Family First Physicians
2345 E Southern Ave Ste 101
Mesa, AZ 85204

Patient Demographics

Account #:_____

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable):
Date of Birth:	Sex : ☐ Male ☐ Female		Preferred Gender: ☐ Male ☐ Female ☐ Other:
Mailing Address:			Apt #
City/State/Zip:		Email:	
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact (Please Select Only One Option) ☐ Voice ☐ Text ☐ Email			If voice, please select preferrerd number ☐ Home ☐ Cell ☐ Work ☐
Guarantor/Financially Responsible Name:		Phone Number:	
Guarantor Address:			Guarantor D.O.B.:
Emergency Contact:	Phone Number:		Relationship:

Race:
☐ Caucasian ☐ American Indian/Native American ☐ African American ☐ Asian ☐ Hawaiian/Other Pacific Islander ☐ Other:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic/White ☐ Other	Preferred Language: ☐ English ☐ Spanish ☐ Other:

Insurance Information

Primary Insurance- Complete with as much information as possible

Insurance Plan Name:	Member ID:	Group Number:
Policy Holder Name:	Policy Holder D.O.B.:	Relationship:
Policy Holder Address:	City/State/Zip:	Policy Holder Phone Number:
Employer:	Occupation:	Policy Holder SSN:

Secondary Insurance- Complete with as much information as possible

Insurance Plan Name:	Member ID:	Group Number:
Policy Holder Name:	Policy Holder D.O.B.:	Relationship:
Policy Holder Address:	City/State/Zip:	Policy Holder Phone Number:
Employer:	Occupation:	Policy Holder SSN:

Can we leave a message regarding your medical care & test results? Yes ☐ No ☐	**I do NOT wish to be web enabled for the Patient Portal ☐**

Preferred Pharmacy:	Major Cross Streets:	Phone Number:

_____ Print Name

_____ Signature

_____ Date

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Medical Treatment Agreement

Medical Treatment: The patient consents to the treatment, services and procedures which may include but are not limited to: laboratory procedures, medical and surgical treatments or procedures, or anesthetics under the general or specific instructions of the responsible health care provider. As part of our mission to provide optimal health care for our patients, we allocate the use of the Arizona Prescription Monitoring program. The program is a tool used to promote the public health and welfare by detecting diversion, abuse and misuse of prescription medications classified as controlled substance(s) under the Arizona Uniform Controlled Substances Act

Teaching Program: Family First Physician's participates in training programs for physician assistants and health care personnel. Some patient services may be provided by person's in training under the supervision and instruction of the physician or practice employee's. These person's in training may also observe care given to the patient by physician(s) and/or practice employee's.

Contraband: Drugs, alcohol, weapons and other articles specified as contraband by Family First Physicians is not allowed on office premises. Any illegal substance will be confiscated and turned over to the authorities.

Valuables: Neither Family First Physician's nor the health care provider's will be responsible for loss or damage to items brought by the patient to the facility, including but not limited to: cell phones, tablets, laptops, glasses, contact lenses, dentures, hearing aids, jewelry, money or any other personal items.

Photography/Video Recording: I understand and agree that a photograph may be taken of me for identification purposes or for other treatment purposes. I will not take pictures or record videos of any Family First Physician staff member without their permission.

Release of Information: According to Arizona State Law, A.R.S. §12-2294 and §12-2294.01 require physicians to disclose medical records without the patient's written authorization as required by law or when ordered by a court or tribunal of competent jurisdiction. This includes subpoenas. When required for diagnosis or treatment of the patient, a physician may disclose the medical records without written authorization from the patient to other health care providers. And the doctor may disclose them to other health care providers who have previously treated the patient without the patient's written approval. Doctors may also release them to ambulance attendants, to a private agency that accredits health care providers, to the Arizona Medical Board, to health care providers for peer review, to a person or entity that provides billing and administrative services, to an attorney for the purpose of obtaining legal advice, to the patient's third-party payor, or to the Industrial Commission of Arizona. Included information may be regarding alcohol or drug abuse as well as HIV related or other communicable disease.

HIPAA: The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. You will be provided with a copy of the office's HIPPA regulations which is your copy to keep.

By signing below, I confirm that I have read and understand Family First Physician's Medical Treatment Agreement.

_____	_____	_____
Print Name	Signature	Date

Patient:_____ DOB:_____

Who are your current medical providers?	
Provider Name	Specialty, or condition for which they treat you

Preventative Care					
	Date		Date		Date
Annual Physical		Dental exam		Pap Screen	
Bone Density		Diabetes screen		Mammogram	
Colonoscopy		Eye Exam		Prostate Screen	
Cholesterol test					

Immunizations					
	Date		Date		Date
Tetanus (Td or Tdap)		HPV (Gardasil)		Influenza (Flu)	
Hepatitis A		Hepatitis B		Meningitis	
Pneumonia		Shingles		Other (please write below)	

Please list all medications, supplements, over the counter drugs, creams and inhalers.		
Name	Dose/Strength	Frequency taken

Allergies or intolerances to medications?	
Name	Reaction

Advance Directives		
Do you have a living will?	Yes	No
Do you have a medical power of attorney?	Yes	No
If you answered yes to either, please make sure our office has a copy		
If no, would you like information or a copy of advance directive forms?	Yes	No

Patient:_____ DOB:_____

Please check all current of past medical problems or conditions					
ADD/ADHD		Depression		HIV/AIDS	
Anemia		Diabetes Type 1		Hyperthyroidism	
Anxiety		Diabetes Type 2		Hypothyroidism	
Arthitis		Emphysema		Kidney Disease	
Asthma		Glaucoma		Migraines	
Bipolar Disorder		Heart Attack		Seizures	
Blood Clots		Heart Artery Disease		Seasonal Allergies	
Blood Transfusion		Heart Failure		Sexually Transmitted Infection	
Cancer		Heart Murmur		Stomach/Intestine Ulcers	
Cataracts		Heartburn		Stroke	
Chronic Lung Disease		High Blood Pressure		Substance Abuse	
Chronic Pain		High Cholesterol		Valley Fever	

Please check all major operations or surgeries					
None		Eye		Joint Replacement	
Appendectomy		Fracture Repair		Ovaries	
Breast Augmentation		Gallbladder		Spine	
Breast Surgery		Heart Bypass		Thyroid Surgery	
Cesarean Section		Heart Valve Surgery		Tonsillectomy	
Colon		Hernia Repair		Tubes Tied	
Coronary Artery Stent		Hysterectomy		Vasectomy	
Cosmetic Surgery					

Family Medical History- Please check the appropriate box if a condition is/was present.					
				If unknown or if you were adopted, please check here:	
	Father	Mother	Siblings	Children	Other
Year born					
Alive?					
If no, put year deceased					
Alzheimer's					
Arthritis					
Cancer					
COPD					
Depression					
Diabetes					
Alcohol/Drug Abuse					
Hearing Loss					
Heart Disease					
High Cholesterol					
High Blood Pressure					
Kidney Disease					
Mental Illness					
Miscarriages					
Stroke					
Vision Loss					
Other:_____					

Patient Name:_____ DOB:_____

Social History

Tobacco Use- Please check your response.

☐ Smoke every day ☐ Smoke some days ☐ Former Smoker ☐ Heavy Smoker
☐ Light Smoker ☐ Never smoked ☐ Second-hand exposure

If current smoker: How soon after you wake up do you smoke your first cigarette?

☐ within 5 minutes ☐ 6-30 minutes ☐ 31-60 minutes ☐ after 60 minutes

If ever smoked, how many cigarettes/day average?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

How many years smoked?

You ever chewed?

☐ Yes ☐ No

If you currently use any tobacco product, are you ready to quit?

☐ Yes ☐ No ☐ Thinking about quitting

Alcohol Use- Please check your response.

Did you have a drink containing alcohol in past year? ☐ Yes ☐ No

If Yes: How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

If yes: How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

If yes: How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Drug Use- Please check your response.

Have you used drugs other than those for medical reasons in the past 12 months? ☐ Yes ☐ No

Sexual History

Have you had sex (vaginal, oral, or anal) in the past 12 months? ☐ Yes ☐ No

Have you ever had a Sexually transmitted disease? ☐ Yes ☐ No

Miscellaneous

How often do you drink bevarages with caffeine?

☐ Never ☐ Occasionally ☐ 1-2 cups per day ☐ 2-3 cups per day
☐ 3-4 cups per day ☐ More than 4 cups per day

How often do you exercise? (At least 15 minutes or more of physical activity)

☐ Never ☐ Occasionally ☐ 1-2 times per week ☐ 2-3 times per week
☐ 3-4 times per week ☐ 5-6 times per week ☐ Daily

Do you wear your seatbelt?

☐ Yes ☐ No

In the last 6 months, have you travelled outside the United States?

☐ Yes; Where?_____ ☐ No