Internal Medicine of Yuma

Medical History form

Name: _____ **Date**: _____

Past Medical History:

___High Blood Pressure
___High Cholesterol
___History of Heart Attack or Heart Disease
___Stroke or TIA (mini-stoke)
___DVT/Pulmonary Embolism/Blood Clots
___Diabetes: Type 1 ___ Type 2 ___
___Atrial Fibrillation
___Asthma/COPD
___ Acid Reflux/Ulcers
___ Hypothyroidism/Thyroid Disease
___Arthritis/Autoimmune Disease/Lupus/Sjogren
___Osteoporosis
___Seizure Disorder
___Cancer (type)? _____
___Sexually Transmitted Disease, type? _____
___Depression
___Sleep Apnea
___Hepatitis/Cirrhosis of the Liver
___Kidney Stone
Other_____

Past Surgical History:

___Tonsillectomy
___Appendectomy
___Biopsy (site?): _____
___Pacemaker Implant
___Heart Bypass: How many Vessels? _____
___Back or Neck Surgery
___Joint Replacement
___Vasectomy
___Hysterectomy
___Tubal Ligation
___C-Section
___Heart Valve Surgery
___Breast Augmentation
___Gall Bladder Removal
___Bowel Resection
___Splenectomy
___Colon Polyp Removal
___Hemorrhoidectomy
Other _____

Medication Allergies: None_____

Yes, please list which ones and reaction:

_____
_____

Medications :(List name and dose): None_____

_____ _____
_____ _____
_____ _____
_____ _____

When was the last time you went to the dentist?
(Month/Year) _____
Last Colonoscopy? _____
Last Mammogram? _____
Last DEXA Bone Scan? _____

If you are female:

Last PAP? _____
How Many pregnancies have you had? _____
How many live births? _____

Social History:

How long in Arizona? _____.
Occupation _____.
Do you smoke? ___Never ___Used to, but quit _____ (list year) after how many years _____.
___Yes, currently smoke. (How long)_____.
Do you drink alcohol? ___No ____Yes: how many drinks per week? _____.
Do you use drugs recreationally? ___No ___Yes
If yes, what type and how often? _____.
Do you exercise? ___No ___ Yes. If yes, how often? _____.

Family History:

Anyone in the family with the following:

___Diabetes, who? _____
___Colon Cancer, who? _____
___Breast Cancer, who? _____
___Prostate Cancer, who? _____

___Heart Attack (who and age.) _____
_____
Other_____
_____

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Internal Medicine of Yuma

***Referred By*:** _____ Date: _____

Name: _____ SSN#: _____-_____-_____

Address: _____ City _____ _State_____ Zip Code_____

E-mail Address: _____

Telephone #s: Home: _____ Cell/Mobile: _____ Work: _____

Gender: __M __F Age: _____ Birth date_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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Your cooperation with the following information is appreciated for national research purpose:

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian

☐ Native Hawaiian or other Pacific Islander ☐ Other Race _____ or ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline or Other_____

Primary Language: ☐ English ☐ Spanish ☐ German ☐ Greek ☐ Arabic ☐ Chinese Other _____

Are you employed? ☐ No ☐ Yes, if so then: ☐ Full-time ☐ Part-time ☐ Retired

Employer _____ Employer's address_____

Insurance Information:

Primary Insurance _____ Policy Holder Name_____

Patient relationship to insured_____

SSN of Account Holder _____ Date of Birth _____

Policy # _____ Group # _____

Secondary Insurance (If applicable only); _____

*If you are a minor, who is the responsible party _____

Pharmacy Information:

Local Pharmacy _____ Phone _____

Address (or cross streets) _____

Mail Order Pharmacy _____ Phone _____ Fax _____

THANK YOU FOR ALLOWING US TO BE A PART OF YOUR HEALTHCARE TEAM!!

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Internal Medicine of Yuma

EMERGENCY CONTACTS

Name: _____ Date: _____

Please list ALL the telephone numbers that **YOU** may be reached at for results of labs / studies:

Telephone numbers: Home _____

Cell: _____

Work: _____

I,_____GIVE PERMISSION to Internal Medicine of Yuma's office to release information from my record to the list of people listed below. Please be aware that information might include lab/imaging results, messages, and/or billing inquiries.

If you **DO ALLOW us to release such medical information please place initials under their name.
Otherwise we will contact the individual for emergency return calls ONLY.

Name: _____
Relationship: _____
Phone#:_____
**initial_____

Name: _____
Relationship_____
Phone#: _____
**initial_____

Name: _____
Relationship: _____
Phone#:_____
**initial_____

Name: _____
Relationship_____
Phone#: _____
**initial_____

Name: _____
Relationship: _____
Phone#:_____
**initial_____

Name: _____
Relationship_____
Phone#: _____
**initial_____

(Please update this form as needed with our office as changes with numbers/contacts occur)

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Internal Medicine of Yuma

CANCELLATIONS/MISSED APPOINTMENTS

Missed appointments represent a cost to us, to you and other patients who could have been seen in the time set aside for you. Cancellations are requested at least 24 hours prior to your appointment. We reserve the right to charge for missed or late cancelled appointments: $25.00 for 15 minute visits (follow up visits) and $75.00 for 30 minute appointments (Physicals, procedures, post hospital and new patient visits)

I have read and understand the Financial Policy. I agree to assign insurance benefits to **Internal Medicine of Yuma** whenever necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charge by the collection agency for cost of collections.

_____ _____

Signature of the insured/authorized representative Date

Co-payment

*Co-pays are to be collected at the time of the office appointment.

I understand that payment is due at the time of service unless arrangements have been made and that I will be given an insurance form in order to file for reimbursement. **If for any reason I am unable to pay the co-pay due at the time of service a $10.00 fee will be applied to my bill.** I hereby assign my insurance benefits to be paid directly to Internal Medicine of Yuma LLC. I understand that I am financially responsible for non-covered services. I also authorize Internal Medicine of Yuma LLC to release any information required to process the claim. I agree that this office may release records pertaining to my treatment to my insurance company of other third parties responsible for the payment of my medical charges, including review activities related to my physician's participation with my plan.

_____ _____

Patient/Parent Signature Date

Internal Medicine of Yuma

HEALTH CARE POWER OF ATTORNEY & LIVING WILL

Combined Form

I, _____ as principal designate____ _____ as my agent for all matters relating to my health care including, without limitation, full power to give or to refuse consent to all medical, surgical, hospital, psychiatric and related health care. This power of attorney is effective whenever I am unable to make or to communicate health care decisions. All of my agent's actions under this power have the same effects on my heirs and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or to continue to server, I hereby appoint _____ as my agent.

In acting under this power, I want my agent to give great weight to following statements: I am in favor of trail treatment. That means I want all necessary medical care to treat my condition until, and only until, my doctor and my agents reasonably decide that I am an irreversible coma, or in a persistent vegetative state, or a locked-in state, or cannot be expected to return to a fully conscious state. If following the guidelines stated above, my doctors and my agents decide that further medical care is inappropriate.

1. I want only comfort care and I don't and I do not want to undergo artificial administration of foods or fluids.
2. I do not want to be resuscitated in case I stop breathing or my heart stop beating.

If my doctors and my agents reasonably decide that I have a terminal illness, I want all decision concerning my medical and surgical care to be made in light of the expected length of life which would results from such care and the predictable effects on me of undergoing treatment. If I cannot be expected to have a significant period of conscious life even after medical or surgical care, then I want comfort care only. (Example: I do not want any surgery or other care designed to prolong my life. I do not want artificially administered food or fluids and I do not want to be resuscitated.)

This combined health care directive is made under 836-3221 and 836-3261, Arizona Revised Statutes. It continues in effect for all who may relay on it, expects those to whom I have given notice of its revocation.

_____ _____

Date Signature of mark of person making living will or granted Health care power of Attorney

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Internal Medicine of Yuma

Physician Disclosure of Financial Interest

As your physician, it is my duty to do everything I can to provide you with the highest quality of care. While I will provide services to you through my practice, it is possible that you will also require treatment, services or medical products from third parties. It is possible that I will recommend you obtain such treatment services or products from specific providers or entities. Any such recommendation will be based entirely and exclusively on what I believe to be in your best interest as my patient.

The purpose of this document is to inform you that as a member of the business community I have financial interests and other relationships with other entities that work in the field of healthcare. In an effort to be as transparent as possible, I want to disclose to you all such relationships (see below).

Please be aware that you have the right to be treated by and at any healthcare entity of your choice. The physician-patient relationship that exists between us will not be affected, nor will you be treated differently, if you choose to obtain any such items or services from another healthcare provider or entity.

Facilities/Entities in which Dr. Aguiar-Olsen has a Financial Interest or other Relationship*

Entity Name	Type of Relationship
Internal Medicine of Yuma	Ownership
Yuma Regional Medical Center *	Medical Staff
Associated Rehabilitation Medicine Doctors	Ownership

*A Medical Staff or Faculty relationship does not imply any conflict of interest, as Dr. Aguiar-Olsen does not stand to benefit financially in such a relationship.

By signing below, you, or your legal representative, acknowledge that

(i) this disclosure has been made in advance of the date of the service;

(ii) you recognize the Dr. Aguiar-Olsen has a financial relationship or other affiliation with the listed
entities/facilities;

(iii) you are aware of your freedom to choose a facility or entity through which to receive the referred item or service; and

(iv) Dr. Aguiar-Olsen has not required you to receive any item or service through a facility/entity in which she has a financial interest or other affiliation.

_____
Date

_____ _____
Print Name of Patient D.O.B Signature of Patient

_____
Signature of Parent/Guardian (if applicable)

_____
Print Name of Parent/Guardian (if applicable)

Internal Medicine of Yuma

Acknowledgement of receipt of privacy practice notice

By signing this acknowledgement you are not agreeing or disagreeing, only stating that it was given to you for review and record purpose for the future references.

_____

Print name here

Have received and/or been given a copy of the privacy practice for Internal Medicine of Yuma

_____

Signature

_____

Date

Welcome to Internal Medicine of Yuma!

It is our goal to provide patients with the best medical care possible. Internal Medicine of Yuma has a policy on tests ordered by your provider and the results of any test ordered. Results from either office procedures (biopsies, cultures, spirometry etc..) or imaging studies (MRI, CT, ultrasounds etc..) are not given over the phone. In order to obtain results, an office visit will be scheduled to review the clinical findings of the test ordered and to make further recommendations for your care.

Thank you.

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