ELLEN M. EICHLER, M.D.

WELCOME TO DR EICHLER'S PRACTICE

I am pleased that you have placed your trust in me for your medical care. I am committed to providing you with the best care possible. In turn, I expect that you as my patient will treat the staff with the same courtesy and respect.

Please arrive 15 minutes prior to your appointment to check-in and complete any paperwork that may be necessary for your visit that day. Your insurance and personal information need to be updated periodically. If you are late for your appointment, you might need to reschedule. I strive to be on time, but sometimes unexpected situations may put me behind schedule.

PATIENT RESPONSIBILITY

This office will file your claim to your insurance company. However, it is your responsibility to ensure we have the most current and correct information on file. Please notify the front desk prior to your appointment If your personal or insurance information has changed since your last visit.

Please be prepared to show your insurance card and pay your co-pay and any balance on your account at every visit. If your information is incorrect, your account will be considered self-pay and you will be responsible for all charges.

CANCELLATION/NO-SHOW POLICY

There will be a $50.00 fee for late cancellation with less than 24 hours' notice and a $50.00 fee for failure to show for a scheduled appointment. This applies to tele-visit and in-office appointments. If you late cancel or no-show multiple times you may be dismissed from the practice.

_____ _____

Name (Please Print) Signature Date

6367 E Tanque Verde Rd. Suite 110

Tucson, AZ 85715

Phone (520)298-3000 Fax (520)547-5715

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

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 (09)
☐ Unknown (98)
☐ Declined (99)

Ethnicity (check one)

☐ Hispanic
☐ Non- Hispanic
☐ Unknown

E-mail (optional)

_____

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 Signature

☐_____
Patient declined filing out the form
Staff signature required

ELLEN M. EICHLER, M.D.
6367 E. Tanque Verde Rd., Suite 110
Tucson, AZ 85715
520-298-3000

NAME:_____ TODAY'S DATE:_____

DATE OF BIRTH:_____ AGE:_____

ADDRESS:_____

PLEASE COMPLETE THIS QUESTIONNAIRE. IF YOU ARE UNSURE OF ANY OF THE QUESTIONS, PLEASE LEAVE IT BLANK. THANK YOU.

PAST MEDICAL HISTORY:

	NO	YES	IF YES, DATE
HEART DISEASE	___	___	_____
HEART ATTACK	___	___	_____
HYPERTENSION	___	___	_____
HIGH CHOLESTEROL	___	___	_____
DIABETES	___	___	_____
ASTHMA	___	___	_____
LUNG DISEASE	___	___	_____
STROKE	___	___	_____
THYROID DISEASE	___	___	_____
LIVER DISEASE	___	___	_____
HEPATITIS	___	___	_____
BLOOD TRANSFUSION	___	___	_____
KIDNEY DISEASE	___	___	_____
GASTRIC OR DUODENAL ULCERS	___	___	_____
COLON OR BOWEL	___	___	_____
CANCER (TYPE)	___	___	_____
OTHER	___	___	_____

NAME:

SOCIAL HISTORY:

MARITAL STATUS:

OCCUPATION:

CHILDREN:

DO YOU SMOKE?	IF YES, HOW MANY PACKS A DAY?
DO YOU DRINK ALCOHOL?	IF YES, HOW MANY DRINKS PER WEEK?
DRUG USE?	IF YES, INTRAVENOUS DRUGS?

FAMILY HISTORY:

	NO	YES	IF YES, WHO?
HEART DISEASE	___	___	_____
HIGH CHOLESTEROL	___	___	_____
DIABETES	___	___	_____
DEPRESSION	___	___	_____
CANCER (TYPE)	___	___	_____

HEALTH CARE MAINTENANCE:

	DATE		DATE
MAMMOGRAM	_____	PSA (PROSTATE)	_____
PAP SMEAR	_____	EYE EXAM	_____
BONE DENSITY	_____	CHEST XRAY	_____
COLONOSCOPY	_____	EKG	_____
ANNUAL BLOOD TEST	_____		

NAME:

PAST SURGICAL HISTORY:

	NO	YES	IF YES, DATE
GALLBLADDER	____	____	_____
HYSTERECTOMY	____	____	_____
APPENDIX	____	____	_____
COLON OR STOMACH	____	____	_____
HEART	____	____	_____
TONSILS	____	____	_____
CATARACT	____	____	_____
ORTHOPEDIC	____	____	_____
OTHER	____	____	_____

CURRENT MEDICATIONS: (PLEASE LIST WITH DOSE AND FREQUENCY)

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

ALLERGIES AND REACTIONS TO MEDICINES:

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

IMMUNIZATIONS/VACCINES:

	DATE		DATE
HEPATITIS A	_____	MMR	_____
HEPATITIS B	_____	CHICKEN POX (VARICELLA)	_____
INFLUENZA (FLU)	_____	GARDISIL (HPV)	_____
PNEUMOVAX	_____	ZOSTAVAX (SHINGLES)	_____
TETANUS	_____		

Name: _____ DOB: _____ Date: _____ MRN: _____

FAMILY HISTORY – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

Ellen M. Eichler
6367 E. Tanque Verde Rd, Ste 110
Tucson, AZ 85715

Release of Test Information

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

- o Myself by: _____ (Home Phone) _____ (Answering Machine) _____ (Work) _____ (Other)
- o Spouse _____ Phone # _____
- o Child _____ Phone # _____
- o Parent _____ Phone # _____
- o Other _____ Phone # _____

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

_____

_____

_____

The following information will assist the office in contacting you with any diagnostic test or procedure result. We will maintain this form in your medical record. It will remain effective until you further notify us of any changes.

_____
Patient Name

_____ _____
Patient Signature Date

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

Scan here to request your records online

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 Dr Ellen Eichler

Street Address 6367 E Tanque Verde Ste 110

City/State/Zip Tucson, AZ 85715

Phone # 520-298-3000 Fax# 520-547-5715

Requested format ☐Paper ☐Disc (PDF format) ☐Email*_____

***Email option only available for medical records processed by CIOX.**

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

☒At request of Patient ☐ Other* (specify) transferring care

***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. Please do not submit payment with this request, you will receive a billing invoice.**

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** last 2 years

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

☐ 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**