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

Health Questionnaire PATIENT NAME: _____ DOB: _____ MRN: _____

Reason for visit: _____

FAMILY HISTORY: IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING – PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) EPILEPSY	6) THYROID	11) OSTEOPOROSIS	16) HIGH CHOLESTEROL	_____
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) ALCOHOLISM	_____
3) MENTAL ILLNESS	8) ASTHMA	13) HEART DISEASE	18) HEPATITIS	_____
4) GLAUCOMA	9) ANEMIA	14) STROKE	19) CANCER	_____
5) DIABETES	10) BLEEDS EASILY	15) HIGH BLOOD PRESSURE	20)_____	_____

HOSPITAL ADMISSIONS Not including Pregnancies	**YEAR**	**ILLNESS OR OPERATION**	**YEAR**	**ILLNESS OR OPERATION**
	_____			
	_____			
	_____			

List all medication you are now taking Include those you buy without a prescription			**ALLERGIES**	**VACCINE**	**YEAR OF LAST**	**TEST/ EXAM**	**YEAR OF LAST**
				TETANUS/TD		RECTAL/STOOL	
				INFLUENZA		CHOLESTEROL	
			SUPPLEMENTS	PNEUMONIA		EYE EXAM	
				HEPATITIS		TB TEST	
						HEPATITIS	

MEDICAL HISTORY **MARK(c) FOR CURRENT PROBLEMS. Check (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.**

□ DECREASED HEARING
□ RINGING IN EAR
□ EAR INFECTIONS - FREQUENT
□DIZZY SPELLS □ FAINTING SPELLS
□ FAILING VISION □ EYE PAIN
□ DOUBLE OR BLURRED VISION
□ NOSE BLEEDS - RECURRENT
□ SINUS TROUBLE
□ SORE THROATS – FREQUENT
□ HOARSENESS - PROLONGED
□ HAYFEVER / ALLERGIES
□ PNEUMONIA / PLEURISY
□ BRONCHITIS / CHRONIC COUGH
□ ASTHMA / WHEEZING
□ SHORTNESS OF BREATH
□ ON EXERTION □ LYING FLAT
□ CHEST PAIN
□ HIGH BLOOD PRESSURE
□ HEART MURMUR □ SWOLLEN ANKLES
□IRREGULAR PULSE □ PALPITATIONS
□ LEG PAIN – WHEN WALKING
□ VARICOSE VEINS / PHLEBITIS
□ COLD NUMB FEET
□ LOSS OF APPETITE - RECENT
□ DIFFICULTY SWALLOWING
□ HEARTBURN □ PEPTIC ULCER
□ NAUSEA/VOMITING

□ ABDOMINAL PAIN
□ GALLBLADDER TROUBLE
□ JAUNDICE / HEPATITIS
□ DIARRHEA □ CONSTIPATION
□ DIVERTICULOSIS □ CROHN'S /COLITIS
□ INFLAMMATORY BOWEL SYNDROME
□ BLOODY OR TARRY STOOLS
□ HEMORRHOIDS □ HERNIA
URINATION □ OVERACTIVE BLADDER
□OVERNIGHT MORE THAN TWICE
□MORE THAN 8 TIME/ 24 HRS.
□URGENCY TO URINATE
□ WITH LEAKAGE
□ DECREASE IN FORCE / FLOW
□ PAINFUL
□STRESS INCONTINENCE – URINE LEAKAGE WITH EXERCISE / MOVEMENT
□ BLOOD IN URINE □ KIDNEY STONES
□ URINE INFECTIONS -FREQUENT
□ BED WETTING
□ WEIGHT LOSS / GAIN □HEIGHT LOSS
□ ANEMIA □ BRUISE EASILY
□BLOOD TRANSFUSIONS
□EASILY FATIGUED
□ DECREASED ENERGY / ENDURANCE
□ CANCER _____

□ DIABETES □ THYROID DISEASE
□SEIZURES □ STROKE
□ TREMOR / HANDS SHAKING
□HEADACHES □ NUMBNESS
□ ARTHRITIS / RHEUMATISM
□ BONE FRACTURE / JOINT INJURY
□ OSTEOPOROSIS □ BACK PAIN
□ FOOT PAIN □ GOUT
□ RASH □ HIVES
□ PSORIASIS □ ECZEMA
□ CONCENTRATION PROBLEMS
□ DEPRESSION □ NERVOUSNESS
□ AGITATION □ MEMORY LOSS
□MOODINESS □ SUICIDAL THOUGHTS
□ FEELINGS OF WORTHLESSNESS
□ PHOBIAS □ MENTAL ILLNESS
□ SLEEP PROBLEMS – HOW LONG ___
HOW FREQUENT _____
□ WAKING REFRESHED
□ RHEUMATIC FEVER □ CHICKENPOX
□ SCARLET FEVER □ POLIO
□ MUMPS □MEASLES
□ GERMAN MEASLES □ HERPES
□TUBERCULOSIS □STD □ AIDS/HIV
□ SEXUAL PROBLEMS / ENJOYMENT
□ DECREASED LIFE ENJOYMENT

□ DECREASED WORK PERFORMANCE
□ ALCOHOL ____OZ PER WEEK
□ COFFEE / TEA ____CUPS PER DAY
□ SMOKING – CIG/DAY ___# YEARS
YEAR QUIT_____
□ EXERCISE
□ STREET DRUG
□ UNWANTED FACIAL HAIR
HAIR LOSS: □ PROGRESSIVE □ RECENT
MALES: □PROSTATE PROBLEMS
FEMALES: PLEASE COMPLETE
MENSTRUAL FLOW:
□ REG □ IRREG □PAIN / CRAMPS
DAYS OF FLOW ___LENGTH OF CYCLE__
DATE- 1ST DAY OF PERIOD_____
□ PAIN/BLEEDING DURING OR AFTER SEX
NUMBER OF:
PREGNANCIES____ABORTIONS____
MISCARRIAGES___LIVE BIRTHS____
BIRTH CONTROL METHOD_____
B.C. PILL (NAME)_____
□FLUSHING / MENOPAUSE
DATE OF LAST PAP TEST_____
□NORMAL □ ABNORMAL
DATE OF LAST MAMMOGRAM_____
□NORMAL □ ABNORMAL

NOTES:

PIMA OSTEOPATHIC ASSOCIATES

_____ _____ □Female _____
PRINT PATIENT NAME PT DOB □ Male MRN

Primary-MD PHQ (2 QUESTIONS Screen)

1. During the past 2 weeks, have you often been bothered by feeling down, depressed, or hopeless?
   ❑ Yes ❑ No
2. During the past 2 weeks, have you often been bothered by little interest or pleasure in doing things?
   ❑ Yes ❑ No

Patient Health Questionnaire (PHQ-9)

If you have answered yes to any of the questions above please continue if not STOP

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure of have let yourself or your family down.	0	1	2	3
7. Trouble Concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. 9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
10. How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Add columns _____ + _____ + _____

TOTAL: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Scan under "Health Assessment Tools > PHQ 9

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.
Release of Information Form

Account #_____

Patient Name _____ DOB_____ Date_____

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which a family member or close friend needs access to your health information, or to the health information of someone under your care.

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

Spouse's Name _____Contact Number_____

Child's Name_____ Contact Number_____

_____Contact Number_____

Parent's Name_____ Contact Number_____

_____Contact Number_____

Other's Name _____ Contact Number_____

DO NOT RELEASE Information to the following people: _____

Can we leave detailed lab results, radiological test results or any other imperative information on your mobile phone voice mail?_____ On your home voice mail?_____

Please check if applicable:

_____ I give permission for my child (of >15 years old) to be seen without the presence of an adult.

_____ I give permission for my child (of >15 years old) to have minor procedures or immunizations without the presence of an adult.

_____ I give permission for my child to be taken to medical appointments by:_____

_____

Patient/Parent/Guardian Contact Numbers: Home_____ Work_____ Other_____

Signature of the Patient or their Parent/Legal Guardian _____

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.

Form 116
01/20/2017

PATIENT NAME: _____ DOB: _____ MRN: _____

ADVANCE DIRECTIVES

To comply with Medicare, managed health care plans, and hospital admission requirements, we are required to provide to you information about Federal and State laws that allow you to accept or refuse treatment to formulate Advance Directives. Advance Directives are documents that enable you to give directions about your future medical care. This form is not intended to provide you legal advice but merely to provide information only.

Before making any decision about Advance Directives, please talk with your family, physicians, and/or attorney, if you need assistance. If you already have an Advance Directive or have decided to develop one, please give copies to your family, close friends, and your physician, so that they will be aware of your wishes.

We would like to assure you that this is not required and that you may elect to not have Advance Directives. In the event of a medical emergency, all measures, including life support will be given to those who do not sign Advance Directives.

Please review the enclosed information and sign at the bottom. Your signature does not signify and decision but merely shows that you have been given the information, and offered the opportunity for Advance Directives. Thank you.

_____

Patient Signature

_____

Date