CHAD C. LUNT, M.D.
736 South 900 East #104
St. George, Utah 84790
(435)674-0999
(877)4320168

Name _____Birth Date_____
Last First Middle
Address_____City_____State_____Zip_____

Home Phone_____Work/Cell_____E-mail_____

May we contact you by e-mail? Y_____N_____

SS#_____Occupation_____Employer_____

Spouse's Name _____Spouse's Birth Date_____

Responsible Party (indicate relationship) _____

Contact:. Relative or close Friend not living with you _____Phone_____

Insurance Information:
Medicare part B_____ Medicaid _____
Primary Insurance Co. _____Group No. _____Policy No. _____
Policy holder _____Date of birth _____
Secondary Insurance Co _____Group No. _____ Policy No. _____
Policy holder _____ Date of birth _____

Payment for all medical services is the responsibility of the patient and is expected at the time of service.

I/We agree to pay all attorney fees, court costs, filing fees, including charges of commissions up to 50% that may be assessed to us by any collection agency retained to pursue this matter. I/We further agree to pay interest at the rate of one and one half percent per month (18% per year). I understand there is a $15.00 service charge for all returned checks.

I hereby authorize thr release of medical information concerning my illness and treatment by the doctor to my insurance company, and the Health Care Financing Administration or its agents. I authorize payment of medical benefits to provider or facility.

_____ _____
Today's Date Signature of Patient or Legal Guardian

CHAD C. LUNT, M.D., P.C.
736 S. 900 E., #104
ST. GEORGE, UTAH 84790

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, and/or **CHAD C. LUNT, M.D., P.C., and/or STAFF** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **CHAD C. LUNT, M.D., P.C.**'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **CHAD C. LUNT, M.D., P.C.** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **CHAD C. LUNT, M.D., P.C.** Privacy Officer at 736 S. 900 E., Ste. #104, St. George, Utah 84790.

With my consent, **CHAD C. LUNT, M.D., P.C. and/or STAFF** may call my home or other designated location and speak with me or leave a message on voice mail, or they may e-mail my home or any other designated location in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that CHAD C. LUNT, M.D., P.C. and/or STAFF restrict how they use or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to CHAD C. LUNT, M.D., P.C. and/ or STAFF the use and disclosure of my PHI and TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, CHAD C. LUNT, M.D., P.C. may decline to provide treatment to me.

_____

Signature of Patient or Parent/Legal Guardian

_____ _____

Patient's Name Date

_

_____

Print Name of Parent or Legal Guardian

CHAD C. LUNT, M.D.
736 South 900 East #104
St. George, Utah 84790
(435)674-0999
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Name_____ Birth Date_____
Last First Middle

Family History:

Have any of your immediate relatives (mother, father, siblings, grandparents, spouse) experienced any of the following? *(please indicate which relative)*

Alcoholism	Heart Disease	Anemia	Osteoporosis
Stroke	Diabetes	Suicide Attempt	Kidney Disease
Drug Abuse	Cancer	Epilepsy	High Blood Pressure
Glaucoma	Ulcer	Migraine	Thyroid Disease
Arthritis			

Please list any hospitalizations, surgeries, or major illnesses you have had.

_____

_____

_____

Have you had any of the following? (*please indicate the date)*

Depression	Eye problems	Eczema, rashes, hives
Liver disease	Lung disease	Thyroid disease
Venereal disease	Mumps	Chicken pox
Measles/German measles	Rubella	Heart
Rheumatic fever	Dizzy spells	Frequent urinary tract infection
Migraines	Hayf3ver/allergy	Diabetes
Anemia	Recent weight loss	Polio
Tuberculosis	Scarlet fever	Stroke
Cancer	High blood pressure	Arthritis

What is the reason for your visit today?_____

Please list any medications you are presently taking_____
_____
_____

Please list any known medical allergies_____
_____

Who may we thank you referring you?_____

OB/GYN History:

First day of your last menstrual period_____
Date of last PAP smear?_____ Was it normal?_____
Have you ever had an abnormal PAP smear?_____
Date of last mammogram_____
Number of pregnancies _____ Number of live births _____

Please list any pregnancy complications _____ Number of abortions/miscarriages _____

Have you ever been diagnosed with *(if yes please indicate the date)*

Yeast infection	Bacterial vaginosis	Trichomoniasis_____
Gonorrhea	Chlamydia	Syphilis_____
Human Papilloma Virus (Genital Warts)	HIV (AIDS)	Herpes
	Other infection_____	

Have you experienced any of the following vagina symptoms recently?
Please check all that apply:

Today	Past two months	
_____	_____	Itching or burning
_____	_____	Unpleasant vaginal odor (this may be stronger after sex)
_____	_____	Increased discharge
_____	_____	Discharge that is thick, white and cottage cheese-like
_____	_____	Discharge that is thin, milky-white or gray
_____	_____	Discharge that is yellow-green and frothy
_____	_____	Other symptoms (please describe)_____
		_____

Do you ever douche? _____Y _____N If yes, how often?_____ When did you douche last?_____

What method of birth control do you currently use? _____

Have you ever had vaginal intercourse (sex)? _____Y _____N
Are you sexually active now? _____Y _____N
Have you recently had sex with a new partner? _____Y _____N
Have you had intercourse against you will? _____Y _____N
Have you experienced pain with intercourse? _____Y _____N

Life Style:
Do you smoke? _____Y _____N If yes, how much?_____
Do you drink alcohol? _____Y _____N If yes, how much?_____

Have you experienced emotional change recently?_____

Have you previously or currently been abused by your partner? _____Y _____N
Do you do monthly breast exams? _____Y _____N