PATIENT INFORMATION:

Full Name: _____

Date of Birth: _____ Today's Date: _____

Gender: ☐ Male ☐ Female Race: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Number: _____ Home Number: _____

Email Address: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Text Message

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

EMERGENCY CONTACT:

Full Name: _____

Relationship: _____

Phone Number: _____

INSURANCE INFORMATION:

Primary Insurance Provider: _____

Policy Number: _____

Group Number: _____

Subscriber Name (if different): _____

Subscriber Date of Birth: _____

PHARMACY INFORMATION:

Name: _____

Address or Cross Streets: _____

Phone: _____

Full Name: _____

PREVIOUS PRIMARY CARE PHYSICIAN (So We Can Get Your Medical Records):

Name: _____

Address: _____

Phone Number: _____

SPECIALISTS:

Specialist	Name	Medical Group/Address	Phone Number
Cardiologist			
Dermatologist			
Gastroenterologist			
Ophthalmologist			
Hematologist			
Nephrologist			
Neurologist			
Oncologist			
Orthopedics			
Pulmonologist			
Urologist			
Pain Mgt			
Psychiatry			

CURRENT MEDICATIONS:

Please list all prescription, over-the-counter, and supplements.

Medication Name	Dosage	Frequency

Full Name: _____

Medication Name	Dosage	Frequency

ALLERGIES:

☐ No known drug allergies

If yes, please list:

Allergic To:	Reaction:

Past Medical Conditions (Check All That Apply):

☐	Abnormal Heart Rhythm	☐	Heart Murmur
☐	Anemia	☐	Hepatitis
☐	Anxiety/Stress	☐	High Blood Pressure
☐	Asthma	☐	High Cholesterol
☐	Atrial Fibrillation	☐	HIV/AIDS
☐	Arthritis	☐	Irritable Bowel Syndrome
☐	Colitis/Crohn's Disease	☐	Kidney Failure/Hemodialysis
☐	Cancer	☐	Kidney Stones
☐	Chronic Pain	☐	Obesity
☐	Chronic Kidney Disease	☐	Osteoporosis
☐	Depression	☐	Peptic Ulcer Disease
☐	Diabetes	☐	Peripheral Vascular Disease
☐	Emphysema/COPD	☐	Seizures/ Epilepsy

Full Name: _____

Past Medical Conditions Continued (Check All That Apply):

☐	Gallbladder Disease	☐	Sleep Apnea
☐	Gout	☐	Stroke
☐	Headaches/Migraines	☐	Thyroid Disease
☐	Heart attack/Heart failure		
☐	Heartburn/GERD		

PREVENTIVE HEALTH HISTORY:

Check if you have had any of the following preventative health screening exams

Test	**Date (month/year)**	**Results**	**Physician**
Colonoscopy			
Annual Blood Work			
Cardiac Stress Test			
Bone Density (DXA Scan)			
Mammogram			

VACCINES RECEIVED: **OB/GYN HISTORY:**

Vaccine	**Date (month/year)**	**Number of Pregnancies**	
Tetanus (Td/Tdap)		Number of Full-Term Babies	
Pneumonia		Number of Premature Babies	
RSV		Number of Abortions/Miscarriages	
Influenza (Flu)		Number of Living Children	
Hepatitis B			
Shingles			

Full Name: _____

SURGERIES OR HOSPITALIZATIONS:

Date (month/year)	Surgery/Hospitalizations	Date (month/year)	Surgery /Hospitalizations

Do you have any metal pins/ plates in your body ☐ Yes ☐ No

FAM**ILY MEDICAL HISTORY:**

(Please check if any immediate family members have had the following)

Condition	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents
Diabetes					
Hypertension					
Heart Disease					
Cancer					
Depression					
High cholesterol					
Stroke					
Other					

If your family member(s) is/are deceased, please list their cause of death.

Family Member	Cause of Death	Age at Death

Full Name: _____

SOCIAL HISTORY:

Do you smoke? ☐ Never ☐ Former ☐ Current

If yes, how long have/did you smoke? _____ How many packs per day? _____

Did you quit? ☐ Yes ☐ No If yes, when did you quit what year? _____

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Regularly

If yes, how many alcoholic beverages do you drink per week? _____

How many days per week do you exercise? _____

Do you use recreational drugs? ☐ Yes ☐ No

DO YOU USE /DO YOU HAVE ANY OF THE FOLLOWING EQUIPMENT/ DEVICE:

Device	Check if Yes	Device	Check if Yes
Cane	☐	BI-PAP	☐
Walker	☐	CPAP	☐
Wheelchair	☐	Pacemaker	☐
Electric Scooter	☐	Defibrillator	☐
Motorized Wheelchair	☐	Home Oxygen	☐

REVIEW OF SYSTEMS:

Please check any symptoms you are currently experiencing

Symptom	Check if Yes	Symptom	Check if Yes
Fever/Chills	☐	Nausea or Vomiting	☐
Weight Loss/Weight Gain	☐	Palpitations	☐
Fatigue	☐	Headaches	☐
Chest Pain	☐	Dizziness/Fainting Spells	☐
Shortness of Breath	☐	Joint Pain or Swelling	☐
Cough	☐	Headaches	☐
Abdominal Pain	☐	Depression	☐
Diarrhea/Loose Stools	☐	Anxiety/Stress	☐
	☐		☐

Full Name: _____

CONSENT FOR TREATMENT

I, _____, am voluntarily seeking healthcare and hereby consent to medical treatment, laboratory tests and other healthcare service. I understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree in general, to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physicians assisting in my care.
The consent given shall be valid and binding and the physician can rely on this authorization and accept any consent given by the patient until such time as physician receives written notice that the authorization is revoked.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient/ Legal Representative Relationship

_____
Date

Renaissance MEDICAL GROUP
PHONE: (725) 204-7848 | FAX: (877) 275-8844

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name (Last, First, Middle): _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Number: _____ Home Number: _____

I hereby authorize the following entity to release the Protected Health Information (PHI) below to:

Renaissance Medical Group

Healthcare Provider: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

PHI and Dates of PHI Authorized for Use of Disclosure

Check if Yes	Description	Start & End Date of PHI	Check if Yes	Description	Start & End Date of PHI
☐	ALL PHI RECORDS		☐	History & Physical Exam	
☐	Laboratory Tests		☐	Diagnostic Tests/ Reports	
☐	Progress Notes		☐	Discharge Summary	
☐	Consultation Reports		☐	Itemized Billing Statement	
☐			☐		

The following information will be released unless you indicate DO NOT RELEASE by checking the appropriate box

☐ AIDS/HIV or STD Treatment ☐ Psychiatric/Mental Care ☐ Alcohol/Drug/Substance Abuse ☐ Genetic screening

Other, please specify: _____

I understand that:

- I may refuse to sign this authorization and its strictly voluntary
- My treatment, payment, enrollment of eligibility or benefits may not be conditioned on signing this authorization
- I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but if I do so, it will not have any effect on any actions taken prior to receiving the revocation
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
- I have the right to receive a copy of this form after I sign it
- I will receive a photocopy only of my medical record and that the original will remain with Renaissance Medical Group

_____ _____

Signature of Patient or Authorized Representative Date

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to nominate one or more person(s) to act on your behalf with respect to the protection of health information that pertains to you. By completing this form, you are informing us of your wish to designate the named person(s) as your "personal representative." You may revoke this designation any time by signing and dating the revocation section of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I, _____ Date of Birth: _____
hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involving the use and/ or disclosure of health information that pertains to me.

PRINT NAME OF PERSONAL REPRESENTATIVE(S)	**RELATIONSHIP TO PATIENT:**

The authority of this person when serving as my "personal representative" is restricted to the following functions:

☐ This person is to be afforded all the privileges that would be afforded to me with respect to my health information

☐ This person is restricted to the following information about my healthcare:

_____

_____

_____

_____ _____

Signature of Patient or Authorized Representative Date

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to: Renaissance Medical Group
2870 S. Maryland Pkwy, #220
Las Vegas, NV 89109

I further understand that any such revocation does not apply to the extent that the person authorized to use or disclose my health information have already acted in reliance on this designation.

REVOCATION SECTION:

I hereby revoke the designation of _____ as my personal representative.

_____ _____
Signature of Patient Date of Birth

_____ _____
Patient Name Date

NOTICE OF FINANCIAL POLICY SUMMARY & AGREEMENT

Thank you for choosing Renaissance Medical Group.
We are committed to providing quality care and clear communication about your financial responsibilities. Please review the summary below and sign at the bottom.

KEY FINANCIAL POLICIES

Payments:
All copays, deductibles, and balances are due at check-in unless prior arrangements are made.

Accepted Payments:
We accept cash, check, VISA, MasterCard, and AMEX. Returned checks may incur a $35 fee.

Insurance:
We will bill your primary insurance as a courtesy. You must provide current insurance info and notify us of changes. You are responsible for any unpaid portion.

Referrals/Authorizations:
If your plan requires a referral or pre-authorization, you must obtain it prior to your visit. Without it, your appointment may be rescheduled and charges may become your responsibility.

Out-of-Network/No Insurance:
If we are not in your insurance network or you are uninsured, payment is due at the time of service. Self-pay patients must make arrangements in advance.

Billing & Collections:
You will receive up to 2 statements. If unpaid after 90 days, your account may be sent to collections. Collection costs are your responsibility.

Missed Appointments:
A $50 fee applies for missed appointments without 24-hour notice.

Forms & Records:

- Form completion (e.g., FMLA): $50 per form, allow 5 business days.
- Patient medical records: No charge.
- Attorney/insurance record requests: Fees apply based on page count and request type.

Workers' Comp & Third-Party Claims:
We do **not** accept workers' compensation or bill third-party insurers (e.g., auto). You must pay in full and seek reimbursement.

Hardship:
If you're experiencing financial hardship, speak with our billing staff about possible payment plans. Proof of hardship may be required.

ACKNOWLEDGMENT & AGREEMENT

I have read, understand, and agree to the above Financial Policy. I accept full responsibility for any charges not covered by my insurance.

Signature of Patient	Date of Birth
Patient Name	Date

HIPAA NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGMENT FORM

This summary explains how your health information may be used and shared. Please read and sign below.

Our Responsibilities:

- We are required by law to protect your health information.
- We may update this notice and will inform you of any changes.
- You will be notified if your health information is breached.

How We Use and Share Your Information

We may use and disclose your information for:

- Treatment – To provide and coordinate your care.
- Payment – For billing and insurance purposes.
- Health Care Operations – For administrative, quality improvement, and compliance efforts.
- Family/Caregivers – When involved in your care or during emergencies.
- Business Associates – Outside vendors who help us operate (e.g., billing, legal).\
- Appointments & Services – To contact you regarding care or services
- Research/Fundraising – With privacy safeguards or your permission.

Uses Requiring Written Authorization

We must get your written permission to use or share:

- Psychotherapy notes (with limited exceptions)
- Genetic information
- Information for marketing purposes
- Information for sale (with few exceptions)

Your Rights

You have the right to:

- Access and get a copy of your medical records
- Request corrections to your health information
- Request limits on how we use or share your information
- Ask for a list of disclosures we have made
- Receive confidential communication in the way you prefer
- Get a paper copy of this notice
- Be informed of any data breach
- File a complaint without fear of retaliation

Questions or Complaints?

Contact our **Office at renaissancemedicalgroup05@gmail.com | (725) 310-7859**
Or contact the **U.S. Department of Health and Human Services:**

Office for Civil Rights
Department of HHS
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312, New York, NY 10278
Phone: (212) 264-3313 | Fax: (212) 264-3039