Medical History

Name _____ Date _____

Please List and Supply the Dates of:

Operations _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery _____ _____

_____ _____ _____

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? _____

Other? ☐ No ☐ Yes When? _____

Pneumovax immunization? ☐ No ☐ Yes When? _____

Flu immunization? ☐ No ☐ Yes When? _____

Tetanus immunization? ☐ No ☐ Yes When? _____

When was your last:

Pap Smear? _____ Breast Exam? _____ Colon Cancer Test? _____

Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other _____		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear seat belts? ☐ Yes ☐ No If no, why not? _____

Do you wear a bike helmet? ☐ Yes ☐ No ☐ N/A

Do you exercise regularly? ☐ Yes ☐ No If yes, type, duration and number of times per week? _____

Do you smoke? ☐ No ☐ Yes If yes, how many packs per day? _____

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how much per week? _____

Do you drink coffee? ☐ No ☐ Yes If yes, how many cups per day? _____

Do you drink tea? ☐ No ☐ Yes If yes, how many cups per day? _____

If there is a gun in your home, do you keep it unloaded and out of children's reach? ☐ Yes ☐ No ☐ N/A

Do you use drugs? (marijuana, cocaine, crack, etc.) ☐ No ☐ Yes If yes, explain: _____

Have you ever engaged in any activity which has put you at risk of getting AIDS? ☐ No ☐ Yes If yes, explain: _____

Do you wish to be tested for AIDS? ☐ No ☐ Yes

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ☐ No ☐ Yes If yes, explain: _____

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ No ☐ Yes

Do you ever feel afraid of your partner? ☐ No ☐ Yes ☐ N/A

Do you have a "living will"? ☐ Yes ☐ No

Do you have a donor card? ☐ Yes ☐ No

Method of birth control? _____

This information is for use by your physician as part of your confidential medical record.

Aetna

Medical History

Date _____

Name _____ Age _____ Birthdate _____

Address _____ Sex ☐ Male ☐ Female

_____ Home Phone _____

_____ Work Phone _____

Occupation _____ Emergency Contact _____

Phone _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name _____

Children's names and ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History and Review of Systems

Please check off if you have had any problems with or are presently experiencing any of the following:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest pain/chest tightness
- ☐ Shortness of breath
- ☐ Swollen ankles
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Frequent urination
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ T.B.
- ☐ Hay fever
- ☐ Abdominal discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Change in bowel habits
- ☐ Unexplained weight gain/loss
- ☐ Hemorrhoids
- ☐ Gall Bladder disease
- ☐ Colitis
- ☐ Hepatitis or jaundice
- ☐ Thyroid disease
- ☐ Head or neck radiation
- ☐ Headache
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Difficulty urinating
- ☐ Arthritis
- ☐ Low back problems
- ☐ Skin diseases
- ☐ Blood disorders
- ☐ Venereal diseases
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Gout
- ☐ Impotence or Erectile Dysfunction
- ☐ Other

_____

_____

_____

_____

_____

_____

_____

Gynecologic and Obstetric History

Age at onset of periods _____ Frequency _____ Length of period _____

Pregnancies _____ Births _____ Miscarriages _____

Prolonged or abnormal bleeding ☐ No ☐ Yes (Please describe) _____

Leakage of urine ☐ No ☐ Yes (Please describe) _____

Pelvic pain ☐ No ☐ Yes (Please describe) _____

Abnormal discharge ☐ No ☐ Yes (Please describe) _____

History of abnormal Pap smear ☐ No ☐ Yes (Please describe) _____

This information is for use by your physician as part of your confidential medical record.

Please continue on the next page

ARIZONA FAMILY CARE

Tel: 623-773-2848 Fax: 623-773-0370

Last Name:_____First Name:_____MI:_____

Mailing Address:_____
City: _____State: _____ Zip Code: _____

Primary Phone: _____ Cell Phone: _____

E-Mail Address:_____@_____
ELECTRONIC STATEMENT ☐ YES ☐ NO

Date Of Birth: _____ Social Security #: _____
Sex: ___M ___F Marital Status: S D M W O

Race: ___Am Indian ___AK Native ___Asian ___African Am/Black ___White
___Hispanic/Latino ___Non Hispanic/Latino

Preferred Language: _____

Is Your Spouse the Policy Holder of your Primary Insurance? ☐YES ☐ NO
Spouse's Name: _____ Spouse's Date of Birth: _____
Spouse's Employer: _____

Primary Insurance: _____
Policy Holder Name: _____Relationship to Patient: _____
Policy Holder Date of Birth _____
Policy ID # _____ Group # _____
Claims Address: _____

Emergency Contact Name (not living with you): _____
Relationship to Patient: _____
Telephone #: _____
Address: _____ City: _____ State: _____

Assignment and Release

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I authorize the provided to release any information necessary to process this claim. I authorize the office to release all Medical Information Necessary to any hospital, specialist office and any insurance company acting on my behalf concerning advise, care, treatment, services including drug, alcohol or mental and nervous treatment unless specifically excluded by me below, for purposes of medical treatment and evaluating and administering claims.

Signature:_____Date:_____

ARIZONA FAMILY CARE, P.L.L.C
(623) 773-2848
PRIVACY NOTICE ACKNOWLEDGMENT AND COMMUNICATION CONSENT

Patient Name:_____ DOB: ____/____/_____
PLEASE PRINT NAME

Name and Phone number of your family physician

_____ (____) _____ - _____

Please list below the pharmacy you use including address or cross streets:

_____

We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

Can we leave detailed or confidential messages on your home phone?
Yes ___ No ___ Home Number: _____

Can we leave detailed or confidential messages on your cell phone?
Yes ___ No ___ Cell Phone: _____

Can we mail test results to your home?
Yes ___ No ___

Exclusions/Alerts (Please note any information that you do not want released to authorized individuals: _____

_____

We must call you at times to give you what is classified as protected health information. Can we speak to anyone other than you regarding lab results, radiology results or other issues regarding your health?

NAME	RELATIONSHIP	SECRET QUESTION (i.e. Mother's maiden name, city of birth, favorite color, optional)	ANSWER
1)			
2)			

Must Sign Below for all information given:
My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Arizona Family Care, P.L.L.C. Notice of Privacy Practices. ____/____/_____
Date

_____ _____
Patient Name (please print) Signature

_____ _____
Patient or Person Authorized to Sign If not patient, relationship to patient (parent, legal guardian, personal representative, etc.)

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided was Emergent
_____ Other: _____ _____ ____/____/_____
Employee Name Date

ARIZONA FAMILY CARE CASH SERVICES
Please print clearly

PATIENT INFORMATION:

LAST NAME:_____FIRST NAME:_____DOB:_____

In an effort to service our patients more efficienty, we have made changes to some of our **CASH/SELF PAY** *services that are not covered by insurance. If you would like to take advantage of any of the following services, we will require that you pay with cash, check or credit card prior to receiving the services.*

UNSCHEDULED PRESCRIPTION REFILLS (not given at scheduled office visit):
$50.00

PHONE CONSULTATIONS (phone consultations are not for new patients, new symptoms, new diagnosis or to treat and give medical advice):
$75.00

FORMS PER OCCURRENCE (FMLA, LIFE INSURANCE, ETC):
$55.00

I have read and understand the above information and I hereby agree to pay for services rendered to the above mentioned patient when charges are incurred. In the event of default, I understand I am responsible to pay any collection costs and reasonable attorney fees as it may be required to collect for my services.

SIGNATURE OF PATIENT/PARENT/GUARDIAN OF MINOR:

_____**DATE:**_____

FINANCIAL POLICY

Welcome to Arizona Family Care

(Effective July 10, 2015)

YOU WILL BE REQUIRED TO SIGN A NEW FINANCIAL AGREEMENT EVERY 12 MONTHS.

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Thank you for choosing Arizona Family Care. We are committed to providing the finest personalized family care. Please carefully read and sign the following statement of our office policies prior to your treatment. Feel free to speak to our practice manager or billing department if you have any questions.

INSURANCE:

You are ultimately responsible for payment of services if your insurance carrier does not pay for any reason. **IT IS THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY/REPRESENTATIVE TO KNOW THEIR INSURANCE COVERAGE.** Please present your insurance card at each visit. Insurance companies deny claims that are not submitted within 90 days of the date of service. If you do not submit your current insurance to the office at the time of your visit, you may be responsible for denied claims. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for your visit. Insurance policies exclude some non-covered services; however, this does not mean services or tests are not necessary. It means the policy you have does not cover certain necessary services. Please keep in mind your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover.

The patient is responsible for obtaining all necessary information regarding referrals or authorizations to another physician. Failure to do so may result in denial or delay of payments. Referral will be done at appointment only. Please be sure to bring your insurance card to every visit to ensure we have the most up to date information.

NO SHOW/LATE CANCELLATION FEE:

If you need to cancel your appointment, please contact our office **at least 24 hours before** your appointment time. Because of the high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. A $50.00 fee will be assessed for all missed appointments not cancelled with **at least 24 hour** advance notice. Should you no show or late cancel repetitively, we may discharge you from our practice.

BILLING:

As a courtesy to you, we will bill your insurance company for services rendered. In order to do so, we must have complete billing information, picture identification and your insurance card. Arizona law

requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.

In order to keep billing costs to a minimum, all co-pays, co-insurance and deductibles are to be paid on the day of the visit without exception. We reserve the right to reschedule your appointment if the applicable co-payment is not paid in full at the time of appointment check-in. For your convenience, we accept credit and debit cards from Master Card, Visa, cash and check.

In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an "out of network provider" for your insurance, the deductibles and co-insurance amounts may be higher. Your insurance policy, not our office, determines the amounts. After your insurance company processes your claims, you will receive a statement every month from our office showing your account balance. Your statement will indicate which portion of the balance is due from you. Patient balances are due and payable in full upon receipt of your statement. Accounts which remain unpaid after 30 days will be assessed a late fee of $5.00 per month. Delinquent accounts will be transferred to a collection agency or our attorney after 90 days.

In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for as long as the law provides.

Please understand maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare you deserve and expect.

There will be a $50.00 service fee for all returned checks. Any checks returned for any reason must be paid with certified funds (cashier check, money order or cash).

PRESCRIPTION REFILLS:
Please plan ahead for prescription refills. We encourage you to address refills at the time of your office visit. Any changes in medication, new prescription, or mail in prescription problems require an office visit. No prescription refills will be granted on weekends, after hours or during routine well visits.

We respect your time and every attempt is made to run on schedule. Therefore, we ask you to arrive on time for your appointment. If you are late, you may be asked to reschedule. If your doctor is running behind due to emergencies and you need to reschedule, please notify the office staff. If you choose to stay, your visit will be given the same consideration.

Forms:
FMLA (Family Medical Leave Act) or Short Term Disability forms are not included with your medical care. We will complete your forms if you qualify. There is a fee of $55.00 for each form due and payable prior

to the provider completing the form(s). You must make an appointment in order to determine eligibility. This is not a covered benefit by your insurance company.

I have read and understand the above policy and I agree to abide by the terms stated within.

Printed name of patient	Signature of patient/responsible party	Date

updated 10/10/2016