HENRY OSEI, MD

6850 N. Durango Drive, Suite 211 Las Vegas, NV 89149 Phone (702) 202-2233

PATIENT INFORMATION: PLEASE PRINT (BLACK INK ONLY)

First Name: _____Middle_____Last Name: _____ Date of Birth: _____

___Male: ____ Female: ____ Age: ____ Social Security # _____-_____-_____ Marital Status: _____

Address: _____City:_____ State: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Employer: _____Address:_____ _____

Emergency Contact: _____Phone No._____ Relationship:_____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ Member ID: _____ Group # _____

Claims Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security # ____-_____-_____ Insurance Phone Number: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ _____ Member ID: _____ Group # _____

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security # ____-_____-_____ Insurance Phone Number_____

AUTHORIZATION TO TREAT (PLEASE SIGN & DATE)

I hereby authorize medical treatment for the above patient. I fully acknowledge that all office visits are on a cash basis and will be paid in full at the time of visit, unless otherwise contracted by my insurance. I further understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to Dr. Henry Osei, for any fees not covered by insurance.

Patient/Authorized Signature: _____ Date: ___/___/_____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT
PLEASE INITIAL

I hereby authorize medical treatment for the above patient. I fully acknowledge that all office visits are on a cash basis and will be paid in full at the time of visit, unless otherwise contracted by my insurance. I further understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to Dr. Henry Osei, for any fees not covered by insurance.

X_____ I understand that my insurance will be billed as a courtesy to me. I also understand that it is my responsibility to follow up with my insurance company 30 days from the date of service, to make sure they are processing my claims. Any claims not paid within 90 days will be my responsibility.

X_____ If I do not pay my co-pays or deductible at the time of service or agreed arrangement, I understand that I will be responsible for additional administrative fees for each event.

X_____ I also understand there will be a charge of $25.00 for a NO-Show or Cancellation without a 24-hour notice, within my appointment time, except for medical emergency.

X_____I understand there are fees to complete certain miscellaneous medical forms required by Employers, and /or requested by Third Parties. I also understand there may be a fee to release my medical records directly to me.

X_____ In the event of default on any payments due to Dr. Henry Osei, I agree to pay costs of collection, including attorney fees. I hereby authorize the filing of my claims to my insurance in force and the direct payment to Dr. Henry Osei of any amounts on my claim. I further authorize the office of Dr. Henry Osei to release any and/or all pertinent medical records necessary to facilitate insurance billing for my medical care. I further authorize the creditor or higher agent to make any employment and/or insurance verification and to release all information needed to process claims.

X_____ I hereby authorize the office of Dr. Henry Osei to Receive, Mail, Fax, or E-Mail my records to another physician and /or medical facility in the course of my medical treatment and for continuation of care.

Patient/Authorized Signature: _____ Date: ___/___/_____

BACKGROUND INFORMATION FORM

Patient Name: _____ _____Date of Birth: _____

Due to the recent legislation changes, the Government is requiring medical facilities to collect the following information. Please check all that applies:

Primary Language Spoken	Check		Race \ Ethnicity	Check
English			Asian	
Chinese			Black or African American	
Japanese			Caucasian / White	
Spanish			Hispanic/Latino	
Portuguese			Native Hawaiian/Other Pacific Island	
Refuse to Report			Native American/Indian Descent	
Other(List)			Refuse to Report	
			Other(List)	

Preferred Pharmacy Name: _____

Pharmacy Cross Streets: _____ Phone# _____

****Consent to RX History: Yes / No (circle one)**

(RX History consent allows the Doctor to review and/or retrieve your RX (medication) history for medical care.)

Patient/Authorized Signature: _____ Date: ___/___/_____

RETREIVING YOUR OWN MEDICAL RECORDS

If you chose to retrieve your medical records, how would you prefer them?

Please number in priority order with (1) being the most preferred and (5) being the least preferred.

a) Electronic E-Flash Drive (___)

b) Paper Copied Records (___)

c) Emailed to secure e-mail (___) (depends how large file is) Secure E-Mail address: _____

d) Mailed (___)

Preferred address: _____ _____City: _____ State: ___Zip Code: _____

e) I prefer to pick up my records (__) Contact Phone # _____

Note:

All Medical Records request must be in writing and signed by Patient or Authorized Individual with Power of Attorney. There is a minimal fee to release medical records directly to Patient or Representative (@ $0.60 per Page Printed and/or $30 per Disk)

Patient/Authorized Signature: _____ Date: ___/___/_____

PATIENT PORTAL ACCESS

Patient Name: _____ Date of Birth: _____

Our Patient Portal is now up and running. Please indicate if you would like access to the patient portal. The patient portal allows you to have access to some of your medical information and be proactive in your healthcare.

Secured e-mail address is required to have access to the patient portal.

1) I would like access to the Patient Portal **Yes / No** (circle one)

   If **YES** please provide secured E-Mail address: _____

2) If NO, please circle one

   a) Refuse to participate

   b) Does not have e-mail

   c) Will not disclose

   d) No interest in the Patient Portal

   e) Other _____

Patient/Authorized Signature: _____ Date: ___/___/_____

HENRY OSEI, MD
6850 N. Durango Drive, Suite 211 Las Vegas, NV 89149 Phone (702) 202-2233

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS(1 of 2)

In the event Dr. Henry Osei may need to give your results or medical information, may we…

(Check all that apply)

____ Leave a detailed message on answering machine.

____ Leave a message with your spouse or family member.

____ Call you on your cellular, Cell Phone number is _____

____ Speak to you directly, ONLY.

I, _____ Date of Birth _____,

Give Dr. Henry Osei and Staff, authorization to disclose my protected health information to the following Family, Friends, and/or Caregivers:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

*I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. *I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment or payment of healthcare operations as cited in the Notice of Privacy Practices.

*I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment or payment of healthcare operations as cited in the Notice of Privacy Practices.

HENRY OSEI, MD
6850 N. Durango Drive, Suite 211 Las Vegas, NV 89149 Phone (702) 202-2233

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS (2 of 2)

*I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment or payment of healthcare operations as cited in the Notice of Privacy Practices.

*I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not to sign this form to assure treatment. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have question about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtained from my doctor's office.

*Unless, otherwise revoked, this Authorization will expire on the following date, event, or condition:

_____.

If I fail to specify a date, this Authorization will expire five (5) years from the signature date on this form.

Patient Signature: _____ _____Date: ___/___/_____

Guardian / Authorized Signature: _____Date: ___/___/_____

Employee /Staff Witness Signature: _____ _____Date: ___/___/_____

HENRY OSEI, MD
6850 N. Durango Drive, Suite 211 Las Vegas, NV 89149 Phone (702) 202-2233

NOTICE OF PRIVACY PRACTICES

I, _____, Date of Birth_____

acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the practices use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Patient/Authorized Signature: _____ Date: ___/___/_____

MEDICARE PATIENT INFORMATION FORM

Patient Name: _____ Date of Birth_____

Whom may we thank for referring you to us? _____

Phone: _____ Who is responsible for this bill? _____

Did you sustain an injury at work?	Y	N
Are your injuries accident related?	Y	N
Are you currently employed?	Y	N
If yes, name employer _____		
Are you covered under an employer or a union policy?	Y	N
Is your spouse or other family member employed?	Y	N
Do you have a secondary insurance policy?	Y	N
Do you have a disability?	Y	N

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status on the above information.

Patient/Authorized Signature: _____ Date: ___/___/_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ **Date of Birth**: _____

Date of Request _____ **Social Security #** _____ _____ _____

Address: _____ _____ ____ _____

RECEIVE RECORDS FROM:

Physician /Facility Name:_____Specialty_____

Phone # _____ Fax # _____

Address: _____ _____

RELEASE RECORDS TO: FAX RECORDS TO: FAX# 702-685-6738

Mountainside Internal Medicine / Henry Osei, M.D.
6850 N. Durango Drive, Suite 211 Las Vegas, NV 89149
Fax# 702-685-6738 **Phone# 702-202-2233**

Please send a copy of my medical records: **Date(s) Requested** _____ **to** _____

***SELECT ALL THAT APPLY**: Chart/Progress Notes /H&P____ Lab Reports ____ X-ray Reports____ DischargeSummary ___ **All Records**____ Other: _____*

Purpose of releasing medical information: _____.

I understand that my express consent is required to release any health information relating to testing, diagnosis, and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42C.F.R. Part 2) prohibits you from making any further disclosure of these records without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Patient / Authorized Signature: _____ _____ Date: ___/___/_____

Employee /Staff Witness Signature: _____ _____ Date: ___/___/_____

MEDICATION LIST

Date_____ Office Use: Reviewed-MA /Staff Initials_____

Patient Name: _____ Date of Birth_____

MEDICATION LIST		**MEDICATION LIST**
Brought a List - Yes / No		
Medication Bottles Provided - Yes / No		
List:		**List:**
Medication Dose How many times a day		Medication Dose How many times a day
Sample Drug 30mg 2x / day or month		*Sample Drug 30mg 2x / day or month*

MEDICAL HISTORY (1 of 2)

Date_____ ___ Office Use: Reviewed-MA /Staff Initials_____

Patient Name: _____ ____ Date of Birth_____

ALLERGIES: (List all allergies to medicines or other substances and Reaction)

SURGERY / HOSPITALIZATION	
DATE	**SURGICAL PROCEDURE**

ACCIDENTS/INJURIES:	
DATE	**TYPE**

HOSPITALIZATIONS	
DATE	**REASON**

ILLNESSES: (List any chronic or recurrent illnesses- Dates of onset)	
DATE	**ILLNESS**

IMMUNIZATION HISTORY:
Tell Us: Yes or No and Date of Last Shot
Chicken Pox or Vaccine? _____ Date: _____
Hepatitis B Series or Vaccine? _____ Date: _____
Influenza Vaccine? _____ Date: _____
Pneumonia Vaccine?_____ Date: _____
Rubella Vaccine or Blood Test? ____ Date: _____
Tetanus Vaccine? _____ Date: _____

MEDICAL HISTORY (2 of 2)

Date_____ Office Use: Reviewed-MA /Staff Initials_____

Patient Name: _____ Date of Birth_____

	CHECK ANY THAT YOU HAVE HAD OR NOW HAVE				
	Abnormal Pap Smear		AIDs or HIV		Malaria
	Alcohol Overuse of Abuse		Allergies or Hay Fever		Migraine Headaches
	Anemia/Low Iron		Anxiety or Panic Attacks		Nervous Breakdowns
	Arthritis or Gout		Asthma		Phlebitis
	Back Problems		Bladder Infection		Pneumonia
	Blood Clots or BleedingProblems		Blood Transfusion		Rheumatoid Arthritis
	Boils or Cysts		Bone or Joint Disease		Seizure/Convulsions/Epilepsy
	Bowel or Colon Disease		Broken or Cracked Bones		Sickle Cell Disease or Trait
	Breast Lumps		Bronchitis-Recurrent		Skin Infections-Recurrent
	Bursitis or Tendonitis		Cancer		Sprains/Dislocations-Severe
	High Cholesterol		Colitis		Thyroid Disease
	Concussion or Head Injury		Depression/Suicidal Thoughts		Ulcer Disease/Gastritis
	Diabetes		Drug Overuse or Abuse		Venereal Disease
	Emphysema		Excessive Stress		Yellow Jaundice
	Gallbladder Disease/Gallstones		Glaucoma		Meningitis
	Gonorrhea/Syphilis/Chlamydia		Headaches-Severe		Muscle Disease/Weakness
	Hearing Problem		Heart Attack		Pancreatitis
	Heart Murmur/Heart Disease		Hepatitis/Cirrhosis		Pleurisy
	Herniated/Ruptured Disc		Herpes		Polio
	High Blood Pressure		Hodgkin's Disease/Lymphoma/Leukemia		Rheumatic Fever
	Irritable Bowel Syndrome		Kidney Disease/Nephritis		Sexually Transmitted Disease
	Kidney Stones		Liver Problems		Skin Disease-Chronic
	Lung Problems		Lupus		Sleep Difficulties/Disorders
					Stroke/Brain Attack
					Tuberculosis (TB)-Positive Test
					Varicose Veins
					Vision Problem
					Other:___

FAMILY & SOCIAL HISTORY (1 of 2)

Date_____ Office Use: Reviewed-MA /Staff Initials_____

Patient Name: _____ Date of Birth_____

FAMILY CONDITION:	WHO:
Diabetes	
High Blood Pressure	
Heart Disease	
Stroke	
Mental Illness	
Cancer (please specify type)	
Unknown	
Tobacco Use	
Alcohol/Drug Abuse	
High Cholesterol	
E. Coli	
Kidney Failure	
Kidney Disease	
Seizures/Epilepsy	
Autoimmune Disease	
Suicide/Depression	
Arthritis/Gout	
Thyroid Disease	
Sickle Cell Anemia	
Asthma	
Psoriasis	
Bleeding Disorder	
Glaucoma	
HIV/AIDS	
Migraine Headaches	
Other	

FAMILY MEMBERS:	IF ALIVE, AGE:	IF DECEASED, AGE & CAUSE OF DEATH:
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Paternal Uncle		
Brother(s)		
Sister(s)		
Son(s)		
Daughter(s)		

Comment / Additional Information:

_____

_____

FAMILY & SOCIAL HISTORY (2 of 2)

Date_____ Office Use: Reviewed-MA /Staff Initials_____

Patient Name: _____NickName _____ Date of Birth_____

My Current Status is: Married Single Widowed Separated Divorced

DIET & EXERCISE & HABITS:

Current weight: _____ Desired: _____ 1 Year Ago: _____

Do you follow a special diet? _____ Caffeine Use: _____

What kind exercise do you do? _____ How often: _____

TOBACCO USE:

Do you smoke? Yes No If yes, what type? _____, how much _____/per day

Have you quit smoking? Yes No If yes, when? _____What type_____ how much _____/per day

ALCOHOL USE:

Do you drink alcohol? Yes No If yes, what type? _____, how much _____/per day/week
More than 6 (six) drinks in one occasion? Yes No Has anyone ever expressed concerns about your alcohol use? Yes No

If yes, please explain: _____

DRUG USE:

Do you now or have you ever used drugs? Yes No If yes, what type? _____

How would you describe your sexual orientation? _____ What kind(s) of Birth Control/Protection do you and/or your partner use _____

With whom do you live with? _____ Highest education achieved? _____

Student Status: _____School /Trade _____

Employment Status: _____Employer _____Previous jobs: _____

Exposure to hazardous conditions/substances at work? No Yes - Type? _____

Do you have a living will? Yes No Are you an organ donor? Yes No

Religious preferences/beliefs? _____

Have you traveled outside the U.S within the past year? No Yes – Date _____ ___

QUESTIONS FOR WOMEN ONLY:

Do you have or have you ever had breast implants? Yes No If yes, when? _____
Last Menstrual Period: _____ Age period began: _____ How often: _____ PMS (Pre-Menstrual Syndrome) Yes No
Total number of pregnancies: _____ Full Term: _____ Premature: ___ Miscarriages: ___ Abortions/Complications: _____

ADDITIONAL FORMS:

HIE(Health Information Exchange) Consent Forms

Notice of Privacy for Review

_____

_____

_____

Revised 02/07/2017la