and I assign benefits, otherwise payable to me, to the doctor or the group indicated on the claim. All professional services rendered are charged to the patient. I understand that the patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to the lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover the money due to the doctor. If patient is a minor I authorize the above named patient to be seen and treated at this office as deemed necessary.

Print Patient/Guardian Name (if different)

Signature

Date

Frontline Medical Group

PATIENT HISTORY

PERSONAL INFORMATION

Name: _____ Date of Birth: _____
Social Security: _____ Age: _____ Gender: M ☐ F ☐
Phone# Home: _____ Work#: _____
Occupation: _____ # of Children: _____
Place of birth (optional) _____ Sexual Preference (optional) M ☐ F ☐
Religion (optional) _____ Next of Kin _____
Race: ☐ African American ☐ Am Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

PATIENT HISTORY

High Blood Pressure	___ Yes	___ No	___ Date
Diabetes Mellitus	___ Yes	___ No	___ Date
Heart Attack	___ Yes	___ No	___ Date
Congestive Heart Failure	___ Yes	___ No	___ Date
High Cholesterol	___ Yes	___ No	___ Date
Blood Clots	___ Yes	___ No	___ Date
Stroke	___ Yes	___ No	___ Date
Emphysema (COPD)	___ Yes	___ No	___ Date
Asthma	___ Yes	___ No	___ Date
Hepatitis (A, B, C,)	___ Yes	___ No	___ Date
Hypothyroidism (underactive thyroid)	___ Yes	___ No	___ Date
Hyperthyroidism (overactive thyroid)	___ Yes	___ No	___ Date
Arthritis	___ Yes	___ No	___ Date
Cancer	___ Yes	___ No	___ Date
What Kind? _____			
Anemia (low blood count)	___ Yes	___ No	___ Date
Kidney Stones	___ Yes	___ No	___ Date
Stomach Ulcers	___ Yes	___ No	___ Date
Irregular Heart Beats	___ Yes	___ No	___ Date
TB	___ Yes	___ No	___ Date
HIV	___ Yes	___ No	___ Date
STD's Type: _____	___ Yes	___ No	___ Date

FAMILY HISTORY

___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship

Other, Please specify: _____

PAST SURGICAL HISTORY

Have you ever had any of the following? If so, when:

Appendectomy	___ Yes	___ No	___ Year
Tonsillectomy	___ Yes	___ No	___ Year
Gallbladder Removal	___ Yes	___ No	___ Year
Hysterectomy	___ Yes	___ No	___ Year
Bypass Surgery	___ Yes	___ No	___ Year
Cataract Laser	___ Yes	___ No	___ Year
Hemorrhoidectomy	___ Yes	___ No	___ Year
Hernia Repair	___ Yes	___ No	___ Year
Colonoscopy / Sigmoidoscopy	___ Yes	___ No	___ Year
Other, Please specify:			

PREVIOUS PHYSICIANS

Name: _____ Phone # _____

Address: _____

Name: _____ Phone# _____

Address: _____

CURRENT MEDICATIONS

Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____

ALLERGIES

Seasonal _____ Yes _____ No

Animals _____ Yes _____ No

Medications, (please list) _____ Yes _____ No

Medicine _____ Type of reaction _____

Medicine _____ Type of reaction _____

Medicine _____ Type of reaction _____

Medicine _____ Type of reaction _____

SOCIAL HISTORY

History of Smoking Do/Did you smoke? ☐ Yes ☐ No

How many packs a day? _____ For how many years? _____ If stopped, how long ago? _____

History of Alcohol

How many drinks? _____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never

History of Substance Abuse ☐ Yes ☐ No

Type? _____ How much? _____ If stopped, how long ago? _____

Do you exercise regularly? ☐ Yes ☐ No

Are you on any special diet? ☐ Yes ☐ No

Do you need any special assistance? ☐ Yes ☐ No

What Kind? _____

Have you traveled outside the state or country recently? ☐ Yes ☐ No

What Kind? _____

LIVING WILL

Please provide a copy, if possible ☐ Yes ☐ No

DATE

SIGNATURE

Frontline Medical Group

It is the goal of this office to provide the highest quality health care to our patients with the greatest efficiency possible. Hence, we would like to inform all our patients of the following office policies that are put forth to provide a more effective office flow:

No-Discrimination Policy

It is our policy and mission to provide the best medical care we can to every member of our community equally; we will not discriminate against any individual regardless of gender, race, color, religion and sexual orientation.

Missed-Appointment Policy

As a respect to all our patients who may need urgent medical care we follow the American Medical Association Code of Ethics regarding office visits. We ask all our patients to notify the office at least 24 hour prior to any scheduled appointments that they will not be present for. There will be a **\$25.00 fee** for any **missed appointment** or **cancellation** without a **24 hour notice**. Because of limited space and high technical costs involving **ECHO'S** and all **Ultrasounds**, we ask for a **48 hour notice** for any missed appointments or cancellations. Otherwise, a **\$50.00 charge** will apply.

Referral Policy

Please note that all referrals are sent promptly to the respective insurance companies. However, it usually takes about **5-6 business days** to get a response back. We appreciate you being **patient** with us during this waiting period.

Refill Policy

We ask that you allow a minimum of **3 business days** to process all prescription refill requests. I _____ understand and respect the above policy and hereby agree to take financial responsibility as outlined above.

Signature of patient/responsible party

Date

Acknowledgement of Notice of Privacy Practices

Alpha Medical Group reserves the right to modify the privacy practices outlined in the previous notice.

Signature

I have reviewed the notice of privacy practices for Alpha Medical Group

Name of Patient

Signature of Patient

Date

Signature of Patient Representative(Required if patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Authorization of Use and Disclosure of Protected Health Information

Are you agreeable to receive your health related records by unencrypted email? ☐ Yes ☐ NO

There may be some level of risk that the information in the email could be read by a third party, due to being unencrypted.

Are you agreeable for us to leave messages on your phone number(s)? ☐ Yes ☐ NO

Do you consent for all CommonWell and Carequality participants to access your electronic health information?

☐ Yes ☐ NO

Persons Authorized to use or disclose Information(i.e. Your spouse, family member, etc.)

Name/Relationship

Name/Relationship

Expiration Date of Authorization

This authorization is effective as of the date of this letter unless revoked or terminated earlier by the patient or the patient's personal representative.

Frontline Medical Group

Narcotic Contract

Patient's Name: _____ DOB: _____ Date: _____

I understand and agree to the following terms regarding any controlled substance prescription(s), whether opiates or sedatives, that I may obtain from Dr. Sassan Kaveh.

- If I am recommended an opiate or sedative for the treatment of an acute or chronic pain condition I would try it after I understand the risks & benefits as well as the alternative therapies.
- I will take my medication only as prescribed and would not take it more often than I am supposed to or share it with anyone else.
- I will promptly notify Dr. Kaveh of any side effects or problems with my medication or if it stops working for me and/or no longer needed.
- I understand that from time to time efforts may be made to taper, change or discontinue the medication in order to optimize my care.
- I agree to meet with Dr. Kaveh regularly to assess my progress with the treatment. I may need to be seen at least once a month or more frequently as necessary.
- I will be responsible for my prescription/medication and will not ask for early refills. Otherwise, an early refill or replacement may not be available until the next scheduled appointment or when a refill is due.
- I agree to obtain narcotic/sedative prescriptions only from one doctor and one pharmacy, unless it is already cleared by Dr. Kaveh.
- I agree to potential and random urine/blood samples to assess my compliance with my treatment.
- If I deviate from these guidelines, obtain opiate medications from other sources, or misuse the medications in any other way, I may have the opiate medication discontinued and/or discharged from the practice.
- I agree to notify Dr. Kaveh of any deviations from above and to allow the office to review my opiate usage with other doctors/pharmacies involved with my care.
- I agree that any violation of State of Nevada Opiate Medication Law may make me subject to a criminal prosecution and discharge from FMG.
- We will regularly check a "Drug Utilization Report" from NV State Board of Pharmacy Prescription Monitoring Program Registration on all our Patients on pain meds.

Patient's Signature: _____ Date: _____

Pharmacy Information

#1) Name: _____ #2) Name: _____

Address: _____ Address: _____

Cross St: _____ Cross St: _____

Phone: _____ Phone: _____

Frontline Medical Group

MEDICAL RECORDS RELEASE

I, HEREBY, REQUEST THAT MY MEDICAL RECORDS BE RELEASED

FROM: _____ TO: **Frontline Medical Group**
Sassan Kaveh, M.D.
Fax: (702)233-3055

PLEASE RELEASE ONLY THE FOLLOWING:

☐ ALL HOSPITAL PHYSICIAN DICTATIONS, TRANSCRIPTIONS AND
RADIOLOGY REPORTS – None OPUS please.

☐ ALL HOSPITAL PROCEDURES & RADIOLOGY REPORTS

☐ ALL PERTINENT OFFICE NOTES

☐ ALL PERTINENT OFFICE PROCEDURES, TESTS & LABS

☐ _____

☐ _____

PLEASE INCLUDE THE ABOVE RECORDS FOR ONLY THE FOLLOWING PERIOD:

LAST: _____ MONTHS _____ YEARS _____ ALL

PATIENT NAME: _____

LAST FOUR OF SS #: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE REQUESTED: _____



For Internal Use Only: MRN _____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME _____
Last First Middle

PREVIOUS NAME(S) _____ GENDER: M ___ F ___

STREET ADDRESS /
P.O. BOX _____

CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER _____ EMAIL _____

DATE OF BIRTH _____ (MM) _____ (DD) _____ (YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

Signature of patient or authorized representative

Date

Time

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

Name of Authorized Representative (Printed)

Relationship

Date

Time

Address of authorized representative signing this form (please print):

Phone number of authorized representative

FOR INTERNAL USE ONLY

Name of Organization: _____ Name of Witness: _____

As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.