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# | RELATIONSHIP OF PATIENT TO SUBSCRIBER (SELF SPOUSE CHILD OTHER)

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# | RELATIONSHIP OF PATIENT TO SUBSCRIBER (SELF SPOUSE CHILD OTHER)

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

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 filling out the form. Staff signature required

ARIZONA COMMUNITY PHYSICIANS, P.C.
AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name_____ Account #_____
Former Name (If any)_____
Daytime Telephone_____ Birth Date_____

INFORMATION TO BE RELEASED FROM
I hereby authorize (name of organization)_____
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 # _____

PURPOSE FOR THE REQUEST_____ (Please check a box)
Moving Treatment or consultation Dissatisfaction Change of Insurance Plans At patients request
Other (specify) _____

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.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information understands that it is prohibited from making any disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Signature of Patient or Personal Representative Who May request Disclosure
I understand that Arizona Community Physicians may not condition my treatment on whether I sign this authorization form unless specified above under Purpose for Request. I can inspect or receive a copy of the protected health information to be used or disclosed. **I authorize Frederick W. Van Hook, MD to use and disclose the protected health information specified above**

_____ _____ _____
Signature of Patient OR Legal Representative **Date** **Please Print Name of signing party**

Patient Requesting Medical Record Copies
The charge for copying medical records from a paper chart will be $0.10 a page. For offices using our Electronic Health Record system, patients may request a copy of their chart on a "CD" for $10.00.

FORM # 100

Consent to Release Test Information

I, _____ hereby give my consent for my physician's office to provide lab results, radiological test results or any other imperative information to:

☐ Myself by: _____ _____ _____ _____
Home Phone Answering Machine Work Other

☐ Spouse _____ Phone # _____

☐ Child _____ Phone # _____

☐ Parent _____ Phone # _____

☐ Other _____ Phone # _____

Please list any information that you would NOT like released and to whom:

_____
_____
_____

Limitation of liability

In no event shall the Arizona Community Physicians its physicians, officers, directors, employees, agents, licensors, and their respective successors and assigns be liable for damages of any kind, including, without limitation, any direct, special, indirect, punitive, incidental, or consequential damages including, without limitation, any loss or damages in the nature of, or relating to medical injury, personal injury, wrongful death or any other loss incurred in connection with my use, misuse or information loss due to technical failures.

Indemnity

I agree to indemnify, defend, and hold harmless Arizona Community Physicians and its providers, officers, directors, employees, agents, licensors, and their respective successors and assigns, from and against any and all claims, demands, liabilities, costs, or expenses whatsoever, including, without limitation, legal fees and disbursements, resulting directly or indirectly from (i) my breaching any of the terms and conditions of this Agreement; (ii) or information loss due to technical failures.

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

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.

Patient Name [PRINTED]:_____ Acct. No._____

Patient signature _____

Witness signature _____

Date

J. David Burgess, MD
5240 E. Knight Dr. #106
Tucson, AZ 85712

ARIZONA COMMUNITY PHYSICIANS

Patient Information Sheet

Office Hours: Our office hours are from 8:00am – 12:00pm and 2:00 – 4:00pm Monday thru Thursday and 8:00am – 12:00p on Fridays. On the occasion when Dr. Burgess is away from the office for an extended period, the Doctor on call will be available for your medical needs.

Emergencies: Any problem that needs emergency treatment such as chest pain, heavy bleeding or sudden severe pain needs to be treated at the emergency room. Dr. Burgess will be notified by the emergency physician if you should need to be admitted. Less serious problems that arise after office hours can be discussed with the doctor on call, who can be reached by calling the office then pressing "0". If you need to be evaluated by a physician after hours, please check your health plan for a list of authorized urgent care centers and hospital emergency rooms.

Appointment times: Dr. Burgess does not like to prescribe over the phone for a medical problem he has not seen, therefore we will try our best to fit you in on the same day or within 24 hours of your request. Walk ins are strongly discouraged. If you do happen to walk in, we will be glad to schedule an appointment at the earliest time possible.

- 24 hour notification is required to cancel or reschedule an appointment to avoid a charge.

Prescription refills: Please call your pharmacy for all routine prescription refills several days in advance. The pharmacy will provide you with any available refills and will contact our office if additional refill authorizations are required. Please allow 1 – 2 business days for your refill request to be processed. If your medication request needs additional authorization from your insurance company please allow 7 – 10 business days for them to reply.

- Medication refills during office hours only please.

Telephone messages from patients are usually answered at the end of each half day.

Test results: Please do not assume "no news is good news". Our office reports all test results within 2-3 weeks. If you have not heard back from us by then, give us a call at 547-5812 so we can track down your results.

- I have read and agree to the above policies _____ Date _____
  Patient signature

Printed patient name: _____ Date of Birth: _____

ARIZONA COMMUNITY PHYSICIANS

Patient Name: _____
Today's Date: _____
Date of Birth: _____ MRN: _____
Spouse's Name: _____
Children's Names: _____
_____

Initial History – Adult

Personal History and Habits

Marital Status: _____ Education level: _____ Occupation: _____
Birth control type: _____
Exercise: _____ Frequency: _____ Sleep (hours): _____
Hobbies: _____

Average amount per day

Alcohol (type): _____ Recreational Drugs: _____
Tea, Coffee, Cola: _____
Tobacco (type): _____

Allergies (both medications and non-medications)

Allergic to	Reaction

Medications

Name of medication	Dose	How often?

Non-prescription (Drugs/Vitamins/Supplements)

Name of product	Dose	How often?

Past Medical History (asthma, ulcers, pneumonia etc)

_____
_____
_____

Past Surgical History

Surgery	Year

Your Family Health History:

Please list major illnesses, types of cancer and surgeries for each if applicable. Don't forget anyone with diabetes, stroke, high blood pressure or heart disease. Write "none" if completely healthy.

Maternal	Condition	Approximate age of onset
Grandfather		
Grandmother		
Paternal		
Grandfather		
Grandmother		
Your mother		
Your father		
Your brother(s)		
Your sister(s)		
Your son(s)		
Your daughter(s)		

Immunizations:

Vaccine	Yes	No	Year last received
Tetanus			
Pneumonia			
Flu			
Hepatitis B			
MMR			
Zostavax			
Gardasil			
Other			

Procedures/screening tests:

Test	Most recent date (month/year)	Normal
Mammogram		
Pap/Pelvic exam		
Breast exam		
Prostate/rectal exam		
Bloodwork		
Colonoscopy OR Flexible sigmoidoscopy		
Complete Physical Exam		
Chest x-ray		
Glaucoma test		
TB skin test		☐ Pos ☐ Neg.

OB/GYN (females only):

Age started menstruation (periods): _____

Complications (Pregnancy/delivery): _____

Number of living children: _____ Ages: _____

Number of miscarriages: _____ Abortions: _____