A. CLARK RUTTINGER, D.O.

FAMILY PRACTICE ✯ GERIATRIC SPECIALIST ✯ BOARD CERTIFIED
FELLOW TRAINED ✯ U.S. MILITARY VETERAN

Patient Information

Name: ______________________________ ______________ ______________
Last First Middle Maiden Name

Prefix: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss **Sex:** ☐ Female ☐ Male ☐ Transgender **DOB:** __/__/____ **Age:**___

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **SSN#:** ______-_____-________

Primary Language: ☐ English ☐ Spanish ☐ Other: ____________

Ethnicity: ☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Refused to Report

Race: ☐ White ☐ Hispanic ☐ Asian ☐ African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Unreported/Refused to Report

Billing Address: ____

City: __________________ **State:** ______________ **Zip:** ______________

Home Phone: __________________ **Cell Phone:** __________________

E-Mail: ______________________ **Sign up for Web-Portal (electronic med. file): Y / N**

SECOND HOME/WINTER VISITORS:

Address: ____

City: __________ **State:** ________ **Zip:** __________ **Home Phone:** __________

Responsible Party/Insurance Information

Primary Insurance: ______________	**Secondary Insurance:** ______________
Policy/Member #: ______________	**Policy/Member #:** ______________
Group #: ______________	**Group #:** ______________
Cardholder Name: ______________	**Cardholder Name:** ______________
DOB: __________ **Co-Pay:** ______	**DOB:** __________ **Co-Pay:** ______
Relationship to Patient: ______________	**Relationship to Patient:** ______________
Employer: ______________	**Employer:** ______________
Employer Phone #: ______________	**Employer Phone #:** ______________

I hereby authorize A. CLARK RUTTINGER, D.O., PLLC. as holder of medical information to release to my insurance Carrier or its intermediaries any information needed for this or for future related claim(s). I authorize A. Clark Ruttinger, D.O. PLLC's contracted third party billing company to submit claims on my behalf for any bills or services provided to me by A. Clark Ruttinger, D.O. PLLC. Co-payments are due at sign in, otherwise a $10 fee will be applied in addition to my co-pay. Balances, deductibles and co-insurances are due immediately upon receipt and/or at sign in, otherwise a 20% late fee will be applied to any balances 30 days past due and will accrue on a monthly basis. I understand I am financially responsible to A. CLARK RUTTINGER, D.O., PLLC for any balance not covered under my insurance plan (e.g., the services were not included in my plan, were not deemed medically necessary, were considered investigational or were not pre-authorized). All payments are made payable to A. Clark Ruttinger, D.O., PLLC. In addition, a $50.00 no show fee will be assessed, unless a 24 hour cancellation notice has been made prior to your scheduled appointment. A $30.00 fee will be assessed for any returned checks. Any balances 90 days past due will be sent to collections. I agree to these terms and affirm that this form is correct and completed to the best of my knowledge.

PATIENT SIGNATURE: ______________________________ **DATE:** ______________
(Guardian or Parent Signature if Minor)

If signed by patient representative, state relationship to patient: ______________________

A. CLARK RUTTINGER, D.O.

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ **D.O.B** ____________

I request that all communications to me regarding my health care and related medical issues by Dr. A. Clark Ruttinger, D.O., P.L.L.C and/or staff be handled in the following manner:

May we contact you at home: #(____)________________	☐ Yes	☐ No
May we leave you a message at home:	☐ Yes	☐ No
May we contact you on your cell phone:#(____)__________	☐ Yes	☐ No
May we leave a message on your cell phone:	☐ Yes	☐ No
May we contact you by written communication:	☐ Yes	☐ No
May we contact you at work:#(_____)______________	☐ Yes	☐ No
May we contact you via e-mail: __________________	☐ Yes	☐ No

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors and others who may be taking care of you your PHI unless you say it is **OK**. By signing this paper, you give us your **OK.** We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list.

1.______________________________
Relationship: ______________________
Phone#: __________________________
Main Emergency Contact: ☐

2.______________________________
Relationship: ______________________
Phone#: __________________________

I give Dr. A. Clark Ruttinger, D.O., P.L.L.C consent to use or disclose my protected health information to carry out my treatment, to obtain payment and information from insurance companies, for health care operations like quality reviews, as well as sending Electronic Records to other physicians and/or other entities related to my treatment.

I understand that Dr. A. Clark Ruttinger, D.O., P.L.L.C has the right to change their privacy practices and that I may obtain any reviewed notices at Dr. A. Clark Ruttinger, D.O., P.L.L.C.

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

Signature:______________________________ **Date:** ____________

If signed by patient representative, state relationship to patient: ____________________

This Authorization to Release Protected Health Information is designed to meet the requirements of a valid authorization, as specified by the Standards for Privacy of Individually Identifiable Health Information (the HIPAA Privacy Rule*), 45 CFR., Parts 160 and 164. The prescribed content of a valid authorization is found at 45 CFR 164.508.*

INSURANCE CO.______________________ CO-PAY______________ D.O.B________________

PATIENT:____ PHONE#________________

ADDRESS:____ SS#:________________

PHARMACY:____ PHONE#________________

EMERGENCY CONTACT____

ADDRESS:____ PHONE#________________

****DO NOT WRITE BELOW THIS LINE. FOR DOCTOR'S USE ONLY****

ADVANCED DIRECTIVES: YES________ NO________ REVIEWED____________ LIVING WILL______ HEALTH PROXY______ DNR______ ORGAN DONOR______	ALLERGIES:

DATE	ACUTE/CHRONIC PROBLEMS	SURGICAL PROCEDURES	DATE	DATE	DATE

DATE	MEDICATIONS	DOSE	ROUTE	FREQUENCY	DATE

MEDICAL HISTORY

PLEASE WRITE IN ANY PAST MEDICAL HISTORY SUCH AS DIABETIES, CANCER HEART DISEASE, HIGH BLOOD PRESSURE, LIVER DISEASE, ETC.	PREGNANCY HISTORY YEAR	SEX	COMPLICATIONS

LAST PAP:_____________MAMMOGRAM_____________A-DEXA_____________PROSTATE SCREENING_____________

SURGICAL HISTORY- NONE______ (TONSILLECTOMY,APPENDECTOMY,HYSTERECTOMY,HERNIA,ETC.)

ANY KNOWN DRUG ALLERGIES?? YES______ NO______ (IF YES PLEASE WRITE THE MEDICATION AND EXPLAIN THE TYPE OF REACTION. LIKE HIVES,WHEEZING,UPSET STOMACH, SWELLING, ETC.

ARE YOU ON ANY CURRENT PRESCRIPTION MEDICATIONS?? YES______ NO______

NAME OF MEDICATION	DOSAGE(MG/MCG)	#TIMES PER DAY	QUANTITY

ARE YOU ON ANY OVER THE COUNTER MEDICATIONS? YES_____ NO_____ (TYLENOL,ASPIRIN,IBUPROFEN,,VITAMINS, HERBALS, ETC.)

FAMILY HISTORY

FATHER: LIVING AGE______ DECEASED, AGE OF DEATH______ CAUSE OF DEATH________________________

MOTHER:LIVING AGE______ DECEASED, AGE OF DEATH______ CAUSE OF DEATH________________________

LIST OTHER ILLNESSES IN YOUR FAMILY(EIABETIES,HEART/LUNG DISEASE, COLON/BREAST/PROSTATE CANCER ETC.)

FAMILY MEMBER	ILLNESS	FAMILY MEMBER	ILLNESS
FAMILY MEMBER	ILLNESS	FAMILY MEMBER	ILLNESS

DO YOU SMOKE? YES_______ NO_______ IF YES HOW MANY PER DAY_______ PACKS/WEEK______ YEARS SMOKING______

DO YOU DRINK ALCOHOL? YES NO IF YES HOW MANY PER DAY HOW OFTEN?

LAST EYE EXAM

LAST DENTAL EXAM

LAST PHYSICAL

PATIENT HISTORY FORM

NOTE: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION.

NAME:____________________________________ **D.O.B**________________ **DATE**_______________

REVIEW OF SYMPTOMS

DO YOU OR HAVE YOU EVER HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYMPTOMS?
CIRCLE YES OR NO

CONSTITUTIONAL SYMPTOMS			<COMMENTS>	GENITOURINARY		
WEIGHT CHANGE	Y	N		CHANGE IN STREAM	Y	N
CHILLS	Y	N		NOCTURIA	Y	N
SLEEP DISORDERS	Y	N		URINARY FREQUENCY	Y	N
OTHER	Y	N				
EYES			**COMMENTS**	**MUSCULOSKETAL**		
DOUBLE VISION	Y	N		BONE PAIN	Y	N
GLAUCOMA	Y	N		MUSCLE PAIN	Y	N
CATARACTS	Y	N		JOINT PAIN	Y	N
OTHER	Y	N		OTHER	Y	N
EARS/NOSE/THROAT/MOUTH			**COMMENTS**	**INTEGUMENTARY (SKIN)**		
HEARING CHANGES	Y	N		RASH	Y	N
SORE THROAT	Y	N		LUMPS/BUMPS	Y	N
SINUS PROBLEMS	Y	N		MOLES, SKIN TAGS	Y	N
OTHER	Y	N		OTHER	Y	N
CARDIOVASCULAR			**COMMENTS**	**NEUROLOGICAL**		
CHEST PAIN	Y	N		TREMORS	Y	N
IRREGULAR HEART BEAT	Y	N		DIZZY SPELLS	Y	N
SWELLING IN ANKLES	Y	N		NUMBNESS	Y	N
OTHER	Y	N		TINGLING	Y	N
PSYCHOLOGICAL			**COMMENTS**	**RESPITORY**		
ARE YOU HAPPY?	Y	N		WHEEZING	Y	N
ARE YOU DEPRESSED?	Y	N		FREQUENT COUGH	Y	N
ARE YOU ANXIOUS?	Y	N		SHORTNESS OF BREATH	Y	N
DO YOU FEEL SAFE AT HOME??	Y	N		OTHER	Y	N
ENDOCRINE			**<COMMENTS>**	**GASTROINTESTINAL**		
EXCESSIVE THIRST	Y	N		ABDOMINAL PAIN	Y	N
TOO HOT/COLD	Y	N		NAUSEA/VOMITING	Y	N
TIRED/SLUGGISH	Y	N		HEART BURN	Y	N
OTHER	Y	N		OTHER	Y	N
HEMATOLOGIC			**<COMMENTS>**	**SEXUAL HISTORY**		
SWOLLEN GLANDS	Y	N		CHANGE IN SEX DRIVE	Y	N
BLOOD CLOTTING	Y	N		SEXUAL PERFORMANCE	Y	N
BRUISING	Y	N		SATISFACTORY?	Y	N
OTHER	Y	N		OTHER(SEXUAL TRAUMA)	Y	N
ALLERGIC/IMMUNOLOGIC			**<COMMENTS>**	**LAST EYE& DENTAL EXAM**		
HAY FEVER	Y	N		DATE-LAST EYE EXAM:____________		
DRUG ALLERGIES	Y	N				
FOOD	Y	N		DATE-LAST DENTAL EXAM:____________		
OTHER	Y	N				

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13951 W. Grand Ave.
Suite 203
Surprise, AZ 85374
O: (623) 544-4600
F: (623) 544-4725

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME: ________________________________ DATE OF BIRTH:______________

ADDRESS:____

SOCIAL SECURITY:______________________

I AUTHORIZE THE FOLLOWING PROVIDER(S) OR ENTITIES TO RELEASE MY HEALTH INFORMATION:

NAME: _________________________PHONE:______________FAX:________________

ADDRESS: ____

NAME: _________________________PHONE:______________FAX:________________

ADDRESS: ____

NAME: _________________________PHONE:______________FAX:________________

ADDRESS: ____

HEALTH INFORMATION TO BE DISCLOSED: DATES OF SERVICE(S):____________TO ____________

☐ ENTIRE MEDICAL RECORD

OR

☐ HOSPITAL RECORDS INCLUDING EMERGENCY RECORDS
☐ LAB RESULT
☐ RADIOLOGY REPORT(S)
☐ PHYSICAL/OCCUPATIONAL/SPEECH THERAPY REPORT(S)
☐ OTHER:_____________________________
☐ CONSULTATION REPORTS/NOTES
☐ PATHOLOGY REPORT(S)
☐ OPERATIVE/SURGERY REPORT(S)
☐ SLEEP STUDIES
☐ EKG'S

I understand that this information may include, but is not limited to, information related to Acquired Immune Deficiency/HIV, psychiatric or psychological treatment, and treatment for drug and/or alcohol use.
I understand I may revoke this authorization at any time by sending a written notice to each provider marked above. Revocation will not affect any uses or disclosures provider(s) or any entities may have made before receiving revocation. I understand information used or disclosed in accordance with this authorization may no longer be protected by federal law and could be re-disclosed by the receiving party. I understand I may refuse to sign this authorization and that the provider(s) will not condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization. I understand there may be a reasonable copying fee, as permitted by applicable law.

PATIENT SIGNATURE:______________________________ **DATE:**______________

If signed by patient's legal representative, please complete the following:

PRINTED NAME:___________________________RELATIONSHIP TO PATIENT:______________

PLEASE FAX RECORDS.