

Dr. Christopher Morris
13945 W Grand Ave, Suite 101A
Surprise, AZ 85374
Phone: (480) 944-4298
Fax: (866) 538-7155



Thank you for choosing Arizona Family Health!

Welcome to the Family!

We are pleased that you have chosen our office for your healthcare needs and look forward to providing you with quality, compassionate care.

To help ensure a smooth check-in process for your first visit, please remember to bring the following items with you to your appointment:

- Your insurance card(s)
- A valid photo ID
- A current list of medications
- Any pertinent medical records
- Your completed **New Patient Paperwork Packet**

We kindly ask that you arrive **15 minutes prior to your scheduled appointment time**. This allows sufficient time to complete the check-in process, especially if you are unable to finish the paperwork at home.

Office Information:

Phone: (480) 944-4298

Fax: (866) 538-7155

Office Address:

13945 W. Grand Avenue, Suite 101A

Surprise, AZ 85374

Our office is located near the crossroads of **Grand Avenue and Mountain View Blvd**, in the **southeast corner of the medical plaza**. The entrance is on the **south side of the building**, near the covered parking.

Patient Portal:

<https://healow.com/apps/jsp/webview/signIn.jsp>

Practice Code is: GEFAED

Medical Records:

Medical records may be emailed to wecare@arizonamobilehealth.com

We have also attached a medical records release form for you to complete. Once we receive the completed form, we can fax it to your previous provider's office to request your records.

If you have any questions prior to your visit, please do not hesitate to contact our office. We look forward to meeting you and welcoming you to Arizona Family Health.

Sincerely,

Arizona Family Health

ARIZONA
Family Health



| Patient Information Form | | | | |
|--|----------------|--|-----------|----------|
| Patient Name: | | | | |
| | First Name | Middle Initial | Last Name | |
| Social Security Number: | | | | |
| Address: | | | | |
| | Street Address | City | State | Zip Code |
| Date of Birth: | | | | |
| Sex at Birth: Female Male | | Gender Identity: Female Male Non-Binary | | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | |
| Contact Information | | | | |
| Phone Number: | | | | |
| Secondary Contact Number: | | | | |
| Email Address: | | | | |
| Pharmacy Information | | | | |
| Pharmacy Name: | | | | |
| City: | | | | |
| Cross Streets (if known): | | | | |
| Emergency Contact Information | | | | |
| Emergency Contact Name: | | | | |
| Relationship to Patient: | | | | |
| Phone Number: | | | | |
| May release your medical information to this individual? YES NO | | | | |

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Insurance Information

Primary Insurance Name:

| | | | |
|---------------------------|--|----------------------------|-------------|
| Member ID: | | Group Number: | |
| Responsible Party: | | Relationship to Pt: | DOB: |

Secondary Insurance Name:

| | | | |
|----------------------------------|--|----------------------------|-------------|
| Secondary Ins. Member ID: | | Group Number: | |
| Responsible Party: | | Relationship to Pt: | DOB: |

I hereby authorize **Arizona Family Health, LLC**, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), applicable federal regulations, and the laws of the State of Arizona, to use and disclose my protected health information as permitted by law for purposes of treatment, payment, and healthcare operations.

I hereby assign and authorize payment of medical benefits, if any, directly to **Arizona Family Health, LLC** for services rendered otherwise payable to me under the terms of my insurance policy.

I authorize photocopies or electronic copies of this authorization to be considered as valid and binding as the original.

I understand that all required copayments are due at the time services are rendered. I further understand and agree that I am financially responsible for all charges not covered by my insurance, including but not limited to non-covered services, insurance denials, and services rendered without a required referral if my insurance plan requires such referral.

I agree to promptly pay all statements received from **Arizona Family Health, LLC** for services rendered.

| | |
|--------------------|-------|
| Patient Signature: | Date: |
|--------------------|-------|

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| Patient Medical Intake Form(s) | | | | |
|---------------------------------|---|-----------------------------|-------------------------|--------------|
| Patient Name: | | DOB: | | Date: |
| Latex Allergy: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reaction: | | |
| Allergies to Medication: | <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list below: | | | |
| Medication Allergies | Type of Reaction | Medication Allergies | Type of Reaction | |
| | | | | |
| | | | | |
| | | | | |

| Please list all the medications you are currently taking including prescriptions, over-the-counter, or herbal supplements | | |
|---|----------------|-------------------------------------|
| <input type="checkbox"/> None | | |
| Medication Name: | Dosage: | How often are you taking it? |
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |

| Family History | |
|---|---|
| ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Deficiency <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension(High Blood Pressure) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Illness <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Obesity <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CAD (Coronary Artery Disease) <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoarthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Type: | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CVA(Stroke) <input type="checkbox"/> Yes <input type="checkbox"/> No | Peripheral Vascular Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal/Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Developmental Delay <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: <input type="checkbox"/> Yes |



Social History

Please answer the following questions regarding your social history.

| | | | |
|--|---|----------------------------|----------------------------|
| Tobacco Use? | <input type="checkbox"/> Yes (answer below) <input type="checkbox"/> Former (answer below) <input type="checkbox"/> No - Skip the questions below | | |
| Type of Tobacco Cigarettes? | Packs/Day | For how many years? | Year that you quit? |
| Vape or Nicotine Pen? | | | |
| Chew? | | | |
| Are you exposed to second hand smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Do you consume Alcohol? | <input type="checkbox"/> Yes (answer below) <input type="checkbox"/> Former (answer below) <input type="checkbox"/> No - Skip the questions below | | |
| Type of Alcohol | Frequency? | Drinks per Day? | Last Drink? |
| | | | |
| | | | |
| | | | |

Surgical History

List any and all surgeries/procedures you have had.

None

| Surgery/Procedure Name (Year) | Surgery/Procedure Name (Year) |
|--------------------------------------|--------------------------------------|
| | |
| | |
| | |

Hospitalizations

List any hospitalizations and the facility where you were hospitalized within the last year.

| |
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Please answer the following questions regarding your medical history as best as you can.

Have you ever been diagnosed with any of the following?

No Past Medical History

| Cardiovascular: | Check One | Year | Ear/Nose/Throat: | Check One | Year |
|-----------------------------|---|-------------|-------------------------|--|-------------|
| Coronary Artery Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Hyperlipidemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Chronic Ear Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Gastrointestinal: | Check One | Year | Hearing Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Nasal Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| GERD (Acid Reflux) | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Recurrent Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Genitourinary: | Check One | Year | Hematologic: | Check One | Year |
| Prostate Enlargement | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Kidney Stones | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Bleeding Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Acute Renal Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Clotting Issues | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Infectious Disease: | Check One | Year | Immunologic: | Check One | Year |
| Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Seasonal Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Valley Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Food Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Metabolic/Endocrine: | Check One | Year | | | |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Hypothyroidism | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

Continue to next page to complete....

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| Psychiatric | Check One | Year | Pulmonary | Check One | Year |
|-----------------|--|------|---------------------------------|--|------|
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | | COPD/Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Bipolar | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Eating Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | | CPAP | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Neurologic | Check One | Year | Miscellaneous | Check One | Year |
| Migraine | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Anesthesia Reaction | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| CVA(stroke) | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Pediatric | Check One | Year |
| Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Complications During Pregnancy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Alzheimer's | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Complications during delivery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dementia | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Failed Newborn Hearing Screen | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Parkinson's | <input type="checkbox"/> Yes <input type="checkbox"/> No | | NICU | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Review of Systems

Check any of the following problems you have recently had or are currently experiencing.

General Health Problems

Fatigue Fever Unintentional Weight loss Weight Gain Sleep Problems

Eye Problems

Blurred Vision Double Vision Itchy Eyes Eye Pain Redness Swelling

Ear Problems

Hearing Loss Ear Pain Dizziness Ear Infections Ringing in the ears Discharge

Nose and Sinus Problems

Nose Bleeds Chronic Congestion Nose/Sinus Problems Runny Nose Sinus Pressure

Brain and Nervous System

Fainting Frequent Headaches Seizures Numbness Migraines Weakness in limbs
Facial Pain

Heart or Circulation Problems

Chest Pain Heart Murmur Irregular Heart Beat Swelling in ankles Blacking Out Light-headed upon standing

Lung or Respiratory Problems

Wheezing Shortness of Breath Cough Pneumonia Bronchitis COVID Heavy Chest

Stomach Problems

Vomiting Heartburn No Appetite Increased Appetite Constipation Abdominal Pain Diarrhea
Nausea

Blood or Lymph Node Problems

Swollen Glands Bruising Easily Bleeds excessively after injury Enlarged Lymph Nodes

Review of Systems continued on the next page..

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| |
|--|
| Muscle Problems |
| <input type="checkbox"/> Muscle Pains <input type="checkbox"/> Joint Pain <input type="checkbox"/> Leg Cramping <input type="checkbox"/> Muscle Spasms |
| Skin Problems |
| <input type="checkbox"/> Rash <input type="checkbox"/> Itchiness <input type="checkbox"/> Dry Skin <input type="checkbox"/> Growth/Lesions <input type="checkbox"/> Swelling <input type="checkbox"/> Hives <input type="checkbox"/> Eczema |
| Glands and Hormones |
| <input type="checkbox"/> Increased thirst <input type="checkbox"/> Mood Swings <input type="checkbox"/> Intolerance to hot/cold <input type="checkbox"/> Unusual Hair Growth <input type="checkbox"/> Neck Enlargement <input type="checkbox"/> Increase irritability <input type="checkbox"/> Increased Emotions <input type="checkbox"/> Change in sex drive or performance |
| Allergy Problems |
| <input type="checkbox"/> Frequent Sneezing <input type="checkbox"/> Frequent Runny Nose <input type="checkbox"/> Food Intolerances <input type="checkbox"/> Insect Bites |
| Annual Wellness Questions |
| Please answer the questions below regarding your last annual wellness exam... |
| Have you had your annual wellness exam this year? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had any recent labs completed or ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you typically complete your annual wellness exam? <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | |
|---------------------------|--|
| Patient Signature: | |
| Date: | |

Dr. Christopher Morris
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Patient Financial Responsibility Agreement

I understand and agree that I am financially responsible for **all charges** incurred for medical services provided by **Arizona Family Health**, regardless of insurance coverage, including but not limited to:

- Copayments
- Deductibles
- Coinsurance
- Charges for services not covered by my insurance plan
- Charges for services denied, reduced, or not paid by my insurance carrier

I understand that verification of insurance benefits is **not a guarantee of payment**, and final determination of benefits is made by my insurance company. Arizona Family Health may assist with insurance verification when possible; however, patients are ultimately responsible for understanding their insurance plan, benefits, coverage limitations, and financial responsibility.

Non-Covered Services & Insurance Denials

I acknowledge that some services provided by **Arizona Family Health** may be considered non-covered, not a plan benefit, or not medically necessary by my insurance carrier. I agree to be personally responsible for payment of these services, if my plan denies, considers the services not medically necessary, or does not cover the services rendered.

If my insurance denies or delays payment for any reason, I agree to pay the full balance owed.

If I do not have active insurance coverage, I understand that I am responsible for **payment in full** for all services rendered.

Authorization to Release Medical Information

(HIPAA & Arizona Revised Statutes §12-2294)

I authorize **Arizona Family Health** to release my medical, billing, and treatment information as necessary to insurance carriers, third-party payers, and billing services for purposes of treatment, payment, and healthcare operations.

This authorization remains in effect unless revoked in writing.

Assignment of Benefits

I authorize my insurance carrier to make **direct payment** to **Arizona Family Health** for all services rendered. I understand that this assignment does not release me from responsibility for charges not paid by my insurer.

Referrals & Prior Authorization

I understand that certain insurance plans (including HMO, Medicare Advantage, and AHCCCS plans) require referrals or prior authorization.

I am responsible for obtaining required referrals and authorizations prior to services being rendered. Failure to do so may result in denial of payment, for which I am financially responsible.

Payment Terms, Late Fees & Collections

(Arizona Revised Statutes §12-341.01)

I understand and agree that:

- Payment is due according to **Arizona Family Health** billing policies
 - Late fees may be applied as permitted by Arizona law
 - Unpaid balances may be sent to a collection agency
 - I am responsible for reasonable collection costs, including attorney fees and court costs, as allowed by law
-

Returned Payments

I understand that a fee may be charged for returned checks, rejected electronic payments, or insufficient funds, as permitted under Arizona law.

Acknowledgment & Consent

I acknowledge that I have read and understand this Financial Responsibility & Insurance Authorization Form. I have had the opportunity to ask questions, and this agreement applies to **all current and future visits** to **Arizona Family Health** unless revoked in writing.

I understand this is a **legally binding agreement**.

Patient Signature and Acknowledgment

| | | |
|-----------------------------------|--|-------|
| Patient Name (Print Only): | | |
| Patient Signature: | | Date: |

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HIPAA Authorization for Release of Medical Information

| | |
|---|--|
| Patient Full Name — First and Last Name: | |
| Date of Birth: | |
| Address: | |
| City, State, Zip: | |
| Phone Number: | |
| Email: | |

Authorization

I hereby authorize **Arizona Family Health** to use and/or disclose my protected health information as described below.

Organization Authorized to Release Information

Arizona Family Health

Address: 13945 W Grand Ave, Suite 101A
Surprise, AZ 85374

Phone: (480) 944-4298 Fax: (866) 538-7155 Email: wecare@arizonamobilehealth.com

Person or Organization Authorized to Receive Information

| | |
|--------------------------------------|--|
| Name: | |
| Relationship (if applicable): | |
| Address: | |
| Phone Number: | |
| Fax Number: | |
| Email: | |

Information to Be Released (check all that apply)

- Complete medical record
- Office visit notes
- Lab results
- Imaging reports
- Medication records
- Billing/insurance records
- Mental health records (if applicable)
- Other: _____

Purpose of Disclosure

- Continuity of care
- Personal use
- Insurance
- Legal
- Other: _____

Expiration

This authorization will expire on:

- **Date:** ____ / ____ / _____
- **OR**
- Upon the following event: _____

Patient Rights

- I understand that I may revoke this authorization at any time by submitting a written request, except to the extent that action has already been taken.
- I understand that information disclosed under this authorization may no longer be protected by HIPAA once released.
- I understand that my treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Patient Signature and Acknowledgment

| | |
|-----------------------------------|--------------|
| Patient Name (Print Only): | |
| Patient Signature: | Date: |

Dr. Christopher Morris
 13945 W Grand Ave, Suite 101A
 Surprise, AZ 85374
 Phone: (480) 944-4298
 Fax: (866) 538-7155



Medical Records Request Form

| | |
|---------------------------|-------|
| Patient Name: | |
| Date of Birth: | |
| Phone: | |
| Address: | |
| City, State, Zip: | |
| Patient Signature: | Date: |

Please acknowledge this request from Arizona Family Health as a request for the patient's above medical records. Please send the requested records as soon as possible to help ensure continuity of care.

Requesting Patient's Information From:

| | |
|------------------------------------|--|
| Name of Clinic or Facility: | |
| Previous Provider Name: | |
| Address: | |
| Phone: | |
| Fax: | |

Records Requested (check all that apply):

- Pre-operative evaluations
- Operative reports
- Post-operative notes
- Office visit notes
- Imaging reports
- Laboratory results
- Discharge summary
- History & Physical
- Entire medical chart/complete record**

Purpose of Request:

- Continuity of care
- Surgical clearance
- Second opinion
- Personal use
- Legal/administrative

Delivery Method:

- Fax to: (866) 538-7155
- Secure email to: wecare@arizonamobilehealth.com
- Mail to address above
- Patient will pick up

Authorization

I hereby authorize the release of my protected health information as specified above. I understand that this authorization is voluntary and that I may revoke it in writing at any time, except to the extent that action has already been taken in reliance on it.