Rowena Achin, MD ☐
Don Pepito, MD ☐
Danilo Duenas,MD ☐
Yoyen Espartero, APRN ☐

HOPE MEDICAL CLINIC

INTERNAL MEDICINE
7455 West Azure Drive Suite 140 Las Vegas, NV 89130 | Phone: 725.780.4351 | Fax: 725.780.4339

PATIENT REGISTRATION

Last Name:	First Name:	Date of Birth:	Sex:
Address:			
Home Phone:	Cell Phone:	Work Phone:	
Social Security Number:		Email: (Do we have permission to email you? Yes or No)	
Occupation:		Employer:	
Insured Name:		Relationship to Patient:	
Insurance Carrier:	Insurance ID#:	Insurance Group#:	
Secondary Insured Name:		Relationship to Patient:	
Secondary Insurance Carrier:	Insurance ID#:	Insurance Group#:	
Emergency Contact's Name:		Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:	
Preferred Pharmacy Name:		Pharmacy Address:	

Please place your initials next to the statements below indicating you have read and understand them:

____ I authorize the insurance listed above to pay directly to Hope Medical Clinic. I will pay for all such charges that may be denied by the insurance company(ies) above mentioned.

____ I hereby consent to treatment rendered by Hope Medical Clinic which could include in office procedures and injections.

_____ _____
Patient's Signature Date

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New Patient Health & History Form

Today's Date: _____

_____ Last Name

_____ First Name

_____ Date of Birth

Past Medical History

☐High Blood pressure	☐Diabetes	☐ Stroke	☐ Anxiety
☐High Cholesterol	☐Colon Disease	☐COPD/Emphysema	☐Depression
☐Hypothyroid	☐Peptic Disease/GERD	☐ Asthma	☐Cancer/Type_____
☐Anemia	☐Heart Disease	☐Allergies	☐Skin Disease
☐Hepatitis	☐Seizure Disorder	☐Arthritis	☐Kidney Disease/Stones

Allergies to Medications	**Reaction**
Latex Allergy? ☐ Yes ☐ No	

Medication Name/ Strength	**How many times a day?**

Previous Surgeries/Procedures	**Date**

Hospitalizations	**Date**

Family History		**Significant Diseases**
Father	Alive? ☐ Yes ☐ No/Age of death _____	
Mother	Alive? ☐ Yes ☐ No/Age of death _____	
Siblings	Alive? ☐ Yes ☐ No #____ Brother #____ Sister	
Children	Alive? ☐ Yes ☐ No #____ Son #____Daughter	

Social History

Do you live: ☐ Alone ☐with Spouse ☐with Family ☐ Other	
Marital Status: ☐ Married ☐Single ☐Widowed ☐ Divorced	
Tobacco use:	☐ Current smoker/ #_____cigaretted per day / week / month (please circle one) ☐ Former Smoker ☐ Nonsmoker ☐ E-Cigarette ☐ Chewing Tobacco
Alcohol use:	☐ I do not drink ☐ Socially ☐ Everyday / I drink # _____ beer / wine / liquor (please circle one)

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Reason for your visit:

_____

_____

_____

_____

Do you currently have any of the following symptoms today? -OR- ☐ None

General ☐ Change in appetite	☐ Fever	☐ Night Sweats	☐ Weight gain		
Ophthalmologic ☐ Blurred Vision	☐ Eye pain	☐ Itching and redness			
ENT ☐ Decreased Hearing	☐ Nosebleed	☐ Snoring	☐ Swollen glands		
Endocrine ☐ Cold intolerance	☐ Excessive thirst	☐ Heat intolerance	☐ Weight loss		
Respiratory ☐Cough	☐ Shortness of breath	☐ Wheezing			
Cardiovascular ☐ Chest pain	☐ Fluid accumulation in the legs	☐ Irregular heartbeat	☐ Palpitations		
Gastrointestinal ☐Abdominal Pain	☐ Blood in stool	☐ Constipation	☐ Diarrhea	☐ Nausea	☐ Vomiting
Genitourinary ☐ Blood in urine	☐ Difficulty urinating	☐ Frequent urination	☐ Painful urination		
Musculoskeletal ☐ Back/Neck problems	☐ Painful joints	☐ Weakness			
Skin ☐ Dry Skin	☐ Itching	☐ Rash			
Neurologic ☐ Dizziness	☐ Headache	☐ Memory loss	☐ Tingling/Numbness		
Psychological ☐ Anxiety	☐ Depressed mood				

Preventive Medicine

Female	Date/Name of Doctor	Male	Date/Name of Doctor
Last menstrual period?		Last colonoscopy?	
Last mammogram?		Last PSA?	
Last pap smear?			
Last bone density test?			
Last colonoscopy			

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CONTACT INFORMATION

Cell Phone: _____

May we leave a message? YES / NO (circle one)

Home Phone: _____

May we leave a message? YES / NO (circle one)

Work Phone: _____

May we leave a message? YES / NO (circle one)

Other #'s: _____

May we leave a message? YES / NO (circle one)

I give Dr. Rowena Achin/Dr. Don Pepito and the staff, my permission to discuss my condition, treatment, and diagnosis with the following individuals.

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Patient's Name (PRINT) Patient's Signature/Date

_____ _____

HOPE MEDICAL CLINIC

FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need to ensure your understanding of our payment policy.

Claims for insurance companies with which Dr. Rowena Achin and Dr. Don Pepito participates, are submitted electronically. For those insurance companies with whom we do not participate, we are pleased to provide you with an itemized bill, that you can submit for reimbursement.

All co-pays and coinsurance amounts are due at the time of service and, cannot be waived. All patient balances as determined by your insurance company, are due and payable within 30 days of our invoice. All balances over 30 days are automatically forwarded to our billing company. *All balances over 60 days are automatically referred to a collection agency and assessed a $100 collection fee.* Please pay your balance promptly. If you have financial difficulties, please notify us as soon as possible to avoid this eventuality.

FEES

1. **Payment for services is due at the time services are rendered.** We accept cash, checks, MasterCard, Visa and American Express. To ensure a stress-free visit, *please verify that Dr. Achin and Dr. Pepito participate with your insurance plan*. It is not possible to keep up with all plans available today.
2. Returned, unpaid checks will be added to your account with a $35.00 charge fee.
3. There will be a $25 cancellation/no-show fee if you are unable to make your appointment without giving at least24 hour notice.

☐ **I have read HOPE MEDICAL CLINIC Financial Policy.**

_____ _____

Patient Signature/Policy Holder Date

_____ _____

Signature of Policy Holder if other than patient Witness