



Cheryl Vallie, RN, CFNP

REGISTRATION FORM

(Please Print)

Today's date:

PCP:

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Mr. Miss Marital status (circle one)
 Mrs. Ms. Single / Mar / Div / Sep / Wid

Is this your legal name? Yes No If not, what is your legal name? _____ (Former name): _____ Birth date: ____/____/____ Age: ____ Sex: M F

Street address: _____ Social Security no.: _____ Home phone no.: _____
 ()

P.O. box: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____ Employer phone no.: _____
 ()

Chose clinic because/Referred to clinic by (please check one box): Dr. Insurance Plan Hospital
 Family Friend Close to home/work Yellow Pages Other

Other family members seen here: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birth date: ____/____/____ Address (if different): _____ Home phone no.: _____
 ()

Is this person a patient here? Yes No

Occupation: _____ Employer: _____ Employer address: _____ Employer phone no.: _____
 ()

Is this patient covered by insurance? Yes No

Please indicate primary insurance B.C.B.S. Aetna Cigna Health Smart Humana
 United Health Care Medicare Chips Medicaid (Please provide coupon) Other

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: ____/____/____ Group no.: _____ Policy no.: _____ Co-payment: _____
 \$

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____ Relationship to patient: _____ Home phone no.: _____ Work phone no.: _____
 () ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date



Cheryl Vallie, RN, CFNP

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

List any medical problems that other doctors have diagnosed

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Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
----------------------------------------	----------------------------------------------------------

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			Grandmother	
	<input type="checkbox"/> F			<i>Maternal</i>	
<input type="checkbox"/> M			Grandfather		
<input type="checkbox"/> F			<i>Maternal</i>		
<input type="checkbox"/> M			Grandmother		
<input type="checkbox"/> F			<i>Paternal</i>		
<input type="checkbox"/> M			Grandfather		
<input type="checkbox"/> F			<i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Cheryl Vallie, RN, CFNP

In Collaboration with Diana Casanova, MD
3423 Caldera Blvd. Midland, TX 79705 P: 432-699-6271 F: 432-699-6296



Release of Information Form:

TO WHOM IT MAY CONCERN:

I _____ am giving Cheryl Vallie RN, CFNP and her staff my permission to discuss my care, lab reports, x-rays, and any medical including scheduling with the following person(s).

NAME	PHONE	RELATION

I also hereby give my permission to leave a message concerning my medical care at (home#) _____ (cell#) _____ (work#) _____ or at a alternate # _____.

Signature _____ Date: _____

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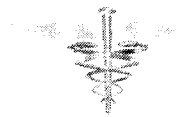
Patient Financial Responsibility:

We are committed to providing you with the best possible medical care; if you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time the services are provided. For your convenience we accept cash, check, Visa, MasterCard, and Discover.
2. Our office participates with a variety of insurance plans. It is YOUR responsibility to:
 - Make sure we are In-Network or know if we are Out-of-Network. Ask or check under Cheryl Vallie, RN, CFNP, if on the list you are most likely covered. Never a guarantee of payment of services.
 - Bring your up to date insurance card with you to EVERY visit.
 - Be prepared to pay your co-payment and any balance due at time of service and or visit.
 - For medical care **not covered** under your insurance you will be billed and payment is expected when bill is received or at time of next visit.
3. If you have insurance that we **do not participate** in, our office is happy to file the claim upon request; however, payment in full is expected at time of service.
4. If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is **YOUR** responsibility to inform us **BEFORE** your visit or payment will be expected at time of service.
5. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (phone number is on insurance card).
6. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. If you consistently refuse to pay for services rendered, the office of Cheryl Vallie, RN, CFNP may choose to cease providing services to you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Question about financial arrangements, past due and current balances should be addressed **BEFORE** services are provided and to the Office Manager.

Signature of Patient/or Responsible Party _____



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Payment Terms: co-payments and /or deductibles are due immediately at time of services. There will be a service charge of **\$35.00** for non-sufficient funds. If it is not taken care of in a timely manner, it will be turned over to the district attorney's office.

Interaction and Correspondence Terms:

Threatening and /or abusive treatment of medical staff members will not be tolerated. The right is hereby reserved to terminating service immediately upon verbal or written notification. Cheryl Vallie reserves the right to terminate the patient/physician relationship for any other reason. IF termination takes place, a reasonable time period will be provided in order to all patient to establish care and another physician.

Minor Patient term:

Patient under 18 years of age are to be accompanied by an adult retaining guardianship or legal aid representation. Non-parental relationships will require legal documentation expressing rights of guardianship of legal aid verification.

Service Restriction Terms:

Patient requiring chronic inpatient, nursing home care, and/ or disability exams will need to seek an alternative provider. Cheryl Vallie will not participate or testify in insurance or lawsuit case. No workman's comp cases will be seen. Patient must be seen in clinic setting for service. Patients who cannot be brought to the clinic for regular check-ups will need to seek an alternative provider. Non English speaking patient must be accompanied by a translator or be rescheduled. Only one visitor may accompany each patient visit due to limited seating.

Insurance affiliations:

We are currently enrolled in some health insurances as participating providers but we ask that you check with us about your specific insurance. If we are not in network with them you will have a balance due.

No Show Appointments:

We have experienced high volume of **"NO SHOW"** appointments and therefore we are now charging a **\$50.00** No-show fee. This fee will not be charged if we have at least 24 hour notice of the cancelled appointment.

I have read, understood, and agree to the terms above.

Patient/Guardian Signature _____ Date: _____

Cheryl Vallie, RN, CFNP

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this form indicate that you received a copy of Cheryl Vallie, RN, CFNP Notice of Privacy Practices, effective January 26, 2004, on the date indicated below.

If you have any questions regarding the information set forth in this Notice of Privacy Practices, please do not hesitate to contact the Office Manager at Cheryl Vallie, RN, CFNP.

Printed Name of Patient	Signature of Patient	Date

Signature of Patient's Representative	Relationship to Patient	Reason Patient Unable to Sign