MISSION RANCH PRIMARY CARE INC.

Shirley L. Huffman, PA-C • Bob Kurts, PA-C • Sameena S. Khan, M.D.
Miriah Roach, FNP • Bryan G. Furst, M.D. • Mark K. Weeber, M.D.
Stuart E. Mishelof, PA-C • Debbie Peterson, PA-C • David W. Skillin, FNP

Dear: _____

Your annual preventative visit, or complete physical exam, is scheduled with

_____MD/DO/PA-C/FNP on _____ at _____ AM/PM

Please complete the enclosed paperwork and bring the following with you on the date of your appointment:

- A list of your current medication(s), including strengths and dosage. (See enclosed form)
- A current health history, completed in dark ink. (See enclosed forms)
- Your current insurance card(s).

☐ **Lab work is needed prior to appointment.**
☐ **No lab work is needed at this time.**

PLEASE HAVE YOUR LAB WORK DONE ONE WEEK PRIOR TO YOUR APPOINTMENT.

You will need to fast for 12 hours prior to having your blood drawn—nothing to eat or drink, except water. Take all your medications with water only. Please bring the enclosed lab slip to the lab when you have your blood drawn. Valley Clinical Laboratory (affiliated with Oroville Hospital) has a draw station in our office. Your lab results will be ready for the doctor to go over them with you at the time of your appointment, avoiding the need for a return appointment and/or phone call for lab results.

PLEASE NOTE: There may be an additional charge for discussions involving acute or chronic conditions that are outside of preventative care. A copay and/or deductible may be applied by your insurance if this occurs.

WOMEN: If it is time for your annual mammogram, please have this done prior to your appointment and have the results forwarded to our office.

If you have any questions, please call us at (530) 894-0500.

Thank you,
Mission Ranch Primary Care

Mission Ranch Primary Care, Inc.

Patient's Name: _____
First **Middle** **Last**

Nickname/Preferred Name:_____ **Gender** (at birth): Male Female

Race/ Ethnicity: _____ Primary Language(s) Spoken: _____ Decline to State □

Date of Birth: _____ Age: _____ **Marital Status**: S M W D Sep Minor
(circle)

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Main Contact Number: ( ) _____ SS#:_____-_____-_____ Driver's Lic. #: _____

Alternate Number: ( ) _____ E-Mail Address: _____

OKAY TO LEAVE MESSAGES ON PROVIDED CONTACT NUMBERS? **BOTH** **MAIN** **ALTERNATE**

Employed by: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Phone Number: ( ) _____ OKAY TO LEAVE MESSAGES AT WORK? **YES** **NO**

Spouse's Name or ***(IF PATIENT IS A MINOR)*** Parents' Name: _____

Employed By: _____ Occupation: _____

Phone Number: ( ) _____

EMERGENCY CONTACT: Name: _____

Phone Number: ( ) _____ Relationship to Patient: _____

Please present your insurance card(s) with this completed form.

Primary Insurance: _____ Secondary Insurance: _____

ASSIGNMENT OF BENEFITS-CONSENT FOR TREATMENT-RELEASE OF INFORMATION

I hereby assign all rights, including the right to bring suit, and medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and/or any other plan to Mission Ranch Primary Care, Inc. This assignment is irrevocable. A scan and/or photocopy of this assignment will be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release information necessary to secure payment. (The holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.) I hereby authorize Mission Ranch Primary Care, Inc. to perform any medical treatment deemed necessary.

Signature: _____ **Date:** _____

NO CHANGE TO ABOVE INFORMATION: _____**(Patient initials)** _____**(Date)**

NO CHANGE TO ABOVE INFORMATION: _____**(Patient initials)** _____**(Date)**

Name: _____ Date of Birth: _____ Date: _____

Family History: Please indicate any *changes* over the past year.

	If living, list new health problems in the past year	If deceased, list cause of death or major problems	Age of death
Father			
Mother			
Brother/Sister			
Brother/Sister			
Spouse			
Daughter/Son			
Daughter/Son			
Daughter/Son			

Vaccinations: Please indicate *date* and *location* other than Mission Ranch Primary Care.

Pneumonia (regular) _____ Prevnar 13 (New Pneumonia) _____

Zoster (Shingles) _____ Tetanus _____ Flu Shot _____

Covid-19 Vaccine _____

Please list any *new* health problems:

_____

_____

Please list any *surgeries* in the past year:

_____

_____

Please list any *new* allergies (medication or food) and the reaction _____

_____

Do you have trouble with your sleep? _____

Tobacco use history (current/past, type, amount, quit date) _____

Alcohol use per week _____

Exercise (type and how often) _____

Hobbies _____

What would you like to discuss at your appointment? _____

_____

_____

_____

Name:_____ Date of Birth: _____ Date: _____

Prescription and Non-Prescription Medications

(Including vitamins and other supplements)

I am not taking any medications or supplements _____(initials)

Medication	Strength	Frequency (How Often)	Indication (diagnosis/reason)
Please attach a separate list if medications exceed the space provided			

Current and Recent Physicians
(and other health practitioners or therapists)

Physician Name	Specialty (and reason seen)

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Release of information according to HIPAA, notice of Privacy Practices

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, notice of Privacy Practices, your doctor and the staff at Mission Ranch Primary Care must have WRITTEN permission to speak with any other person, such as your spouse, caregiver, family member, friend, etc. regarding your care.

You may designate the person(s) of your choice in the spaces provided below. In doing this, you are giving our office permission to speak to these individuals regarding your treatment, test results, billing, appointments, prescriptions, etc. **Anyone not indicated on this form will not be given access to your information.**

This form does not apply to other treating physicians, only to family and friends.

This form is effective for any services delivered and will be effective until written notice is given to void this agreement.

I, _____, give Dr. _____and his/her staff authorization to communicate with the following person(s) in regards to my care:

Name	Relationship	Phone

I do not wish to designate anyone. _____ (Initials)

_____ _____

Signature **Date**

114 Mission Ranch Blvd., Ste. 10 • Chico, CA 95926 • Phone: (530) 894-0500 • Fax: (530) 345-2532