HealthFirst Primary Care, P.L.C.
2153 E. Baseline Rd #101
Tempe, AZ 85283

Please check which doctor you see
- ❑ Dr. Parvathala
- ❑ Dr. Bhatnagar

****Please Print**
First name: _____ Last name: _____

Date of birth: _____ Social security#:_____ Male/Female Marital status_____

Race: _____ Ethnicity: _____ Preferred Language: _____

(Please circle preferred number to reach you)

Message number (for appointment reminders, lab results etc.)_____

Home phone: _____Work phone: _____ Cell phone: _____

Address: _____Apt#_____City:_____State_____zip:_____

Email address: _____

Pharmacy Name, Cross streets, and Phone:_____

Employer name and address: _____

Emergency contact name and phone number: _____
Do you authorize this office to discuss your care or treatment with any other person besides another physician or insurance company? Yes_____ no_____ if yes please list the first and last name of person or persons: _____

****Insurance information:**
Primary insurance name: _____ **Id#**_____

Group #_____**insured full name:** _____ **DOB**_____

Insured's SS#_____ **Relationship to patient**_____

Secondary insurance name_____ **Id#**_____
****** I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with regular rates and payment terms. If my account is referred for collection, I agree to pay reasonable collection expenses including attorney's fees. In the event that I am entitled to health insurance or other benefits available to cover the costs of treatment by this office, I hereby assign those benefits to this office to apply to my bill. This office may release all records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges. I also agree to pay any additional charges for any and all medical forms, such as FMLA, Disability, insurance benefits, etc.....

_____ _____ _____
Signature of patient or guardian printed name of patient Today's Date

CONFIDENTIAL MEDICAL RECORD, AUTHORIZED PERSONEL ONLY

Health First Primary Care, PLLC

Patient Name:_____ **Date:**_____

Occupation:_____ Highest level of education:_____

1. Do you Smoke cigaretes ,cigars,pipe? ❑ Yes ❑ No How many per day?_____

2. Have you smoked in the past? ❑ Yes ❑ No How many Years?_____

3. Do you drink alcohol? ❑ Yes ❑ No How much?_____

4. Do you drink caffeine? ❑ Yes ❑ No How much?_____

5. Do you use illegal drugs? ❑Yes ❑ No List type_____

6. Do you exercise? ❑ Yes ❑ No What type?_____ How often_____

7. How tall are you?_____ How much do weigh?_____ 5 years ago_____ 10 years ago_____

8. Do you have risk factors for AIDS or HIV? ❑ Yes ❑ No if yes, please list risk_____

9. Do you wear a seat belt? ❑ Yes ❑ No ❑ Sometimes ❑ Always

Please list year when you last had any of these procedures.

____Complete physical	____Cholesterol screen	____Colonoscopy
____Pap Smear	____Mammogram	____Prostate check
____Chest X-ray	____EKG	____Stress test
____Tetanus	____Flu shot	____Pneumonia
____HPV	____MMR	____Shingles vaccine

Gynecological History (Females Only)

____Age of first menstrual period _____Age at menopause _____ Type of birth control

____Number of pregnancies _____Number of Children _____Number of abortions

Family History (blood Relatives)

List members who have had the following medical problems:

Asthma:_____ High blood pressure:_____

Diabetes: _____ Heart Attack:_____

High cholesterol:_____ Kidney Disease: _____

Cancer:_____ Thyroid Disease:_____

Other:_____

Do you have a living will or other health care directives?_____ if no, would you like information, please ask the physician.

CONFIDENTIAL MEDICAL RECORD AUTHORIZED PERSONAL ONLY

Health First Primary Care, PLLC
Adult questionnaire

Patient Name: _____ **Date:** _____

This questionnaire will help your physician obtain a large amount of information while still being able to focus on your most important problems. Please answer all questions as best as you can. If you are uncertain about a question your physician will help you. All answers will be kept confidential.

Sex: _____ Age: _____ Date of Birth: _____

Current and past medical problems (for example: anemia, asthma, arthritis, bleeding problems,colitis,cancer,depression,diabetes,epilepsy,glaucoma,heart attack, heart murmur, hepatitis, HIV, high blood, pressure, high cholesterol, kidney problems, migraines, pneumonia, thyroid, valley fever.)

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Operation (for example: appendix, breast implant, cesarean section, gallbladder, heart bypass or valve operation, hernia, hysterectomy, tonsillectomy, vasectomy.)

1._____ 4._____
2._____ 5._____
3._____ 6._____

Medications (list all medications you currently take including dosages and frequency take.)

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Over the counter medications (example Advil, Tylenol etc.)

1._____ 3._____
2._____ 4._____

Allergies to medications (list all medications that you cannot take or have a reaction to.)

Medication	reaction	medication	reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CONFIDENTIAL MEDICAL RECORD, AUTHORIZED PERSONNEL ONLY

HealthFirst Primary Care

Patient consent for use and disclosure of protected health information

With my consent, HealthFirst Primary Care may use and disclose protected health information(PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to HealthFirst Primary Care's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have a right to review the Notice of Privacy Practices prior to signing this consent.

HealthFirst Primary Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HealthFirst Primary Care Privacy officer at 2153 E Baseline Rd. #101 Tempe, AZ 85283

With my consent, HealthFirst Primary Care may call my home, or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, HealthFirst Primary Care may mail to my home or other designated locations with any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that HealthFirst Primary Care restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to HealthFirst Primary Care's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, HealthFirst Primary Care may decline to provide treatment to me.

_____ _____

Signature of patient or legal guardian Date

_____

Print name of patient or legal guardian