PATIENT REGISTRATION FORM

Read carefully & complete

Post Office Box 660 · 85 Sierra Park Road · Mammoth Lakes, CA 93546 · 760-934-3311 · Fax 760-924-4029 · www.mammothhospital.com

PATIENT INFORMATION Have you ever been a patient at any Mammoth Hospital facility? Y N

Last Name:_____ First Name: _____ Middle Name: _____

E-mail address _____ Cell Phone # (___)_____

Street Address/City/State/Zip _____

Mailing Address (if different than above) _____Phone(___) _____

City _____ State_____ Zip _____ County_____ Country _____

Birth Date _____ Age _____ Sex _____

Marital Status M S D W Social Security #: _____ Refused *please initial* _____

Any changes in the above section? Yes No Initials _____

Race: _____ *or (circle)* White Native American Other Black Asian Unknown Pacific Islander

Any changes in the above section? Yes No Refused *please initial* _____

Ethnicity: _____ *or (circle)* Hispanic Non-Hispanic Unknown

Any changes in the above section? Yes No Refused *please initial* _____

Primary Language: _____

Employer's Name _____ Phone ___ _____

Employer's Address _____

Occupation_____ Full Time Part Time Self Employed Retired Student

If visiting the area, please leave a local phone # & location where you can be reached:_____

_____

INSURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance:** _____

Group Policy ***OR*** *Individual Policy* *Group Policy* ***OR*** *Individual Policy*

Address: _____ Address: _____

Telephone # (___) _____ Telephone # (___) _____

ID # _____Group # _____ ID # _____Group # _____

Insured's Name: _____ Insured's Name: _____

Address: _____ Address: _____

Birth Date: _____ Gender M F Birth Date: _____ Gender M F

Employer's name: _____ Employer's name: _____

Address:_____ Address:_____

FT PT Seasonal Retired/Date _____ FT PT Seasonal Retired/Date _____

Occupation _____ Occupation _____

Relationship to Patient: _____ Relationship to Patient: _____

Third Insurance (If any) _____

**** A copy of your insurance card and other ID is required for billing*

Any changes in the above section? Yes No Initials _____

EMERGENCY CONTACT (preferably someone outside of the home) Relationship to patient _____

Name _____

Mailing Address _____ City _____State_____ Zip _____

Home Phone # (___) _____ Work Phone # (___) _____

CONSENT FOR TREATMENT

M.R. #

Patient Name

Date of Birth

Medical and Surgical Consent: The patient is under the control of his/her attending physicians and the Hospital is not liable for any act or omission in following the instructions of said physicians, and the undersigned consents to any x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physicians. The undersigned recognizes that all medical doctors furnishing services to the patient, including radiologists, pathologists, anesthetists and the like are independent contractors and are not employees or agents of the Hospital.

General Duty Nursing: The Hospital provides only general duty nursing care. Under this system, nurses are called to the bedside of the patient by a signal from the patient. If the patient is in such condition as to need continuous or special duty-nursing care, it is understood that such care must be arranged by the patient, or his/her legal representative, or his/her physicians, and the Hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability which may or might arise from the fact that the undersigned patient is not provided with such additional care.

Personal Valuables: It is understood and agreed that the Hospital maintains a safe for the safekeeping of money and valuables and the Hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs, fur coats and fur garments or other articles of unusual value and small compass, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the Hospital for safekeeping.

Financial Agreement: The undersigned agrees, whether he/she signs as the patient or as agent, that in consideration of the services to be rendered to the patient, he/she hereby obligates himself/herself to pay the account of the Hospital in accordance with its financial terms (attached). Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Medicare Assignment of Benefits: If applicable, I certify that the information given by me in applying for payment under Title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Assignment of Benefits: I hereby authorize payment directly to Mammoth Hospital of insurance benefits otherwise payable to me for payment of this hospitalization, but not to exceed the Hospital's regular charges. It is agreed that payment to the Hospital pursuant to this authorization by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that the Hospital does not accept responsibility for collecting my insurance proceeds or negotiating a settlement on a disputed claim. It is also understood that I am financially responsible for charges not covered by this assignment.

I UNDERSTAND THAT ONCE THIS CONSENT FOR TREATMENT IS SIGNED, IT WILL REMAIN IN EFFECT FOR ALL FUTURE CLINIC VISITS UNTIL REVOKED IN WRITING.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT, THE PATIENTS LEGAL GUARDIAN OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AGREEMENT AND ACCEPTS ITS TERMS.

Signature of patient/patient's legal representative

Date

If signed by other than patient, indicate relationship

MAMMOTH HOSPITAL Southern Mono
Healthcare District

FINANCIAL POLICY

Thank You for choosing Mammoth Hospital's Sierra Park Clinics for your health care needs.

The following is a general statement explaining our financial policies.

FINANCIAL AGREEMENT The financial agreement is a contract between you, the patient or responsible party, and the hospital.

USUAL AND CUSTOMARY RATES Fees charged at Mammoth Hospital are usual and customary for our area. You are responsible for payment in full regardless of rate reductions made by your insurance company based on their fee schedule.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Some services provided at Mammoth Hospital may not be deemed reasonable by your insurance company and may therefore be considered "non-covered". Mammoth Hospital will bill your insurance carrier as a courtesy when provided with complete and accurate information. It is YOUR responsibility to make the necessary calls to ensure your insurance company will pay for your treatment. If you are enrolled with an HMO or are assigned to a Primary Care Physician (PCP) or Primary Medical Group (PMG), it is critical that you notify them of your treatment at Mammoth Hospital. READ your insurance card or booklet for specific instructions.

NON-COVERED ITEMS

Non-covered items are services and/or supplies which may be determined by Medi-Cal, CMSP, Medicare or other insurance carriers as not medically necessary for the symptoms, diagnosis and/or treatment of a medical condition. You are financially responsible for ALL services and supplies rendered.

DENIED SERVICES

In the event that all or any portion of an insurance claim is denied by the insurance carrier, the patient/financially responsible party shall be responsible for all charges incurred.

LIMITED COVERAGE If your coverage is for emergency, accident or pregnancy. related services only, you may be responsible for emergency department charges not meeting coverage criteria.

DEFINITION OF EMERGENCY CONDITION

A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain that in the absence of immediate medical care could reasonably be expected to place the health of the individual or unborn child in serious jeopardy, impairment to bodily functions, or dysfunction of any bodily organ or part.

If you have received services such as anesthesia, emergency physician services, physician specialist consultation, had laboratory or pathology services that were sent to an outside laboratory, or arrived at the hospital via Mono County Paramedics, you will receive a separate bill from those providers. Independent physicians and service providers are not covered by Mammoth Hospital insurance contracts.

NOTE: Medicare recipients may have additional rights not outlined above.

I acknowledge receipt of Mammoth Hospital's Notice of Privacy Practices. This document provides information about how Mammoth Hospital may use and disclose my protected health information.

Once this financial policy is signed, the financial responsibility will remain in effect for all future admissions until revoked in writing.

I have read and understand the above statements. I acknowledge that I am fully responsible for all charges incurred.

Signature of Patient/Financially Responsible Party	Date
Patient Name	If signed by other than patient, indicate relationship

Mammoth Hospital
Southern Mono Healthcare District USSA

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New Injury Questionnaire

General Information

Primary Care Physician _____ Date _____

Name _____ DOB _____ Age _____
Address _____
City/State/Zip _____
Phone _____ Pager: _____ Fax/Email: _____
Occupation: _____

Work Status: Full Limited Retired Off-work
Since When: _____
Who referred you? Name: _____
Address: _____
Hobbies _____
Athletics _____
:

Present Orthopedic Problem

Which (body part) _____ ? Left Right Is problem work related? Yes No
Auto Accident related? Yes No Is legal action pending? Yes No

Date symptoms began (mm/dd/yy) _____ or Date of injury _____
City _____ State _____ Time of Day _____
If injury, please describe, in detail, how it occurred _____
_____
_____

When does it hurt? Grasping Pulling Pushing Carrying Pinching Gripping Lifting
Overhead lifting Walking Running Standing Squatting Stairs
Neck Mid-back Lowback

In Morning At Night When Sleeping All of the time

What makes it better? _____
What makes it worse? _____
Grade the pain: none 1 2 3 4 5 6 7 8 9 10 severe
What medicine helps? _____
Grade pain after medicine: none 1 2 3 4 5 6 7 8 9 10 severe

Do you have numbness? Yes No Where? _____
Do you have weakness? Yes No Where? _____

Have you seen other doctors/therapists/chiropractors? _____
Have you had physical therapy? Yes No How many sessions? _____

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Cortisone injections? Yes No How many? _____ Date of last one?_____
Did it help? Yes No Only for a short time
X-Rays: Yes No Date: _____ Cat Scans: Yes No Date: _____
MRI: Yes No Date: _____

Related Surgeries:
1)_____ Date _____
2)_____ Date _____
3)_____ Date _____
4)_____ Date _____

Did surgery help? Yes No
If *No*, please explain: _____
_____

Unrelated Past Surgeries
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Present Medications
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

Drug allergies
1) _____
2) _____
3) _____

Medical Information Other unrelated medical problems
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Smoking History: Packs per day _____
How many years have you smoked?_____

Alcohol history: Drinks per day_____
Drinks per week _____

Have you had in the past five years or are currently experiencing: Please circle all that apply

Seizures Depression Tremors Change of vision Strep throat Thyroid problems
Shortness of breath Steroid use Heart attacks Diabetes Stomach ulcers Jaundice Gout
Painful Urination Kidney stones Multiple Fractures Easy bleeding Insomnia Drug Dependency
Dizzy spells Severe headaches Chronic rashes Hypertension Asthma/Pneumonia Diarrhea
High cholesterol Chest pain Bloody/Black stool Bloody urine Sexual disease Multiple joint aches
Rheumatoid arthritis Recent weight loss Anesthesia problems Change in hearing

Please explain circled items: _____
_____
_____

Patient signature _____

PRE-ADMISSION QUESTIONNAIRE

MAMMOTH HOSPITAL
Southern Mono Healthcare District USSA

Date: _____

This is a questionnaire that is used to assist the medical team in giving you the most efficient and highest quality care possible. We ask that you answer each question to the best of your ability.

NAME: _____ AGE: _____ ALLERGIES: _____
HEIGHT: _____ WEIGHT: _____ RECENT GAIN OR LOSS: _____
EMERGENCY CONTACT: _____ PHONE: _____

Do You ...	Yes	No
WEAR GLASSES		
WEAR CONTACT LENSES		
HAVE A HEARING AID		
WEAR DENTURES		
HAVE A SPECIAL DIET		
EXERCISE REGULARLY		
EXERCISE MINIMALLY		

DO YOU SMOKE/USE TOBACCO? YES / NO
WHAT TYPE(S): _____
OF YEARS SMOKED/USED: _____
HOW MUCH/DAY OR WEEK: _____
QUIT DATE: _____

DO YOU DRINK ALCOHOL? YES / NO
OF DRINKS: _____/DAY OR _____/MONTH
TYPE: BEER /WINE/ LIQUOR

PLEASE LIST YOUR EXERCISE ACTIVITIES AND FREQUENCIES: _____

IF YOU DO NOT PARTICIPATE IN REGULAR EXERCISE ACTIVITIES, PLEASE ANSWER A-C:

a) CAN YOU COMPLETE HOUSEHOLD CHORES W/OUT BECOMING UNUSUALLY SHORT OF BREATH OR EXPERIENCING CHEST PAIN? YES / NO
b) CAN YOU WALK UP 2 FLIGTS OF STAIRS W/OUT BECOMING UNUSUALLY SHORT OF BREATH OR EXPERIENCING CHEST PAIN? YES / NO
c) CAN YOU WALK MORE THAN 2 CITY BLOCKS W/OUT BECOMING UNUSUALLY SHORE OF BREATH OR EXPERIENCING CHEST PAIN? YES / NO

MEDICAL HISTORY

BLOOD DISORDERS: YES/ NO
(Anemia, excessive bleeding) HIGH
BLOOD PRESSURE: YES / NO

DIABETES: YES/ NO
CANCER: YES / NO
SEIZURES: YES/ NO

HEART DISEASE: YES / NO
RESPIRATORY PROB: YES / NO ANY
ANESTHESIA PROBLEMS: YES / NO

PLEASE EXPLAIN IF ANY MEDICAL HISTORY PROBLEMS: _____

MEDICATIONS YOU TAKE: _____

PLEASE LIST ANY PREVIOUS SURGERIES, HOSPITALIZATIONS, MAJOR ILLNESSES, AND THE DATES: _____

HAVE YOU EVER HAD A HEART EXERCISE STRESS TEST? YES/NO LAST EXAM DATE: _____
HAVE YOU EVER HAD A HEART CATHETIZATION? YES/NO

WHEN WAS YOUR LAST ...
PHYSICAL EXAM: _____
CHEST X-RAY: _____
EKG _____
LAB WORK: _____

(FEMALES)
DATE OF LAST MENSTRUAL PERIOD: _____
HISTORY OF HEAVY PERIODS? Yes / No
RECENT PREGNANCY/DELIVERY? Yes / No
ARE YOU PREGNANT NOW? Yes / No

PLEASE GIVE BRIEF HISTORY & DESCRIPTION OF YOUR PRESENT PROBLEM & YOUR UNDERSTANDING OF WHAT YOUR PHYSICIAN PLANS TO DO? _____