Name: _____ Date: _____ MRN #: _____

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

Form #101

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	_kidney disease or	_thyroid disease
_cancer/tumor,	abuse	stones	_other,
type___	_epilepsy or seizure	_mental illness	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												

Name: _____ Date: _____ MRN #: _____

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)

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

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. 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: _____

Scan under "Health Assessment Tools > PHQ 9"

Name: _____ Date: _____ MRN #: _____

ARIZONA COMMUNITY PHYSICIANS
REGISTRATION ADDENDUM

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 or 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.

Scan under Patient forms

Name: _____ Date: _____ MRN #: _____

Arizona Community Physicians, P.C.
Release of Information Form

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 for patients under 15 years old:

_____ 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

_____ Date_____

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.