Arizona Community Physicians

Patient Information

FIRST NAME | MIDDLE | LAST NAME | ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | EMERGENCY PHONE# | EMERGENCY CONTACT NAME / RELATION

DOB | SEX | MARITAL STATUS | EMAIL | RACE (optional)

PRIMARY CARE PHYSICIAN | STUDENT? FT OR PT | PREVIOUS NAME

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE

Billing Information

(If different than patient)

FIRST NAME | MI | LAST NAME | ADDRESS | CITY | STATE/ZIP | PHONE

Primary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

GROUP ID# | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER (SELF / SPOUSE / CHILD / OTHER)

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

Secondary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

GROUP ID# | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER (SELF / SPOUSE / CHILD / OTHER)

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

By signing this form, I am consenting to Arizona Community Physicians' use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Arizona Community Physicians' Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Arizona Community Physicians for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.

PERSON GIVING CONSENT | RELATIONSHIP IF NOT THE PATIENT | DATE

ARIZONA COMMUNITY PHYSICIANS

REGISTRATION ADDENDUM

Account Number: _____

Patient Name: _____

Due to a governmental mandate that all healthcare is provided fairly, without regard to race or ethnicity, we have added new fields to our patient registration form. This information will be kept confidential.

Race (check one):

- ☐ Black, African American (01)
- ☐ Asian (02)
- ☐ Caucasian (White) (03)
- ☐ American Indian, Alaskan Native (08)
- ☐ Native Hawaiian/Other Pacific Islander (09)
- ☐ Unknown (98)
- ☐ Declined (99)

Ethnicity (check one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Declined

Preferred Language (check one):

- ☐ English (ENG)
- ☐ Spanish (SPA)
- ☐ Arabic (ARA)
- ☐ Chinese (all types) (ZHO)
- ☐ French (FRA)
- ☐ German (DEU)
- ☐ Greek (ELL)
- ☐ Italian (ITA)
- ☐ Japanese (JPN)
- ☐ Korean (KOR)
- ☐ Navajo (NAV)
- ☐ Polish (POL)
- ☐ Russian (RUS)
- ☐ Tagalog' (TGL)
- ☐ Ukrainian (UKR)
- ☐ Vietnamese (VIE)
- ☐ Other_____
  (Specify)

Signature of the Patient or Parent/Legal Guardian _____

_____

Patient declined filling out the form. Staff signature required.

Arizona Community Physicians, P.C.
Release of Information Form

Account #_____

Patient Name _____ DOB_____ Date_____

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which a family member or close friend needs access to your health information, or to the health information of someone under your care.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records, or to your dependents medical records. This information is not limited to but includes appointments, billing information and test results.

Spouse's Name _____ Contact Number_____

Child's Name _____ Contact Number_____

_____ Contact Number_____

Parent's Name _____ Contact Number_____

_____ Contact Number_____

Other's Name _____ Contact Number_____

DO NOT RELEASE Information to the following people: _____

Can we leave detailed lab results, radiological test results or any other imperative information on your mobile phone voice mail? _____ On your home voice mail? _____

Please check if applicable for patients under 15 years old:

_____ I give permission for my child (of >15 years old) to be seen without the presence of an adult.

_____ I give permission for my child (of >15 years old) to have minor procedures or immunizations without the presence of an adult.

_____ I give permission for my child to be taken to medical appointments by:_____

_____

Patient/Parent/Guardian Contact Numbers: Home_____ Work_____ Other_____

Signature of the Patient or their Parent/Legal Guardian _____

I acknowledge that either I or the physician may, at any time, withdraw the option of releasing test information per the terms of this agreement, upon providing written notice. Any questions I had have been answered.

Arizona Community Physicians P.C.
Authorization to Disclose Medical Information

PATIENT INFORMATION

Patient Name_____ Former Name_____ Account #_____
Daytime Telephone_____ Birth Date_____

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____
Street Address _____
City/State/Zip_____
Phone # _____Fax#_____
To release the following medical information contained in patient's medical record.

INFORMATION TO BE RELEASED TO

Name of Physician/Organization _____
Street Address _____
City/State/Zip_____
Phone # _____Fax#_____

PURPOSE FOR THIS REQUEST (**Please check a box**)

☐ Moving ☐ Treatment or consultation ☐ Dissatisfaction ☐ Change of Insurance Plans ☐ At patients request
☐ Other (specify) _____

TYPE OF INFORMATION TO BE RELEASED (**No information will be released unless a box is checked**)

General Release		DATES OF TREATMENT
☐	Medical Records/**Excluding Protected Records** (This will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated)	From_____ To_____
☐	Other Records (specify) _____	From_____ To_____
Information Protected by State/Federal Law		
☐	All of my records including: AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment	From_____ To_____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information understands that it is prohibited from making any disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Signature of Patient or Personal Representative Who May request Disclosure

I understand that Arizona Community Physicians may not condition my treatment on whether I sign this authorization form unless specified above under Purpose for Request. I can inspect or receive a copy of the protected health information to be used or disclosed. **I authorize Arizona Community Physicians to use and disclose the protected health information specified above**

_____ _____ _____
Signature of Patient OR Legal Representative **Date** **Please Print Name of signing party**

Patient Requesting Medical Record Copies

The standard charge for copying medical records is $6.50 for a disc and $0.07 per page for paper. However there maybe additional charges for shipping and handling.

PATIENT HISTORY

NAME: _____ DATE TODAY: _____

DATE OF BIRTH: _____ REFERRED BY: _____

RELATIVE	**AGE**	**CURRENT HEALTH**	**(AGE WHEN DECEASED)**
FATHER			
MOTHER			
SISTER(S)			
BROTHER(S)			
CHILDREN			

SPOUSE'S NAME _____ AGE _____ HEALTH _____

OTHER RELATIVES SEEN HERE _____

HAS ANY BLOOD RELATIVE EVER HAD THE FOLLOWING? **WHO? ↓**

ARTHRITIS _____
ASTHMA _____
CANCER (WHAT KIND) _____
_____
MELANOMA _____
DIABETES _____
HEART ATTACK _____
HYPERTENSION _____
STROKE _____
ALTZHEIMER'S _____
TB _____
OSTEOPOROSIS _____
THYROID _____
ANY INHERITED DISEASE _____

HAVE YOU EVER USED TOBACCO? **YES NO** DO YOU NOW? **YES NO**

HOW MANY PACKS PER DAY DO/DID YOU SMOKE? _____

HOW MANY TOTAL YEARS? _____ WHEN DID YOU STOP? _____

HOW MANY PACKS PER DAY HAVE YOU AVERAGED OVER THAT TOTAL TIME? _____

ALCOHOL USE: ☐ **NONE** ☐ **1-2 DRINKS/DAY** ☐ **2+/DAY** ☐ **1X/WEEK** ☐ **2X/WEEK** ☐ **SOCIALLY** ☐ **RARELY**

WHAT DO YOU DO FOR EXERCISE? _____

FREQUENCY PER WEEK? _____ DURATION PER SESSION? _____

HOW MUCH COFFEE, TEA OR CAFFEINATED SODA PER DAY? _____

DO YOU CONSIDER YOUR DIET: ☐ **LOW FAT** ☐ **MODERATE FAT** ☐ **HIGH FAT**

WHAT KIND OF WORK DO YOU DO? _____

WHO WAS YOUR PREVIOUS PHYSICIAN? _____

ANY HAZARDOUS HABITS? _____

WHO LIVES WITH YOU? _____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS?

	MEDICINE	REACTION YOU HAD	YEAR
1.			
2.			
3.			

HAVE YOU EVER HAD A BLOOD TRANSFUSION? **YES NO** WHAT YEAR? _____
HAVE YOU HAD THE PNEUMOVAX VACCINE? **YES NO** WHAT YEAR? _____
HAVE YOU HAD THE PCV-13 PNEUMONIA VACCINE? **YES NO** WHAT YEAR? _____
WHEN WAS YOUR LAST TETANUS SHOT? _____
HAVE YOU HAD YOUR HEPATITIS B SHOTS? **YES NO** HEPATITIS A SHOTS? **YES NO**
HAVE YOU HAD COLONOSCOPY? (YEAR) _____
HAVE YOU HAD SHINGLES OR THE VACCINE? (YEAR) _____

PLEASE LIST ALL OF YOUR HOSPITALIZATIONS

	DATE	PROBLEM OR OPERATION	HOSPITAL OR CITY	DOCTOR
1				
2.				
3.				
4.				
5.				
6.				
7.				

DO YOU HAVE ANY PRESENT MEDICAL PROBLEMS?

	PROBLEM	WHEN IT BEGAN	PRESENT TREATMENT
1.			
2.			
3.			
4.			
5.			

DO YOU HAVE ANY PAST MEDICAL PROBLEMS?

	PROBLEM	YEAR	TREATMENT
1.			
2.			
3.			
4.			
5.			

PLEASE LIST ALL MEDICINES YOU ARE CURRENTLY TAKING (BOTH PRESCRIPTION AND NON-PRESCRIPTION)

	MEDICINE	DOSE	FREQUENCY	PRESCRIBED BY
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

DO YOU NOW HAVE, OR HAVE YOU EVER HAD THE FOLLOWING?

NOW	OR	WHAT YEAR	NOW	OR	WHAT YEAR
_____	_____	EYE TROUBLE	_____	_____	EAR TROUBLE
_____	_____	NOSE/SINUS TROUBLE	_____	_____	FAINTING SPELLS
_____	_____	SEIZURES	_____	_____	PARALYSIS
_____	_____	DIZZINESS	_____	_____	HEADACHES/MIGRAINES
_____	_____	THYROID DISEASE	_____	_____	SKIN DISEASE
_____	_____	COUGH	_____	_____	CHEST PAIN/ANGINA
_____	_____	SPITTING UP BLOOD	_____	_____	NIGHT SWEATS
_____	_____	SHORTNESS OF BREATH	_____	_____	SLEEP TROUBLE
_____	_____	PALPITATIONS	_____	_____	SWELLING OF LEGS/FEET
_____	_____	SEVERE TIREDNESS/WEAKNESS	_____	_____	KIDNEY STONES
_____	_____	TROUBLE URINATING	_____	_____	KIDNEY INFECTIONS
_____	_____	PROSTATE TROUBLE	_____	_____	ABNORMAL THIRST
_____	_____	CHRONIC INDIGESTION	_____	_____	ULCER
_____	_____	LIVER DISEASE/HEPATITIS	_____	_____	WEIGHT LOSS
_____	_____	COLON/BOWEL TROUBLE	_____	_____	GALL BLADDER TROUBLE
_____	_____	BLOOD IN STOOL	_____	_____	HEMORRHOIDS
_____	_____	CONSTIPATION	_____	_____	BLACK TARRY STOOLS
_____	_____	DIARRHEA	_____	_____	NIGHT VOIDING
_____	_____	DEPRESSION/BREAKDOWN	_____	_____	CHANGE IN EATING OR
_____	_____	SEXUAL FUNCTION PROBLEM			BOWEL HABITS

HEARING SCREENING

DO YOU EVER EXPERIENCE FEELINGS OF DIZZINESS?	**YES**	**NO**
DO YOU HAVE RINGING (TINNITUS) OR OTHER NOISES IN YOUR EARS?	**YES**	**NO**
DO OTHERS COMPLAIN THAT YOU WATCH TELEVISION WITH THE VOLUME TOO HIGH?	**YES**	**NO**
DO YOU FREQUENTLY HAVE TO ASK OTHERS TO REPEAT THEMSELVES?	**YES**	**NO**
DO YOU HAVE TROUBLE UNDERSTANDING IN GROUPS OR NOISY SITUATIONS?	**YES**	**NO**
DO YOU HAVE TO SIT UP FRONT IN MEETINGS IN ORDER TO UNDERSTAND?	**YES**	**NO**
DO YOU HAVE DIFFICULTY UNDERSTANDING WOMEN OR YOUNG CHILDREN?	**YES**	**NO**
DO YOU HAVE TROUBLE KNOWING WHERE SOUNDS ARE COMING FROM?	**YES**	**NO**
ARE YOU UNABLE TO UNDERSTAND WHEN SOMEONE TALKS TO YOU FROM ANOTHER ROOM?	**YES**	**NO**
HAVE OTHERS TOLD YOU THAT YOU DON'T SEEM TO HEAR THEM?	**YES**	**NO**
DO YOU AVOID MEETINGS OR SOCIAL SITUATIONS BECAUSE YOU "CAN'T UNDERSTAND?"	**YES**	**NO**

WOMEN ONLY

AGE AT START OF PERIODS? _____ USUAL DURATION OF FLOW? _____

CYCLE (START TO START) _____ DATE OF LAST PERIOD? _____

BIRTH CONTROL METHOD, IF ANY? _____

NUMBER OF PREGNANCIES? _____ NUMBER OF LIVING CHILDREN? _____

DATE OF LAST PAP TEST? _____ HISTORY OF ABNORMAL PAP? **YES NO**

DONE BY? _____ WHEN? _____ TREATMENT? _____

DATE OF LAST MAMMOGRAM? _____ REGULAR BREAST SELF-EXAMINATIONS? **YES NO**

DATE OF LAST BONE DENSITY STUDY? _____ RESULT? _____

1._____

_____

2._____

_____

3._____

_____