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

El Sol Family Medicine

Name: _____ Date: _____ MRN #: _____

Health History Questionnaire

Patient Information:

By what name to you wish to be called? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced/ Separated ☐ Partner ☐ Widowed

Risk Assessment/Social History:

Do you currently smoke? ☐ No ☐ Yes If yes, how many packs per day? _____ For how many years? ____

Did you smoke in the past? ☐ No ☐ Yes If yes, when did you quit? _____ How many packs per day did you smoke? _____ For how many years? _____

Do you now, or have you ever, used other types of nicotine or tobacco? _____

How many alcoholic drinks do you have in a typical day? _____ in a typical week? _____

Have you used illegal or recreational drugs in the past year? ☐ No ☐ Yes

Do you exercise regularly? ☐ No ☐ Yes How many times per week? _____

What is your occupation? _____

Medications: *List all medications; include over-the-counter medications, vitamins and supplements.*

Medication/vitamin/supplement name	Dose (mg)	How many times per day?

Allergies:

Please list all medication allergies food or environmental allergies and reactions (ie, penicillin – rash peanuts - shortness of breath).

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Past Medical History: *Have you ever had or been diagnosed with any of the following?*

_anemia	_COPD/emphysema	_heart disease	_skin disease
_arthritis	_diabetes	_high blood pressure	_stroke
_asthma	_drug or alcohol abuse	_kidney disease or stones	_thyroid disease
_cancer/tumor, type___	_epilepsy or seizure	_mental illness	_other, specify_____

Hospitalizations/Surgeries _____

Family History:

	Lung disease	Heart disease	Cancer	Mental illness	Diabetes	Glaucoma	Epilepsy/ Seizures	Kidney Disease	High Blood pressure	Kidney disease	Alzheimer's	Stroke
Father												
Mother												
Father's Parents												
Mother's Parents												
Siblings												
Children												

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Review of Systems: Name: _____ MRN: _____ Date: _____

If you have experienced any of these issues in the past two weeks, please mark the positive box.

Constitutional	+	-	*Respiratory*	+	-
Activity change			Apnea		
Appetite change			Chest Tightness		
Chills			Choking		
Diaphoresis (sweating)			Cough		
Fatigue			Shortness of Breath		
Fever			Stridor (noise when breathing)		
Unexpected weight change			Wheezing		
HENT	+	-	*Cardio*	+	-
Congestion			Chest pain		
Dental problems			Leg swelling		
Drooling			Palpitations		
Ear discharge			*GI*	+	-
Ear pain			Abdominal distention		
Facial swelling			Abdominal pain		
Hearing loss			Anal bleeding		
Mouth sores			Blood in stool		
Nosebleeds			Constipation		
Postnasal drip			Diarrhea		
Rhinorrhea (runny nose)			Nausea		
Sinus pain			Rectal bleeding		
Sinus pressure			Vomiting		
Sneezing			*Endocrine*	+	
Sore throat			Cold intolerance		
Tinnitus (ringing in ears)			Heat intolerance		
Trouble swallowing			Polydipsia (excessive thirst)		
Voice change			Polyphagia (excessive hunger)		
Eyes	+	-	Polyuria (excessive urination)		
Eye discharge					
Eye itching					
Eye pain					
Eye redness					
Photophobia (sensitive to light)					
Visual disturbance					

Please ~~continued~~ Continue on the other side

El Sol Family Medicine

Review of Systems: Name: _____ MRN: _____ Date: _____

If you have experienced any of these issues in the past two weeks, please mark the positive box.

GU	+	-	*Neurological*	+	-
Difficulty urinating			Dizziness		
Dyspareunia(painful intercourse)			Facial asymmetry		
Dysuria (painful urination)			Headaches		
Enuresis (bed wetting)			Light-headedness		
Flank pain			Numbness		
Frequency			Seizures		
Genital sore			Speech difficulty		
Hematuria (blood in urine)			Syncope		
Menstrual problem			Tremors		
Pelvic pain			Weakness		
Urgency			*Hematologic*	+	-
Urine decreased			Adenopathy (swollen glands)		
Vaginal bleeding			Bruises/ bleeds easily		
Vaginal discharge			*Psychiatric*	+	-
Vaginal pain			Agitation		
Penile discharge			Behavior problem		
Penile swelling			Confusion		
Scrotal swelling			Decreased concentration		
Testicular pain			Dysphoric mood (sadness)		
Muscular	+	-	Hallucinations		
Arthralgias (joint pain)			Hyperactive		
Back pain			Nervous/anxious		
Gait problems			Sleep disturbance		
Joint swelling			Suicidal ideas		
Myalgias (muscle pain)					
Neck pain					
Neck stiffness					
Skin	+	-			
Color change					
Pallor (pale skin)					
Rash					
Wound					

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Site Name

ARIZONA COMMUNITY PHYSICIANS

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

Patient Health Questionnaire (PHQ)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Please circle 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. 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 column: _____ + _____ + _____

TOTAL: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

El Sol Family Medicine

Patient Name_____ Date of Birth_____ Date_____

When was the last time you had the following?

	Date	Result
Physical Examination	_____	_____
Medical Wellness visit	_____	_____
Colonoscopy	_____	_____
DEXA Scan (Bone Density)	_____	_____

Immunizations:	Date
Tetanus (Td or Tdap)	_____
Pneumovax 23	_____
Prevnar 13	_____
Influenza (Flu)	_____
Shingrix (Shingles)	_____
COVID	_____

Women:	Date	Result
Well Woman Exam	_____	_____
Mammogram	_____	_____
Pap Smear	_____	_____

List any specialist you have seen.

_____

_____

_____

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

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

Ethnicity

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

Veteran Status

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

Marital Status:

Married
Divorced
Legally Seperated
Single
Widowed
Signifigant Other
Other

Emergency Contact

Name_____
Phone _____
Relationship:_____

Employment Status: _____

Patient Email:_____

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

Patient(or Guardian) Signature:_____ Date:_____

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#_____

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) _____

***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**

ARIZONA COMMUNITY PHYSICIANS

MRN: _____

El Sol Family Medicine

Office Policies and Procedure

The following information will explain our policies and procedures.

Please read the following carefully. Your signature on this form will indicate your agreement and understanding of our policies.

1. All patients should arrive 15 minutes before their appointed check-in times. This policy is in place so the necessary intake efforts can be made and so that you can be roomed in a timely manner. Patients who arrive late create an inconvenience for our providers as well as other patients. Our practitioners reserve the right to ask you to reschedule if you are more than 10 minutes late.

2. If there is a need to cancel your appointment, please do so at least 24 hours in advance. There will be a $50.00 fee if you do not show for your appointment or if you do not give 24 hours' notice when canceling an appointment. Reminder calls are a courtesy, not mandatory.

3. Co-pays and deductibles are due at time of service as dictated by your insurance. We will accept cash, check, Visa, Mastercard, Discover and American Express.

4. Calls to the office during regular business hours will be returned in the order of urgency. Some calls cannot be returned immediately but will be returned within 48 hours as determined by the volume of calls and the serious nature of the call.

5. Please allow 72 hours for refills or written prescriptions. Our on-call doctors will not call-in controlled medications (opioids, etc.). Please call your pharmacy for routine refills of medications.

6. Please bring in an updated list of medications and doses to each visit.

7. Referrals may take up to 14 days depending on your insurance carrier. Some procedures require a prior-authorization, delaying the completion of your referral.

8. Our staff is trained to assist you in providing the best care possible. We strive to provide compassionate professional care. At El Sol Family Medicine, we appreciate and respect our staff. It is our belief that our staff should have an environment free from verbal and physical abuse. We expect you to treat each one of our staff members as you would like to be treated. Outbursts against our staff will not be tolerated and may result in your discharge from our practice.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

El Sol Family Medicine

Melissa Levine, MD • R. Max Lystrup, MD
Narissa Whitelaw, DO
Kathleen Bruno, FNP • Matthew Michaud, FNP

APPOINTMENTS

- ☐ Please arrive 15 minutes before your appointment time.
- ☐ Your appointment may be rescheduled if you are more than 10 minutes late.
- ☐ Telehealth visits may be an option in some cases. This could be at your request or the request of the provider. Please note, not all appointment types or reasons for your visit are appropriate for telehealth.
- ☐ Please bring a current medication list (along with the dosage on the bottle) with you to all appointments.

MYCHART & TELEPHONE MESSAGES

- ☐ Calls during business hours will be returned in the order of urgency.
- ☐ Calls after 4 pm will not be returned until the next business day.
- ☐ The on-call physician can be reached through our answering service. Please call the office phone number to be connected. Please unblock your phone to receive a call back.
- ☐ Please allow 72 hours for medication refills.
- ☐ On-call providers will not fill controlled medications.
- ☐ Requests for antibiotics will require an appointment with one of our providers.
- ☐ MyChart is our online patient portal, you can communicate with the office (*non-urgent messages only*), check-in for appointments, update demographic information, pay your copay, see your results and visit summaries. Please ask us about it.

INSURANCE AND REFERRALS

- ☐ We make every effort to know your insurance requirements, but we rely on you to understand your particular plan requirements.
- ☐ Provide us with your most current insurance information.
- ☐ Referrals may take up to 14 days depending on your insurance carrier.

MEDICAL RECORDS

- ☐ We use an outside service Ciox, for medical record copying.
- ☐ A signed form is required to release your records.
- ☐ In some cases, a fee may apply.
- ☐ If you have a form you need completed, please allow at least 7 days for completion.
- ☐ Some forms may require an office visit for completion.

BILLING

- ☐ Co-pays and deductibles are due at the time of service.
- ☐ There may be a $50.00 fee for appointments that are canceled less than 24 hours before and for "No Show" appointments.
- ☐ Billing questions can be directed to our billing department at 520-795-4783.
- ☐ You can pay your bill online at www.azacp.com, in our office, on MyChart or any ACP location.

MUTUAL EXPECTATIONS

- ☐ We look forward to a long and respectful relationship with you. Please treat our staff with the same respect with which they treat you.
- ☐ Understand that some things are out of our control (insurance decisions, government guidelines, CDC guidelines, etc.).
- ☐ We do not require masks, however if you are sick or have any COVID symptoms you may be asked to wear a mask while in the office.

ACP
ARIZONA COMMUNITY PHYSICIANS

2260 N. Rosemont Blvd, Suite 107 • Tucson, AZ 85712 • Phone (520) 318-1033