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East Valley Primary Care Physicians, P.L.C

Patient Registration Form / Authorization for Release

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

TODAY'S DATE: _____ SEX: _____ EMAIL ADDRESS: _____

PATIENTS NAME: _____ BIRTHDATE: _____ MARITAL STATUS: _____

HOME PHONE: ____-____-____ WORK PHONE: ____-____-____ CELL PHONE: ____-____-____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT NAME: _____ PHONE: ____-____-____

DRIVER'S LICENSE (STATE & ID NUMBER): _____ EXPIRATION DATE: _____

PRIMARY INSURANCE INFORMATION:

PRIMARY POLICYHOLDER'S NAME:

_____

SSN: _____ DOB: _____

RELATIONSHIP TO THE PATIENT: _____

POLICYHOLDER'S EMPLOYER: _____

SECONDARY INSURANCE INFORMATION:

PRIMARY POLICYHOLDER'S NAME:

_____

SSN: _____ DOB: _____

RELATIONSHIP TO THE PATIENT: _____

POLICYHOLDER'S EMPLOYER: _____

AUTHORIZATION:

Do you authorize this office to discuss your care/treatment with anyone other than yourself? YES or NO

If yes, please list the 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 and due to the high cost of billing; a $10.00 charge will be added to each co-payment/co-insurance/deductible that is not paid at the time of service.

- I understand that there will be a $25.00 charge for missed appointments which are not cancelled 4 business hours prior to my appointment time.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE FORM

I, _____, have had the opportunity to read and 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 25, 2013 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: _____

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 South McClintock Drive Suite 100
Tempe, Arizona 85252
Phone: (480) 820-1133 Fax: (480) 820-2175

AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name (print): _____ Sex: M / F Birthdate: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Preferred phone number: _____

I authorize the disclosure of the above named individual's Protected Health Information and request East Valley Primary Care Physicians, PLC to (please check one): ☐ **Obtain from OR** ☐ **Release to the requested information to:**

Name (print): _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Fax: _____

The purpose for this requested information is:
☐Continuity of Care ☐Personal use ☐Consultation ☐School transfer ☐Attorney ☐Insurance
☐Other, please specify: _____
****Notice: There is a flat fee of $25.00 for all records requested for personal use ONLY****

The following information is requested: (check all that apply)
☐Last Two Years of Entire Medical Record **OR** ☐Complete Medical Record
☐Immunization Records ☐Progress Notes ☐Images/X-Rays ☐ Consultations
☐Consent forms ☐Lab Reports (please specify type of test or ALL): _____
☐Psychotherapy Notes ☐Other, specify: _____

_____ **(INITIALS) - I acknowledge and hereby understand that releasing my COMPLETE HEALTH RECORD may contain information relating to HIV or AIDS, treatment for alcohol and/or drug abuse, sexually transmitted disease, or medical testing content.**
DO NOT RELEASE: ☐HIV or AID, ☐Treatment for alcohol and/or drug abuse, ☐Sexually transmitted disease, OR ☐Medical testing content _____ **(INITIALS)**

I understand that:

1. If I do not authorize the release of my full health record, the recipient will be notified that only a limited health record is provided per patient request.
2. Authorizing this release of information is voluntary and I may refuse to sign this authorization.
3. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization except where the treatment is for the purpose of research or solely for purpose of creating a health record for disclosure to a third party.
4. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
5. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations.

This authorization will expire 180 days from date of signature.

East Valley Primary Care Physicians, its employees, and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

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

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient (if not the Patient)