Ina Family Medicine

Medical Health History Form

MRN_____

MEDICAL HISTORY

PATIENT NAME:_____ DOB:_____ DATE:_____

MARITAL STATUS: M [ ] S [ ] D [ ] W [ ] HOW MANY CHILDREN DO YOU HAVE?_____

CURRENT OCCUPATION_____ IF RETIRED, PREVIOUS OCCUPATION_____

PLEASE LIST ANY MEDICATIONS BELOW YOU ARE CURRENTLY TAKING WITH DOSAGE AND FREQUENCY

	MEDICATION	DOSAGE	FREQUENCY
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO AND THE REACTION

	MEDICATION	REACTION
1)	_____	_____
2)	_____	_____
3)	_____	_____

PLEASE LIST ANY CHRONIC MEDICAL PROBLEMS AND/OR SURGERY YOU HAVE AND/OR HAD, EVEN AS A CHILD

(Such as diabetes, high blood pressure, cancer, heart disease, etc.)

1) _____
2) _____
3) _____
4) _____
5) _____

FAMILY MEDICAL HISTORY

PLEASE LIST MEDICAL CONDITION(S) FOR FAMILY MEMBERS

CONDITION	RELATION TO PATIENT	STATUS	AGE
_____	_____	Living/Deceased	_____
_____	_____	Living/Deceased	_____
_____	_____	Living/Deceased	_____
_____	_____	Living/Deceased	_____
_____	_____	Living/Deceased	_____

SOCIAL HISTORY

Smoking:

Do you currently smoke?_____ If no, have you ever smoked?_____ Approx how long?_____

If yes, most amount smoked per day_____ Do you use any other tobacco products? _____

Do you use E-Cigarettes? _____ If yes, How often?_____

Alcohol consumption:

Do you consume alcohol?_____ If no, have you ever consumed alcohol on a regular basis?_____How often?____

If yes, how often?_____ How much alcohol is consumed on a regular basis?_____

Recreational drugs:

Have you ever used recreational drugs?_____ If yes, what kind and explain usage?_____

_____

Exercise:

Do you exercise regularly?_____ What kind?_____ How often?_____

Living arrangements:

Please list the relation of the person/people who you live with?

_____ _____ _____ _____

_____ _____ _____ _____

Have you ever had a shot to prevent pneumonia? ____ If so what year? _____ [ ] Pneumovax 23 or [ ] Prevnar 13

Have you ever had a shot to prevent shingles? _____ If so what year?_____

When was your last tetanus shot? _____ When was your last flu shot? _____

Please fill in if applicable:	Results (circle one)
Last colonoscopy? _____	Normal/Abnormal If abnormal explain _____
Last Mammogram? _____	Normal/Abnormal If abnormal explain _____
Last Pap? _____ (if you have a cervix)	Normal/Abnormal If abnormal explain _____
Last Dexa Scan? _____ (bone density)	Normal/Abnormal If abnormal explain _____
Last Glaucoma/Eye Exam _____	Normal/Abnormal If abnormal explain _____

Are you sexually active? _____

Are you sexually active with a male/female? (circle one)

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# | SELF SPOUSE CHILD OTHER — RELATIONSHIP OF PATIENT TO SUBSCRIBER

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# | SELF SPOUSE CHILD OTHER — RELATIONSHIP OF PATIENT TO SUBSCRIBER

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

Patient Name:_____

Account Number:_____

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
☐ Non- Hispanic
☐ Unknown

E-mail

_____

_____
Patient Signature

_____
Parent/Guardian Signature

Preferred Language (check one)

☐ English (EN)
☐ Spanish (SPA)
☐ Arabic (AR)
☐ Chinese (all types) (ZH)
☐ French (FR)
☐ German (DE)
☐ Greek (EL)
☐ Italian (IT)
☐ Japanese (JA)
☐ Korean (KO)
☐ Navajo (NV)
☐ Polish (PL)
☐ Russian (RU)
☐ Tagalog' (TL)
☐ Ukrainian (UK)
☐ Vietnamese (VI)
☐ Other_____
(Specify)

☐_____
Patient declined filling out the form. Staff signature required

Print Name:_____ MRN_

Ina Family Medicine

Patient Yearly Office Policy Information

In an effort to provide better service and availability, we have developed a policy to reduce the frquency of patients who schedule an appointment and do not cancel 24 hours in advance or fail to show up for that appoitment, (no show). When this happens, it prevents other patients from being treated.

If there is a need to cancel your appointment, please call hours in advance. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these instances may be waived but only with managerial approval.

There will be a $25 fee for any appoitment that has not been cancelled 24 hours prior to the appointment time.

There will be a $25 for a "no show" appointment.

One courtesy "no show" will be allowed per patient.

Presciptions

Presciption refills: If you need a refill, please call your pharmacy **first**. Please allow 48 hours for a presciption to be refilled. If you have not had an appointment within the last 3 months, you may be required to schedule an appointment before we refill your presciption.

Controlled Substances: If you need these types of medications, we can prescibe them when medically appropriate. However, please be aware that if you are requesting these medcations an appointment will be necessary. You may also need to sign a written contract with your provider.

I have read and acknowlege the above information. If you have any questions about our policies, please contact Brittany Chewning, Site Coordinator for Ina Family Medicine at 520-585-5738.

_____ _____

Patient Signature Date

ARIZONA COMMUNITY PHYSICIANS

MRN: _____

WELCOME TO ARIZONA COMMUNITY PHYSICIANS

When you see the provider, your insurance contract may require that we collect some or all of the following:

Co-pay.....Required by the insurance company.

Deductible.....The amount still unpaid for the year.

Co-Insurance...% of the bill not covered by insurance.

Balance Due.....Any previous unpaid balance.

Any deductibles collected are an estimated amount and there may be additional charges. Thank you for helping us stay compliant with your insurance company.

_____ _____

Signature Date

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: From_____ To_____

AIDS/HIV and Other Communicable Disease Information,

Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment

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 or disclose the protected health information as 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.

FORM # 100
Updated: 06/17/2019

ARIZONA COMMUNITY PHYSICIANS

Consent to Release Test Information

I, _____ hereby give my consent for my physician's office to provide lab results, radiological test results or any other imperative information to:

☐ Myself by: _____ _____ _____ _____
Home Phone Answering Machine Work Other

☐ Spouse _____ Phone # _____

☐ Child _____ Phone # _____

☐ Parent _____ Phone # _____

☐ Other _____ Phone # _____

Please list any information that you would NOT like released and to whom:

_____

_____

_____

Limitation of liability

In no event shall the Arizona Community Physicians its physicians, officers, directors, employees, agents, licensors, and their respective successors and assigns be liable for damages of any kind, including, without limitation, any direct, special, indirect, punitive, incidental, or consequential damages including, without limitation, any loss or damages in the nature of, or relating to medical injury, personal injury, wrongful death or any other loss incurred in connection with my use, misuse or information loss due to technical failures.

Indemnity

I agree to indemnify, defend, and hold harmless Arizona Community Physicians and its providers, officers, directors, employees, agents, licensors, and their respective successors and assigns, from and against any and all claims, demands, liabilities, costs, or expenses whatsoever, including, without limitation, legal fees and disbursements, resulting directly or indirectly from (i) my breaching any of the terms and conditions of this Agreement; (ii) or information loss due to technical failures.

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

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

Patient Name [PRINTED]:_____ Acct. No._____ Patient signature _____ Witness signature _____
Date