**DESERET FAMILY MEDICINE NP PATIENT DEMOGRAPHIC FORM - PLEASE PRINT**

**TODAY’S DATE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEX**: MALE FEMALE **DATE OF BIRTH**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE**: \_\_\_\_\_\_\_ **SOCIAL SECURITY #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP TO PT**.: SELF SPOUSE CHILD OTHER

**IS PATIENT**: ⁭ SINGLE ⁭ MARRIED ⁭ DIVORCED ⁭ WIDOWED

**LOCAL ADDRESS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CITY, STATE, ZIP**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUMMER ADDRESS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**CITY, STATE, ZIP**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOME PHONE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **WORK PHONE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CELL PHONE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PREFERRED METHOD OF CONTACT**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY LANGUAGE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **RACE/ETHNICITY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT NAME/RELATIONSHIP**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT PHONE NUMBER (MUST BE DIFFERENT THAN YOUR PHONE #)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREFERRED PHARMACY NAME AND CROSS STREETS/PHONE #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS YOUR SPOUSE/PARENT EMPLOYED?** \_\_\_\_YES \_\_\_\_NO **ARE YOU ON THEIR POLICY?** \_\_\_\_YES \_\_\_\_NO

**ARE YOUR INJURIES WORK RELATED OR ACCIDENT RELATED?** \_\_\_\_YES \_\_\_\_NO

**DO YOU HAVE A MEDICAL MARIJUANA CARD?** \_\_\_\_ YES \_\_\_ NO (If yes, please provide a copy to the front desk)

**DO YOU HAVE A PRESCRIPTION (RX) CARD?** \_\_\_\_ YES \_\_\_ NO (If yes, please provide a copy to the front desk)

**WHO OVER THE AGE OF 18 IS RESPONSIBLE FOR THIS BILL?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**:

 **MUST FILL IN ALL INFORMATION MUST FILL IN ALL INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECONDARY INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INS. CO. ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. CO. ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY HOLDER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY NO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP/CLAIM NO:\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY NO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP CLAIM NO:\_\_\_\_\_\_\_\_

EFFECTIVE DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EFFECTIVE DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER SEX: F M BIRTHDATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY HOLDER SEX F M BIRTHDATE:\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

**SIGNED (Patient or legal guardian)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Deseret Family Medicine**

7165 East University Drive, Ste. 141

Mesa, Arizona 85207

# BILLING POLICY

COPAY/DEDUCTIBLE/COINSURANCE

All payments are required upon check in. If you do not have your payment, you will be asked to reschedule when you are able to pay for the visit. This payment is only an estimate of what you owe. We will not hold any form of payment to deposit at a later date. We accept cash, check, Visa, MasterCard, Discover, or American Express as means of payment.

**MEDICARE:** We are a Medicare participating physician. Patients who are covered by Medicare are responsible for their deductible as well as the 20% of the Medicare allowable charge. We make every attempt to collect the correct amount from our patients at the time of service. There will be circumstances where we have not collected the correct amount and will either request additional payment or make a refund to you. If additional payment is required a statement will be sent to you reflecting the total charges, the total amount paid, and the balance owed by you. The amount paid includes your initial payment, Medicare’s payment, and the required adjusted amount. If Medicare does not file your supplement, we will file your supplement one time for each day of service. If the supplement needs to be refiled this is up to the patient. We will wait 30 days after we have heard from Medicare for the supplement to send payment. If we have not heard from your supplement within that time, then the balance will become your responsibility. If your insurance pays us at a later date, we will refund you.

**HMO/PPO:** These plans vary with each individual. Patients are expected to make copayments at the time of service and or meet their deductible requirements. We file the insurance on your primary HMO/PPO plans we participate with as a courtesy to you. In no way does this release you from any responsibility. In the event that a claim comes back to us denied by your insurance company, you are immediately responsible for your debt and receipt is expected 10 days after you receive a statement.

For our patient’s convenience we will file the claims and allow 30 days for your insurance carrier to make payment. In the event that we have not heard from them, we will submit the claim a second time for processing. If we have had no response after 60 days total, then the debt will become your responsibility. You will be asked to contact your carrier and be required to make payment in full for the services rendered. If your insurance pays us at a later date, we will refund the overpayment to you.

**STANDARD INSURANCE:** These are plans in which we are not a participating provider. Payment will be required at the time of service and you as a patient may submit your claim to your insurance company. Our itemized super bill includes all your charges for that day of service, as well as your diagnosis.

**INDUSTRIAL:** For our patients who have industrial (workman’s compensation) coverage, we will file your industrial claims for you as a courtesy, provided you have filled out a pink industrial form with our office. All information must be complete, or we will hold you responsible for payment. In the event that a claim comes back to us denied by your insurance company, you are immediately responsible for your debt. If your insurance has not paid within 45 days of claim submission, then the debt will become your responsibility. Payment is due within 10 days from receipt of statement. If your insurance pays us at a later date, we will refund you. Industrial claims outside the state of Arizona are not accepted.

**NO INSURANCE:**  For our patients who do not have insurance coverage, full payment for all services provided is required at the time of service.

**FORMS/PAPERWORK:** We reserve the right to charge for any forms or paperwork.

**NO SHOW/LATE FEES:** There may be a $40.00 charge for no shows that are not canceled 24 hours in advance. There may be a $45.00 late fee added to any account that is more than 30 days past due. **This is your advanced notice that all no show and late fees that accrue on your account may be sent to an outside collection agency if not paid.**

**COLLECTIONS/BANKRUPTCY** Once an account has been turned over to our collection agency or you have filed bankruptcy, your account will become a “cash only” account. Payment plans will not be accepted and will always expect cash at time of service based on your past credit history with us. We can still file your insurance if we are a participating provider, but you will need to pay the total charges. If you have any further questions or concerns, please contact our Billing Department at 480-325-3615.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name (PRINTED) Date of Birth**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature (Responsible Party, if minor) Date**

**ASSIGNMENT OF BENEFITS FORM**

**Practice Name**: Deseret Family Medicine **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_

**Address**: 7165 East University Drive, Ste. 141 **Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City, State, Zip**: Mesa, Arizona 85207 **Insurance ID#**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**: (480) 981-3000 **Group#**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** understand that services rendered to me by Deseret Family Medicine is my financial responsibility and that the provider will bill my insurance company, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** as a courtesy. I authorize my insurance company to pay my benefits directly to Deseret Family Medicineand I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me; I will forward the payment to Deseret Family Medicinewithin 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider’s election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Deseret Family Medicine to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of policy holder** **Patient or Guardian Signature**

**DFMG Witness**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deseret Family Medicine

ASSIGNMENT OF PATIENT REPRESENTATIVE

* I hereby authorize the use and disclosure of any protected health information as set forth below.
* I understand that I may revoke this authorization at any time by notifying Deseret Family Medicine in writing. In the event of any revocation of this authorization, the revocation will not affect any action taken by the medical practice in reliance on this authorization.
* I understand that the provision of treatment or health care may not be conditioned on my providing this authorization.
* I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by federal privacy regulations.
* **I understand that if I fail to name a representative for myself, Deseret Family Medicine cannot speak to or release any of my information to my family or friends, even in the case of an emergency.**

Description of information to be used or disclosed:

(Please check all that apply)

**\_\_\_\_** Medical **\_\_\_\_** Financial **\_\_\_\_** Appointments **\_\_\_\_** Scripts **\_\_\_\_** All Information

**\_\_\_\_** I do not wish to assign a patient representative at this time.

 NAME : RELATIONSHIP:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization does not have an expiration date. I can revoke or change this information at any time in writing to Deseret Family Medicine. It is my responsibility to keep this information up to date.

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Parent or Guardian if patient is a minor)

**\_\_\_\_**I am an emancipated minor.

Please use the following as means of communicating with me:

**\_\_\_\_** Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Leave Message: Yes \_\_\_\_\_\_ No\_\_\_\_\_\_\_

**\_\_\_\_**Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_

**\_\_\_\_**Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_

\_\_\_\_\_ Email

\_\_\_\_\_ Text Messages

This information does not have an expiration date. I can change this information at any time by submitting a written request to Deseret Family Medicine. It is my responsibility to keep this information up to date.

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Parent or Guardian if patient is a minor)

7165 East University Drive, Ste. 141

Mesa, Arizona 85207

P: (480) 981-3000

F: (480) 924-6339

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DFM POLICY FOR PATIENT CONDUCT

Deseret Family Medicine strives to provide a safe, secure, comfortable environment for our employees, patients, and vendors who we do business with. In order to achieve this, we treat our employees, patients and vendors with respect and dignity, and we ask that they do the same in return.

It is the expectation of our office that patients will adhere to this policy and follow the outlined appropriate behaviors listed below. These include, but are not limited to:

* Using a normal tone of voice when speaking with our staff
* Treating all staff with dignity and respect whether you are in the office or on the phone
* Using appropriate language when speaking to our staff in the office or on the phone
* Being respectful to the practice’s property and supplies

Depending on the circumstances, Deseret Family Medicine may deem certain behaviors to be in violation of this policy. Violation of this policy may result in verbal counseling from the office manager or owner and may include discharge (removal) from the practice.

By signing below, I acknowledge the above information and agree to abide by this policy for appropriate conduct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature Date

Deseret Family Medicine

Office Policies

Annual Wellness Visits/Physical Examinations:

* Because we care about you and your health, we require that all of our patients receive an annual wellness visit (Medicare and Medicare Advantage Patients) and/or a physical examination once every year. These are important visits that allow you extra time with your provider and these types of visits are free to you. Keeping you healthy is a team effort between you and your provider and these visits are a great way to make sure you are getting the care you deserve. INITIALS: \_\_\_

Patient No-Show/Cancellation:

* In an effort to have same day appointments available for sick patients, we ask that patients who need to cancel their appointment do so with a 24-hour notice. Any appointments not canceled 24-hours in advance are subject to a $40 no-show fee.
* If a patient arrives 6 minutes past their scheduled appointment time, they are considered a no-show and may be charged a $40 no-show fee and their appointment will be canceled. INITIALS: \_\_\_

Patient Late Appointment Arrival:

* In an effort to keep our providers running on time, we respectfully ask that our patients arrive 30 minutes early for a new or re-establish appointment, 30 minutes early for an annual wellness visit or physical examination, 30 minutes early if the patient has not filled out new forms for the current year and 15 minutes early for all other appointments. We need this additional time, before your appointment, so the front desk has time to check you in and the medical assistant has time to room you so the provider can see you at your scheduled appointment time. If you do not show up early as we have asked you to, you may need to be rescheduled.
* If a patient arrives 6 minutes past their scheduled appointment time, they will be moved to a later available appointment slot for the provider they were going to see, scheduled with another provider who has an opening in their schedule or if no appointments are available, they will have to be rescheduled to a different day. INITIALS: \_\_\_

Referrals:

* When your provider orders a referral for you it will be handled 1 of 3 ways depending on your insurance:
	+ You may be handed a referral on the same day as your appointment.
	+ Your referral request may be sent to our referral coordinator for her to complete. If this is the case, please allow her up to 5 business days to complete the referral.
	+ If it is a STAT referral that goes to the referral coordinator, please allow 24 hours for it to be completed.
	+ If you have not been seen in our office for the reason you need the referral during the current year, you will need an appointment before we can complete the referral. INITIALS: \_\_\_

Co-Pays and Account Balances Policy:

* All co-pays and account balances are due at time of service.
* You must present your insurance card at every visit.
* If you are a new patient, we cannot see you without a valid government issued ID.
* You are responsible for making sure your insurance and address are current with us at all times. INITIALS: \_\_\_

Prescription Refill Requests:

* For ALL prescription refill requests, please contact your pharmacy with the request. They will then contact us with your request. Please allow 48 hours for our staff to respond. INITIALS: \_\_\_

HIPAA Privacy Rules:

* We cannot disclose ANY information to anyone who is not listed on your Assignment of Patient Representative form. This is a federal law, and the staff cannot, for any reason, disclose information to anyone you do not give us permission to. Please make sure you assign someone on this form if you want them to be able to talk to us about your medical information. If you are not sure if you have assigned someone, please ask the front desk to look at your documents for you. INITIALS: \_\_\_

Medical Assistant Visits:

* We offer walk in medical assistant visits for things such as injections, blood pressure checks, TB skin test check or other procedures that your provider may require for you outside of a normal office visit. The hours for MA visits are as follows:
	+ Wednesdays: 9:00 AM – 11:00 AM
	+ Wednesdays: 2:00 PM – 4:00 PM
	+ Fridays: 1:30 PM – 4:00 PM INITIALS: \_\_\_

Controlled Substance Prescriptions:

* Any patient receiving a controlled prescription medication must adhere to the following rules:
	+ Be seen by a provider every 30 days
	+ Submit to random drug screen testing
	+ Sign a controlled substance contract
* Arizona State Law requires that all controlled substance prescriptions be sent electronically to your pharmacy.

INITIALS: \_\_\_

In-House Phlebotomist:

* We have an in-house Sonora Quest phlebotomist who can draw blood for all of our patients no matter which insurance plan you are on; they will make sure it gets to the correct lab if the lab of choice is not them. See their hours posted at the front desk. They see patients on a first come, first serve basis.
* They cannot draw labs that were ordered by providers who are not in our office. For example, labs that were ordered by your specialist. INITIALS: \_\_\_

Receiving Your Test Results and Messages:

* We will call you, send you a voice message, send you an email and/or send you a text message regarding any test results or messages. If you have a preferred way to be contacted, please let the front desk know.

INITIALS: \_\_\_

Forms:

* Any forms that a patient needs filled out, i.e. FMLA, adoption, assisted living, etc., will require an appointment and a $25.00 fee will be charged for the forms no matter how many pages the form is. This is in addition to any co-pay amounts and/or balances due on accounts. INITIALS: \_\_\_

I have read and understand the office policies of Deseret Family Medicine as outlined in this document. I agree to abide by these policies. I have been offered a copy of these policies for my records.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name (printed) Patient or Guardian Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

DESERET FAMILY MEDICINE

7165 East University Drive, Ste. 141

Mesa, Arizona 85207

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I also, acknowledge receipt and have read and understand the *Notice of Health Information* Practices regarding my provider’s participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

**Patient Name (printed)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

|  |  |  |
| --- | --- | --- |
| Date | Initials | Reason |

**Deseret Family Medicine**

7165 East University Drive, Ste. 141 ~ Mesa, Arizona 85207

Phone: (480) 981-3000

Fax: (480) 924-6339

**AUTHORIZATION TO RELEASE RECORDS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**From:** Name and address of facility (doctor or hospital) from which records are to be released:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To:** Name and address of facility (doctor or hospital) to which records are to be released:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of copies of the medical records in the possession or control of the above-named facility, its employees and/or agents. These medical records may include confidential records such as HIV-related information (as defined in A.R.S. Section 36-661) and/or confidential alcohol or drug abuse related information (as defined in 42 CFR Section 2.1 et seq.) and/or confidential mental health diagnostic and/or treatment information.

Records to be released (check one and specify details if appropriate):

 \_\_\_\_\_ All medical records

 \_\_\_\_\_ Medical records of the last two (2) years of treatment only

 \_\_\_\_\_ Medical records only for the following period: From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_

 \_\_\_\_\_ Records only pertaining to (specify injury or illness): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and completed the above or have had the information completed on my behalf freely, voluntarily and without coercion. This authorization is valid for only six (6) months from the date of signature. I may revoke this authorization at any time providing I notify Deseret Family Medicine in writing to that effect. I understand that any release, which was made in compliance with this release prior to my revocation of the authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or guardian signature** **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print name of patient or guardian** **Relationship to patient**

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**Staff use only**: Prepared by: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Sent by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the past 2 weeks, how often have you been bothered by any of the following problems?

(use “ √ “ to indicate your answer)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping to much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself, or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead, or of hurting yourself. | 0 | 1 | 2 | 3 |

|  |
| --- |
| If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?Not at all \_\_\_\_\_ Somewhat difficult \_\_\_\_ Very difficult \_\_\_\_\_ Extremely difficult \_\_\_\_ |

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring care)

 Add columns: \_\_\_\_\_\_\_\_ + \_\_\_\_\_\_\_ + \_\_\_\_\_\_\_\_\_\_ + \_\_\_\_\_\_\_\_\_\_

= Total Score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FALLS SCREENING TEST**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PART ONE: Questionnaire**

1. How many times in the past year did you fall?

0 or 1 fall = score 0

2 or more falls = score 1 Score: \_\_\_\_\_\_\_\_\_

 1a. Have you injured yourself from any falls?

 No injury or no fall = score 0

 Any injury (soft tissue, fracture) = score 1 Score: \_\_\_\_\_\_\_\_\_

1. How often does it happen to you that you think you are about to fall but manage to grab something

and then don’t fall?

Never or rarely have “near falls” = score 0

Occasionally or frequently have “near falls” = score 1 Score: \_\_\_\_\_\_\_\_\_\_

 Total Score:\_\_\_\_\_\_\_\_\_\_\_\_

**In office use below**:

|  |
| --- |
| If Total Score is 2 or greater, administer Multi-Factor Falls Assessment below.Respondent is asked to walk at normal pacing speed over a 10 feet distance.Walking speed is recorded with stopwatch.If walking speed is faster than 10 seconds over 10 ft = Score of 0If walking speed is slower than 10 seconds over 10ft = Score of 1 Score: \_\_\_\_\_\_\_\_Gait style is observed and recordedIf gait is even, straight and feet are raised with each step = Score of 0If gait is uneven, shuffling, on a wide base, or unsteady = Score of 1 Score: \_\_\_\_\_\_\_\_ |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Family History-Has any blood relative had any of the following? Please indicate relationship.**

 No significant family history \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Adopted, doesn’t know family history\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Adverse reaction to anesthesia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Alcoholism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HIV Infection \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Alzheimer’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Anxiety Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Liver Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lung Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Bleeding Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Migraine Headache \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cancer (specify type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seizure Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Diabetes Mellitus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you sexually active:** ❑ No ❑ Yes

**If yes, do you use safe sex methods (such as condoms) to prevent sexually transmitted diseases?** ❑ No ❑ Yes

**Pregnancy:**

Total pregnancy # \_\_\_\_\_\_\_\_ Full Term # \_\_\_\_\_\_\_\_ Premature # \_\_\_\_\_\_\_\_

Terminated # \_\_\_\_\_\_\_\_\_\_\_ Miscarriages # \_\_\_\_\_\_\_\_ Ectopic # \_\_\_\_\_\_\_\_\_\_

 Multiple # \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Living # \_\_\_\_\_\_\_\_

 **Menstrual History:**

Age of 1st period: \_\_\_\_\_\_\_\_\_\_\_\_ Flow: Light Medium Heavy

 Last Period: \_\_\_\_\_\_\_\_\_\_ Method of Birth Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Menopause Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age Menopause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History: Please list all serious illnesses, operations and hospitalizations you have experienced and indicate the date they occurred.**

No significant medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Illness/Operation: Date of Illness/Operation:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Past Medical History-Please check any that apply to you.**

\_\_ Allergies

\_\_ Anemia

\_\_ Anxiety

\_\_ Arthritis

\_\_ Asthma

\_\_ Cancer

\_\_ Chronic pain

\_\_ Depression

\_\_ Diabetes

\_\_ Elevated cholesterol

\_\_ Erectile dysfunction/libido issues

\_\_ Eye disease (glaucoma, cataracts)

\_\_ Gastrointestinal issues

\_\_ Heart disease

\_\_ Hepatitis A, B or C

\_\_ Hypertension

\_\_ Insomnia/sleep disorder

\_\_ Kidney disease

\_\_ Migraines

\_\_ Psychological disorder

\_\_ Seizure disorder

\_\_ Stroke

\_\_ Thyroid disorder

\_\_ Urinary disorder

\_\_ Other problem/s not listed here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you experiencing any of the following?**

\_\_ Appetite changes

\_\_ Breast pain/symptoms/lumps

\_\_ Chest pain/palpitations/shortness of breath \_\_ Confusion or other cognitive changes

 \_\_ Cough or other lung symptoms

 \_\_ Difficulty swallowing

 \_\_ Feeling tired or poorly \_\_ Fever/chills

\_\_ GI symptoms (heartburn, nausea, diarrhea, vomiting)

 \_\_ Headaches

\_\_ Joint or muscle pain/stiffness

 \_\_ Libido (sexual) changes

 \_\_ Mood/psychological changes (depression, anxiety)

 \_\_ Neurological problems (seizures, numbness, weakness, tingling)

 \_\_ Rashes or other skin changes

 \_\_ Sleep changes

 \_\_ Urinary changes

 \_\_ Weakness

\_\_ Weight change

Other symptoms you are experiencing that are not listed here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social History:**

Tobacco: ❑ Never ❑ Yes (\_\_\_packs/day x \_\_\_ yrs) ❑ Quit \_\_\_years ago (\_\_\_packs/day x \_\_\_ yrs)

Alcohol: ❑ Never ❑ Socially ❑ Less than 10 drinks per week ❑ More than 10 drinks per week

Recreational Drug Use: ❑ No ❑ Yes Which type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ❑ Single ❑Engaged ❑ Married ❑ Widowed ❑ Divorced ❑ Partner

Lives: ❑ Alone ❑ With Parents ❑ With Spouse ❑ Assisted Living Facility ❑ Nursing Home

 Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you follow a special diet: ❑ Yes ❑ No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you exercise? ❑ Yes ❑ No How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you use seat belts? \_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have a living will and/or power of attorney: ❑ Yes (please provide a copy to the front desk) ❑ No

 **Medications:** Please list all medicines you are currently taking \_\_\_Patient denies taking any Medications

 CURRENT MEDICATIONS : DOSAGE: FREQUENCY:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please List all ALLERGIES (food, drugs, environment):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Flowsheet: Please indicate the last time you had the following done.**

 Annual Physical Exam: \_\_\_\_\_\_\_\_\_\_ Pap Smear: \_\_\_\_\_\_\_\_\_\_ Mammogram: \_\_\_\_\_\_\_\_\_\_ Colon Cancer Screening: \_\_\_\_\_\_\_\_\_\_ Tetanus: \_\_\_\_\_\_\_\_\_\_ Flu Vaccine: \_\_\_\_\_\_\_\_\_\_ Shingles Vaccine: \_\_\_\_\_\_\_\_\_\_ Pneumonia Vaccine: \_\_\_\_\_\_\_\_\_\_

 COVID Vaccine: \_\_\_\_\_\_\_\_\_\_ Glaucoma Screening: \_\_\_\_\_\_\_\_\_\_ DEXA Scan:\_\_\_\_\_\_\_\_\_\_

**PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**