NORTH PHOENIX INFECTIOUS DISEASE

Patient Information Sheet

Date_____

NAME: FIRST _____LAST_____ MIDDLE INITIAL _____

ADDRESS_____

CITY _____ STATE _____ ZIP_____

HOME PHONE _____ CELL_____

WORK PHONE _____ EXT. _____

DATE OF BIRTH _____ SEX _____ SOCIAL SECURITY# _____

MARITAL STATUS: _____

EMAIL (required for patient portal access) _____

PRIMARY CARE DOCTOR _____

PRIMARY CARE PHONE_____

REFERRING PHYSICIAN _____

PREFERRED LANGUAGE_____ RACE_____ ETHNICITY_____

EMPLOYER NAME _____ ADDRESS _____

EMPLOYMENT STATUS: (Full Time/Part Time/Non-employed)

STUDENT STATUS: _____ (Full Time/Part Time)

RESPONSIBLE PARTY: _____ RELATIONSHIP _____

NAME _____ ADDRESS _____

CITY _____ STATE _____ZIP _____ DOB _____

EMERGENCY CONTACT NAME:

FIRST _____ LAST _____ RELATIONSHIP _____

ADDRESS _____CITY _____ STATE ____ZIP _____

HOME PHONE _____WORK PHONE _____ EXT. ____

PERMISSION TO LEAVE MESSAGE: Home _____ Work _____

I AUTHORIZE NORTH PHOENIX INFECTIOUS DISEASE TO ACCESS PRESCRIPTION/MEDICINEHISTORY:

YES_____ NO_____

PREFERRED PHARMACY:

NAME _____LOCATION _____

PHONE _____ FAX _____

PRIMARY INSURANCE _____

POLICY HOLDER NAME _____

POLICY HOLDER SEX _____ POLICY HOLDER DOB _____

POLICY HOLDER SSN#_____

POLICY HOLDER RELATIONSHIP TO PATIENT_____

ID# _____ GROUP # _____

SECONDARY INSURANCE _____POLICY HOLDER NAME _____

POLICY HOLDER SEX _____ POLICY HOLDER DOB _____

POLICY HOLDER SSN#_____

POLICY HOLDER RELATIONSHIP TO PATIENT_____

ID# _____GROUP # _____

I HEREBY AUTHORIZE THIS HEALTHCARE PROVIDER TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

I FURTHER AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

My signature below acknowledges that I have read and agree in entirety to the above office policies.

Signature _____ Date_____

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY
    - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
    - Co-payments are due at time of service.
    - If my plan requires a referral, I must obtain it prior to my visit.
    - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
    - If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
    - I hereby authorize and direct payment of my medical benefits to North Phoenix Infectious Disease on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS
    - I hereby authorize North Phoenix Infectious Disease to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

TELEMEDICINE CONSULTATIONS: PLEASE BE ADVISED THAT ANY PHONE CALL MADE TO OR FROM THE PHYSICIAN, LASTING LONGER THAN 5 MINUTES, WILL RESULT IN A BILLABLE PROCEDURE TO YOUR INSURANCE COMPANY. THIS MAY RESULT IN AN INVOICE BEING SENT TO THE PATIENT FOR SERVICES RENDERED. IF YOUR CONTRACTUAL OBLIGATION RESULTS IN A CO-PAY/CO-INSURANCE OR DEDUCTIBLE. YOU WILL BE RESPONSIBLE TO PAY THIS TO THE PRACTICE. THANK YOU IN ADVANCE FOR YOUR UNDERSTANDING.

_____

Signature of Patient, Authorized Representative or Responsible Party

_____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

I HEREBY AUTHORIZE THIS HEALTHCARE PROVIDER TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I FURTHER AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

My signature below acknowledges that I have read and agree in entirety to the above office policies.

Signature

_____

Date_____

Medical Information Release Form/ (HIPPA Release Form)

Name_____ **DOB** _____/_____/_____

Release of Information

[ ] I DO NOT AUTHORIZE THE RELEASE OF ANY INFORMATION

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be release to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

This release of information will remain in effect until written termination is given to the practice.

Messages

Please Call [ ] My Home [ ] My work [ ] My cell number _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking to please return your call

[ ] other_____

The best time of day to reach me:

[ ] Morning

[ ] Afternoon

[ ] Evening

Patient Signature_____ Date_____

NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____ **Birth date:** ___/___/___ **Date:** ___/___/___

Referring Physician: _____ Address: _____

Pharmacy Name: _____ Phone Number: _____-_____-_____

Reason for today's visit: _____

Please describe this problem: _____

_____

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin?** ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES** (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐ **NO** and Never have ☐ **YES** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ **NO** and Never have ☐ **Socially Only** ☐ **Daily** ☐ **Beer/ Wine** ☐ **Hard Liquor**

Occupation: _____ Hand Dominance: ☐ **RIGHT** ☐ **LEFT**

Please describe any family health issue below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER			
FATHER			
SIBLING(S)			
OTHER HEREDITARY ILLNESS			

Patient Signature: _____ **Date:** ___/___/___

Physician Signature: _____ **Date Reviewed:** ___/___/___

HEALTH HISTORY FORM 2

SYMPTOMS/ILLNESS	NO	YES, EXPLAIN	SYMPTOMS/ILLNESS	NO	YES,EXPLAIN
CONSTITUTIONAL			**SKIN**		
Fever/Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
HEMOTOLOGIC			Last Mammogram		
Hepatitis					
HIV/Other Blood Disorders			**NEUROLOGICAL**		
Bleeding Disorders			Neurological Problems		
ENDOCRINE			Headaches		
Cholesterol Level			**GENITOURINARY**		
Thyroid Problems			Last PAP		
Diabetes			Genital or Oral Herpes		
MUSCULOSKELETAL			S.T.D's		
Arthritis			Blood in Urine		
Mobility/Joint Problems			Urinary Tract Infection		
GASTROINTESTINAL			Problems Urinating		
Last Colonoscopy			PSA Level		
Constipation			Prostate Problems		
Diarrhea			Kidney Problems		
Blood in Stool			**EYES**		
Nausea/Vomiting			Vision Problems		
Liver Problems			**ENT**		
CARDIOVASCULAR			Hearing Problems		
Deep Vein Thrombosis/DVT			Sinus Problems		
Blood Clots in Lungs/Legs			**PSYCHIATRIC**		
High Blood Pressure			Mood Swings		
RESPIRATORY			Anxiety/Depression		
Asthma					
Sleep Apnea					

Patient Signature:_____ **Date:**_____