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
___ Cancer (type)? _____
___ Sexually Transmitted Disease, type? _____
___ Depression
___ Sleep Apnea
___ Hepatitis/Cirrhosis of the Liver
___ Kidney Stone
___History of COVID
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_____

_____ _____
_____ _____
_____ _____
_____ _____

- Last eye exam? (month/year) _____
- Last dental exam? (month/year) _____
- Last colonoscopy? _____
- Last DEXA bone scan? _____
- COVID Vaccines? Yes ☐ No ☐

If you are female:

Last mammogram? _____
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? _____
Sexual orientation? ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Other: _____

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_____
_____

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

---

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!!

2285 S. Elks Lane, Yuma AZ, 85364 Ph| 928-329-4761 Fax| 928-329-6742

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.

2285 S. Elks lane, Yuma AZ, 85364 Ph| 928-329-4761 Fax| 928-329-6742

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: $50.00 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

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)

2285 S. Elks Lane, Yuma AZ, 85364 Phone| 928-329-4761 Fax| 928-329-6742

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