



**PRIMARY
CARE
INC.**

Bryan G. Furst, M.D. • J. Ross Nayduch, M.D.
Marcia F. Nelson, M.D. • A. M. Corky Rey, M.D.
Jennifer L. Parrish, M.D., Inc. • James A. Westcott, M.D.
Stephen Peterson, M.D. • Debra Peterson, PA-C • Mark K. Weeber, M.D.

Dear: _____

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

Dr. _____ on _____ at _____ AM/PM.

Please 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. Please confirm which laboratories are covered by your insurance by contacting your insurance provider. 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.

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 Inc.

Mission Ranch Primary Care

Patient's Name: _____

First Middle Last

Nickname/Preferred Name: _____ Male / Female (circle)

Race/ Ethnicity: _____ Primary Language 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:

Nearest Relative/Close Friend NOT Living With You: _____

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 medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and/or any other plan to Mission Ranch Primary Care. This assignment will remain in effect for one year from date signed. 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. I hereby authorize Mission Ranch Primary Care to perform any medical treatment deemed necessary

Signature: _____ 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 health problems	Age of death
Father			
Mother			
Brother/sister			
Brother/sister			
Brother/sister			
Spouse			
Daughter/son			
Daughter/son			
Daughter/son			

Vaccinations: Please indicate date and/ location other than Mission Ranch
Pneumonia (regular) _____ Pevnar 13(New Pneumonia) _____
Zoster (Shingles) _____ Tetanus _____ Flu _____

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?



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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