vista
HEALTH & WELLNESS

OFFICE USE ONLY

PATIENT NAME

DATE OF BIRTH

NURSING

PERSONAL INFORMATION

FIRST NAME | MIDDLE | LAST

PREFERRED NAME

ADDRESS

CITY | STATE | ZIP

HOME PHONE | CELL

EMAIL

DATE OF BIRTH | SSN

EMERGENCY CONTACT

YOU MAY LIST UP TO TWO PEOPLE

NAME

RELATIONSHIP TO PATIENT

PHONE

NAME

RELATIONSHIP TO PATIENT

PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE

MEMBER ID | GROUP #

INSURED NAME

INSURED DATE OF BIRTH

SECONDARY INSURANCE (IF APPLICABLE)

MEMBER ID | GROUP #

INSURED NAME

INSURED DATE OF BIRTH

TERTIARY INSURANCE (IF APPLICABLE)

MEMBER ID | GROUP #

INSURED NAME

INSURED DATE OF BIRTH

TODAY'S DATE

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REASON FOR YOUR VISIT

LET US KNOW WHAT BRINGS YOU INTO THE OFFICE TODAY

CURRENT PRESCRIPTIONS

DRUG NAME	DOSE	TIMES PER DAY

NON-PRESCRIPTIONS

VITAMINS, HOME REMEDIES, HERBAL SUPPLEMENTS, ETC.

DRUG NAME	DOSE	TIMES PER DAY

ALLERGIES

MEDICATION / FOOD / AGENT	REACTION

SURGICAL HISTORY

PLEASE LIST ALL PRIOR OPERATIONS AND DATES

TYPE OF SURGERY	DATE

TOBACCO USAGE

☐ I have never used any form of tobacco products.

TYPE	USAGE STATUS	USAGE	YEARS USED
CIGARETTES	____ current ____ former	____ per day or week	
CIGARS	____ current ____ former	____ per day or week	
PIPE	____ current ____ former	____ per day or week	
CHEWING TOBACCO	____ current ____ former	____ per day or week	
DIPPING TOBACCO	____ current ____ former	____ per day or week	

Are you interested in quitting? ☐ YES ☐ NO

Have you attempted to quit in the past? ☐ YES ☐ NO

Were you successful? ☐ YES ☐ NO If yes, what was the date? _____

ALCOHOL USAGE

TYPE	NUMBER OF DRINKS
BEER	____ per day or week
WINE	____ per day or week
LIQUOR	____ per day or week
OTHER	____ per day or week

Is alcohol a concern for yourself or others around you?

☐ YES ☐ NO

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PERSONAL AND FAMILY MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY

DISEASE	SELF	MOTHER	FATHER	SISTER	BROTHER	DAUGHTER	SON	OTHER
High Blood Pressure								
Heart Attack (age)								
High Cholesterol								
Diabetes								
Stroke								
Cancer (type)								
Thyroid Disorders								
Asthma								
Depression								
Anxiety								
Substance Abuse								
Heart Failure								
COPD								
Colon polyps								
Osteoporosis								
Stomach Ulcers								
Headaches								
Arthritis								

FOR EVERYONE	DATE
Last colonoscopy?	
Last tetanus vaccine?	
Last pneumovax? (vaccine to prevent pneumonia)	
Last flu vaccine?	
Meningococcal vaccine?	
HPV vaccine? (Gardasil)	
Use recreational drugs? ☐ YES ☐ NO	
Have you ever used needles? ☐ YES ☐ NO	
Do you exercise regularly? ☐ YES ☐ NO	
If yes, how many times per week?	

FOR PATIENTS WITH DIABETES	DATE
Last time your eyes were checked?	

FOR WOMEN ONLY	DATE
Number of pregnancies?	
Last pregnancy?	
Last mammogram?	
Last pap smear?	
Last osteoporosis screening? (bone density)	
Hysterectomy? ☐ PARTIAL ☐ TOTAL	

FOR MEN ONLY	DATE
For men, ages 65-75, who have smoked more than 100 cigarettes in your lifetime , have you ever been screened for abdominal aortic aneurysm? ☐ YES ☐ NO	

TODAY'S DATE _____

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MEDICAL INFORMATION RELEASE (HIPAA)

FIRST NAME | MIDDLE | LAST | DATE OF BIRTH

HOME PHONE | CELL | WORK | BEST TIME OF DAY TO REACH ME

EMAIL

If unable to reach me: ☐ LEAVE A DETAILED VOICEMAIL ☐ LEAVE A MESSAGE ASKING ME TO RETURN YOUR CALL ☐ SEND ME AN EMAIL ☐ DO NOT LEAVE A VOICEMAIL

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING RESULTS OF LABS/RADIOLOGY, RECORDS OF EXAMINATION RENDERED TO ME, AND FINANCIAL AND INSURANCE INFORMATION:

☐ SPOUSE — NAME — PHONE

☐ CHILD(REN) — NAME — PHONE

☐ PARENT — NAME — PHONE

☐ OTHER — NAME — PHONE

☐ NONE
My information should not be released to anyone.

I UNDERSTAND THAT THE INFORMATION IN MY MEDICAL RECORD MAY INCLUDE INFORMATION RELATING TO TREATMENT FOR DRUG OR ALCOHOL ABUSE, SICKLE CELL ANEMIA, PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENTS, SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), AND AIDS RELATED COMPLEX (ARC) AND/OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING VISTA HEALTH & WELLNESS IN WRITING, BUT IF I DO, IT WON'T HAVE ANY EFFECT ON ANY ACTIONS VISTA HEALTH & WELLNESS TOOK BEFORE IT RECEIVED THE REVOCATION. VISTA HEALTH & WELLNESS, ITS EMPLOYEES, AND PROVIDERS ARE HEREBY RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN. I UNDERSTAND THAT BY SIGNING BELOW, I AM AGREEING TO, AND CERTIFYING MY UNDERSTANDING OF ALL STATEMENTS ABOVE. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING. THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT.

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE | DATE

PRINT PATIENT'S NAME | RELATIONSHIP (IF SIGNED BY PERSON OTHER THAN THE PATIENT)

TODAY'S DATE _____