Adult patient history form

Full name_____ MRN_____

Date of birth_____ Birth Gender_____ Gender identity_____

Preferred name_____ Preferred pronoun_____

Medications (If you need more space please use the back of this form).

Name of medication	Dose	Times per day.	Date/year started	Current prescriber

Personal medical history.

Date	Medical problem		Date	Medical problem		Date	Medical problem
	Alcohol/Drug addiction			Cancer (specify type below)			Osteoporosis
	Arthritis						Seizures
	Asthma/Emphysema			Depression			STD or STI
	Bladder/Kidney infection			Heart issues			Stroke
	Bleeding/clotting disorder			High/low blood pressure			Thyroid issues
	Bowel/Digestive issues			High cholesterol			Other (specify below)
	Diabetes			Kidney stones			

Past Hospital/Surgical history

Date	Surgery or reason for hospital stay		Date	Surgery or reason for hospital stay

Family history

Has anyone from your family had one of the following? Please indicate number or disease on the lines below.

1.[Alcohol/Drug addiction] 2.[Alzheimer's] 3.[Breathing issues] 4.[High Cholesterol] 5.[Stroke]

6.[Cancer (please write type)] 7.[Depression] 8.[Diabetes] 9.[Genetic disorders] 10.[Digestive issues]

11.[Bladder/Kidney issues] 12.[Heart attack] 13.[High blood pressure] 14.[Nerve disorders] 15.[Thyroid disorder]

Mother_____

Father_____

Sibling (Indicate gender)_____

Grandfather (Father or Mother side?)_____

Grandmother (Fathers or Mother Side?)_____

Children_____

General health questions (Please circle any applicable)

Substance and Sexuality

1.Tobacco use

- Never
- Former: Packs per day____ For how long_____ Date your quit_____ Type of tobacco_____
- Current use: Packs per day_____ For how long_____ Type of tobacco_____
- Second hand smoke exposure

2. Alcohol use

- None
- Yes. Drinks per week (average)_____

3. Drug use

- None
- Yes. Frequency of use_____ Type of drug_____

4. Are you sexually active?

- Yes. Type of birth control_____
- No.

5. Sexual preference _____

Activities and others

- History of a blood transfusion: *Yes *No
- Caffeine use (coffee, tea, soda): *Yes *No If yes, how frequently_____
- Diet: *Good *Fair *Bad *Vegan *Vegetarian *Keto *Paleo
- Exercise: Type_____ Frequency_____
- Self-exam: * Breasts(Female) *Testes(Male) *Skin

Home situation

- Who do you live with? _____
- Do you feel safe at home? *yes * No

Education and occupation

- Occupation_____ Employer_____
- Highest level of school completed_____
- What is your degree_____

Obstetrics (Female only)

- How many times have you been pregnant? _____ Age at first pregnancy_____ Number of living children_____
- Number of full term pregnancy's____ Number of premature births_____ Number of miscarriages_____
  Number of abortions_____ Number of Ectopic pregnancy's_____ Number of multiple births_____

Immunization history

Vaccine name	Date of last dose		Vaccine name	Date of last dose
Tetanus vaccine			MMR	
Flu vaccine			*Chicken pox	
Pneumonia vaccine			Shingles vaccine	

Did you have Chicken Pox? *Yes *No

Do you have any medication allergies?

*No *Yes (list medication) _____

Health screenings (please write dates and result)

Last Pap_____ Last mammogram_____

Last colonoscopy_____ Last blood panel_____

Last bone density test_____

Arizona Community Physicians

Patient Information

FIRST NAME | MIDDLE | LAST NAME | ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | EMERGENCY PHONE# | EMERGENCY CONTACT NAME / RELATION

/ /
DOB | SEX | MARITAL STATUS | EMAIL | RACE (optional)

PRIMARY CARE PHYSICIAN | STUDENT? FT OR PT | PREVIOUS NAME

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE

Billing Information
(If different than patient)

FIRST NAME | MI | LAST NAME | ADDRESS | CITY | STATE/ZIP | PHONE

Primary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

GROUP ID# | POLICY ID# | SELF SPOUSE CHILD OTHER
RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

/ /
SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

Secondary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

GROUP ID# | POLICY ID# | SELF SPOUSE CHILD OTHER
RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

/ /
SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

By signing this form, I am consenting to Arizona Community Physicians' use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Arizona Community Physicians' Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Arizona Community Physicians for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.

PERSON GIVING CONSENT | RELATIONSHIP IF NOT THE PATIENT | DATE

Patient name:_____ **MRN:**_____

The government mandates that all healthcare is provided fairly, without regard to race or ethnicity. These registration questions are to insure we are meeting these guidelines. This information will be kept confidently.

Race

American Indian/Alaskan Native
Asian Indian
Black, African American
Caucasian (White)
Chinese
Filipino
Guamanian/Chamorro
Japanese
Korean
Native Hawaiian
Other Asian
Other Pacific Islander
Samoan
Vietnamese
Unknown
Decline

Ethnicity

Cuban
Mexican/ Mexican American
Other Hispanic/Lantino/a or Spanish Origin
Puerto Rican
Non Hispanic/Latino/a or Spanish Origin
Unknown
Decline

Marital Status:

Married
Divorced
Legally Separated
Single
Widowed
Significant Other
Other

Preferred Language

English
Spanish
Arabic
Chinese (all types)
French
German
Greek
Italian
Japanese
Korean
Navajo
Polish
Russian
Tagalog
Ukrainian
Vietnamese
Other(Specify)_____
Interpreter Services Needed: YES NO

Veteran Status

No, Currently Serving branch_____
No, Never Serviced
Yes
Yes Combat veteran
If YES, Branch of Service_____

Emergency Contact

Name_____
Phone _____
Relationship:_____

Patient Email:_____

Do you want to sign up for MY CHART -online access to your Medical Records? YES NO

Patient(or Guardian) Signature:_____ Date:_____

ARIZONA COMMUNITY PHYSICIANS
REGISTRATION ADDENDUM

Patient Name:_____

Account Number:_____

Due to a governmental mandate that all healthcare is provided fairly, without regard to race or ethnicity, we have added new fields to our patient registration form. This information will be kept confidential.

Race (check one)

Black, African American (01)
Asian (02)
Caucasian (White) (03)
American Indian, Alaskan Native (08)
Native Hawaiian/Other Pacific Islander (09)
Unknown (98)
Declined (99)

Ethnicity (check one)

Hispanic
Non- Hispanic
Unknown

E-mail

_____

_____
Patient Signature

_____
Parent/Guardian Signature

Preferred Language (check one)

English (EN)
Spanish (ES)
Arabic (AR)
Chinese (all types) (ZH)
French (FR)
German (DE)
Greek (EL)
Italian (IT)
Japanese (JA)
Korean (KO)
Navajo (NV)
Polish (PL)
Russian (RU)
Tagalog' (TL)
Ukrainian (UK)
Vietnamese (VI)
Other_____
(Specify)

_____
Patient declined filing out the form. Staff signature required

Arizona Community Physicians, P.C.
Adult
Release of Information Form

Account #_____

Patient Name _____ DOB_____ Date_____

Guardian Name _____ Contact Number: _____

The confidentiality of our patient's medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information and test results.

Name/relationship _____ Contact Number_____

Name/relationship _____ Contact Number_____

Name/relationship _____ Contact Number_____

By providing the below phone #'(s) you are giving permission, to leave appointment information or detailed information regarding, lab results, radiological results or any other imperative information on the phone # indicated below

Cell/Mobile voice mail _____ (Phone #)

Home voice mail_____ (Phone #)

DO NOT RELEASE Information to the following people: _____

I acknowledge that either I or the physician may, at any time, withdraw the option of releasing test information per the terms of this agreement, upon providing written notice. Any questions I had have been answered.

Name Patient/Guardian: _____ Signature _____Date_____

The information provided on this form will stay in effect until updated by the patient

Arizona Community Physicians P.C.
Authorization to Release Medical Information

PATIENT INFORMATION

Patient Name_____ Former Name_____ Account #_____

Daytime Telephone_____ Birth Date_____

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____

Street Address _____

City/State/Zip_____

Phone # _____Fax#_____

To release the following medical information contained in patient's medical record.

INFORMATION TO BE RELEASED TO

Name of Physician/Organization _____

Street Address _____

City/State/Zip_____

Phone # _____Fax#_____

PURPOSE FOR THIS REQUEST **(Please check a box)**

☐At request of Patient ☐Other (specify) _____

Requested format (if no selection is made, records will be delivered in paper): ☐Paper* ☐Disc (PDF format)*

***The standard charge for copying medical records is $6.50 for a disc and $0.07 per page for paper. However, there may be additional charges for shipping and handling.**

TYPE OF INFORMATION TO BE RELEASED **(No information will be released unless a box is checked)**

General Release DATES OF TREATMENT

☐ Medical Records/**Excluding Protected Records**

(This will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated) From_____ To_____

☐ Other Records (specify) _____ From_____ To_____

Information Protected by State/Federal Law

☐ All of my records including: From_____ To_____

AIDS/HIV and Other Communicable Disease Information,

Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

Signature of Patient or Personal Representative who may request Release of Medical Information: I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____ _____

Signature of Patient OR Legal Representative **Date** **Please Print Name of Signing Party**

Sonora Family Practice

No-Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide at least 24-hour notice. This will allow for another patient who is waiting for an appointment to be scheduled in that appointment time.

Office appointments which are canceled with less than 24-hour notification will be subject to a $25.00 cancellation fee for primary care appointments and $35.00 for specialists.

All appointments without a call to cancel prior to the appointment time, will be considered no-show appointment. If you arrive 10 or more minutes late for your appointment, it will be considered a no-show appointment.

No-show appointments are subject to a $25.00 cancellation fee for primary care appointments and $35.00 for specialist appointments.

If you have three or more canceled, no-showed or a combination of canceled or no-show in a 12-month period you may be dismissed from the practice and denied any future appointments with any of our physicians.

Cancellation and no-show fees are the sole responsibility of the patient (they are NOT covered by your insurance) and must be paid in full prior to your next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these instances may be waived but only with managerial approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. We are happy to discuss any questions you may have about our cancellation, and no-show policy and fees.

Thank You