Richard Gilson, M.D.
David Mickus, M.D.
Jessie Miles, PA-C

EAST VALLEY PRIMARY CARE PHYSICIANS

PATIENT REGISTRATION/RELEASE AUTHORIZATION

Nabil Khouri, M.D.
Regina Wright, M.D.
Tracey Martin, M.D.

Thank you for choosing our office. *In order to serve you properly we will need the following information. All information will be strictly confidential.*

TODAY'S DATE: ___________________________ SEX: Male/Female

PATIENT NAME: ______________________________BIRTHDATE: ___________________MARITAL STATUS: _____

HOME PHONE: ______-______-_________ WORK PHONE: ______-______-_________CELL #:______-______-__________

HOME ADDRESS: ____
STREET SPACE/APT. # CITY STATE ZIP

EMERGENCY CONTACT NAME & PHONE #: ____

DRIVER LICENSE (STATE & #) ____ EXPIRATION DATE: _______________

* *

PRIMARY INSURANCE INFORMATION:

PRIMARY **POLICYHOLDER'S** NAME: _______________________ SS#:______________________ DOB: ____________
POLICYHOLDER'S RELATIONSHIP TO THE PATIENT: Self/Spouse/Parent/Guardian
POLICYHOLDER'S EMPLOYER: ____

AUTHORIZATION:

Do you authorize this office to discuss your care or treatment with any person other than yourself? Yes/No
If Yes, please list name(s) of whom: ____

I hereby authorize direct payment of medical benefits provided by my insurance company to East Valley Primary Care Physicians, P.L.C for all services rendered. I authorize the release of any information necessary to process insurance claims and to obtain reimbursement**.**

I understand that I am financially responsible for any balance not covered by my insurance company. Due to the high cost of billing a $10 charge will be added to each co-pay/co-ins/deductible that is not paid at the time of service.

I understand that there will be a charge for missed appointments which are not cancelled 4 business hours prior to my appointment time.

Signed:Patient/Parent/Guardian____Date:________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE FORM

I ________________________ have had the opportunity to ready/review **The Notice of Privacy Practices Form** provided to me at East Valley Primary Care Physicians, PLC. **The Notice of Privacy Practices** Form will be kept in the lobby for my review beginning April 14, 2003 and will be ongoing. I understand that if I wish to have a copy of The Notice of Privacy Practices Form that I may ask for and receive one at the check in or check out area.

Signature: ____ Date: _____________________________

Inability to Obtain Acknowledgement: (to be completed only if no signature is obtained). It is not possible to obtain the individual acknowledgement please state below the reason why the acknowledgment was not obtained.. Signature: ______________________________ Date: ____________________

EAST VALLEY PRIMARY CARE PHYSICIANS, P.L.C.

ADULT HEALTH QUESTIONNAIRE

Patient Name _____ **Date** _____

This questionnaire will help your physician obtain a large amount of information while still being able to focus on your most important problems. Please answer all questions as best you can. If you are uncertain about a question your physician will help you. All answers will be kept confidential.

Sex _____ **Age** _____ **Date of Birth** _____

Current and Past Medical Problems (For example: anemia, asthma, arthritis, bleeding problems, colitis, cancer, high cholesterol, diabetes, hepatitis, high blood pressure, heart murmur, heart attack, depression, epilepsy, glaucoma, kidney problems, migraines, HIV, thyroid, pneumonia, valley fever)

1. _____ **6.** _____

2. _____ **7.** _____

3. _____ **8.** _____

4. _____ **9.** _____

5. _____ **10.** _____

Operations (For example: tonsillectomy, appendix, gallbladder, hernia, caesarean section, vasectomy, breast implants, heart bypass or valve operation, hysterectomy)

1. _____ **Date** _____ **4.** _____ **Date**_____

2. _____ **Date** _____ **5.** _____ **Date**_____

3. _____ **Date** _____ **6.** _____ **Date**_____

Medications (List all the medications you currently take including prescriptions, cold medications, aspirin, vitamins, herbal remedies, eye drops, and birth control pills. Please list all medication dosages and frequency taken)

1. _____ **6.** _____

2. _____ **7.** _____

3. _____ **8.** _____

4. _____ **9.** _____

5. _____ **10.** _____

Allergies to Medications (List all medications that you cannot take, or have had a reaction to)

Medication:	Reaction:	Medication:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____

Social History

Marital Status _____ Occupation _____

Highest level of education _____ Hobbies _____

1. Do you smoke cigarettes? Yes No How many per day? _____

2. Have you smoked in the past? Yes No How many years? _____

3. Do you drink alcohol? Yes No How many drinks per week? _____

4. Do you use caffeine? Yes No How much? _____

5. Have you used illegal drugs? Yes No List type _____

6. Do you exercise? Yes No What type? _____ How often? _____

7. How much do you weigh? _____ 5 years ago? _____ 10 years ago? _____

8. Do you have any risk factors for AIDS or HIV infection? _____

Health Maintenance

Please list date (year) of the last time you had any of these procedures.

_____ Complete Physical	_____ Cholesterol Screen	_____ Sigmoidoscopy
_____ Pap Smear	_____ Mammogram	_____ Prostate Check
_____ Chest X-ray	_____ EKG	_____ Treadmill
_____ Tetanus Shot	_____ Flu Shot	_____ Pneumonia vaccine
_____ Hepatitis B vaccine	_____ Hepatitis A vaccine	
_____ Measles, Mumps, Rubella vaccine		

Gynecological History

_____ Last Menstrual Period	_____ Age of Menopause
_____ Number of Pregnancies	_____ Number of Children
_____ Number of Miscarriages	_____ Number of Abortions

Type of Birth Control _____

Family Health History (Blood Relatives)
List family members who have had any of these medical problems: Cancer, heart attack, high cholesterol, high blood pressure, diabetes, osteoporosis, sickle cell anemia, kidney diseases, asthma, thyroid or any other common illness.

Illness:	Family Member(s):
_____	_____
_____	_____
_____	_____
_____	_____

East Valley Primary Care Physicians,PLC
4515 S. McClintock Suite 100
Tempe, Arizona 85282
(480) 820-1133 (480) 820-2175-fax

AUTHORIZATION FOR RELEASE OF RECORDS

Patient's Name_____DOB_____

Maiden Name_____Soc.Sec. #_____

Address_____
STREET APT. CITY STATE ZIP

Telephone_____

I authorize East Valley Primary Care Physicians CHECK ONE) TO { }Obtain from: OR { }Release to: `

Facility_____

Address_____
AND STREET APT/LOT # **CITY STATE ZIP**

Telephone_____ Fax_____

I hereby consent to the release of all medical records and other documentation in your possession regarding:

{ } Last 2 Years of Medical Records
{ } Lab Reports, X-Ray Reports
{ } Treatment Related to Specific Injury or Illness_____
{ } Beginning and Ending Dates of Treatment_____

I understand these records may contain information from other health care providers, as well as information, which is administrative in nature. *I specifically consent to the release of any information contained in the medical record, which may relate to infection with Human Immunodeficiency Virus (HIV), AIDS or related conditions.*

I understand that you have no responsibility for the use of distribution of this information by the party to whom it is released. I release you from all liability, which may arise from your compliance with this request to release records.

I authorize you to transmit this information by facsimile transmission (FAX), and release you from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission of my records are transmitted by fax.

_____ _____
Patient/Legal representative signature Date

_____
Witness

If not signed by the patient, list relationship of legal representative here: _____

REDISCLOSURE PROHIBITED: This release, whose confidentiality is protected by state and federal law, prohibits the further release of this information without specific written consent of the patient.

_____ _____
Name Date