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

J & J Medical

Follow – Up Questionnaire

MRN:_____

Patient Name:	Date of Birth:
Reason for Visit:	Date:

Please circle any of the following symptoms that you are currently experiencing:

General
Tiredness
Weight loss
Weight gain
Fever
Increasing thirst
Feeling cold
Feeling hot

Gastrointestinal
Abdominal pain
Decreased appetite
Heart burn
Nausea
Vomiting
Diarrhea
Constipation

Skin
New rash
Open sores
Excessive sweating
Easy Bruising

Eyes
Eye pain/irritation
Blurred vision
Double vision
Loss of side vision

Urinary
Difficulty urinating
Blood in urine
Urinating frequently
Urinating more than once during the night
Yeast infections

Psych
Poor sleep
Depression
Anxiety
Problems concentration

Women
Irregular periods
Missed periods
Hot flashes
Breast discharge
Last period ____/____/____

ENT
Decreased hearing
Dental problems
Sore throat
Trouble swallowing

Musculoskeletal
Muscle pain
Muscle weakness
Muscle stiffness
New joint stiffness
Location: _____

Men
Prostate enlargement
Erectile issues
Loss of sex drive
Breast growth or tenderness

Respiratory
Wheezing
Cough
Shortness of breath with exercise

Heart
Fast heart beat/heart racing
Chest pain with exercise
Ankle swelling

Neuro
Burning, tingling, numbness Or pain in hands/feet
Headache
Tremor
Confusion

Endo
Acne
Stretch marks
Scalp hair loss
Skin bruising
Women only: Dark coarse hair on face, chest or abdomen

INITIAL EVALUATION FORM

Please fill this questionnaire out. If you have any problems answering these questions, leave a question mark. This is a confidential record.

I. PERSONAL INFORMATION

Name: _____ Sex: _____ Date of birth: _____ Age: ___
Marital status: Single Married Widowed Divorced Separated
Who lives with you? _____
Who do you call in case of emergency? _____ phone number: _____
List name and phone number of the person whom we can call in case we cannot reach you?
_____
Your referral Physician is: _____ Your primary care physician is: _____
Do you see other physicians for your health care? If yes, please list name and specialty.
_____
Last complete physical exam: _____
Present occupation: _____ Past occupation: _____
Sports and hobbies: _____
Have you ever smoked? No Yes: Cigarettes Pipe Cigars
How many per day? _____ For how many years? _____ How long ago did you quit? _____
How many alcoholic beverages you have: _____/day _____/week _____/month _____/year

II. PAST MEDICAL AND SURGICAL HISTORY

Record all diseases, including surgeries, injuries and mental illness you have had in the past with year of diagnosis: (use back of this page if you need more space!)

III. MEDICATIONS

List all medications that you are currently taking. Write down exact dose and how you take them. (use back of this page if you need more space!)

Medication	Dosage and frequency	Medication	Dosage and frequency

IV. FAMILY HISTORY

Do you have any blood relatives that has or had: (please indicate who and what age)
Diabetes: _____ Cancer (type) _____
High blood pressure _____ Heart attack _____
Stroke _____ Thyroid disease (indicate who and what kind) _____
Other diseases: _____

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 filing out the form. Staff signature required

MRN: _____

Arizona COMMUNITY PHYSICIANS, P.C.

Release of Test Information

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

☐ Myself by: _____ _____ _____

Home Phone Work Cell

Can we leave detailed results/message on your voice mail yes No

Please list the name of person.

☐ Spouse _____ Phone # _____

☐ Child _____ Phone # _____

☐ Parent _____ Phone # _____

☐ Other _____ Phone # _____

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

_____

_____

_____

The following information will assist the office in contacting you with any diagnostic test or procedure results. 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

J & J MEDICAL
5920 N. LaCholla Blvd Ste 150, Tucson, AZ 85741
Phone: (520) 547-5836 Fax: (520) 547-5841
Vinus Patel, DO Nora Barsony, MD

MRN: _____

- **No Show/Cancellation Policy**

Western Endocrine Associates goal is to provide quality medical care in a timely manner. In order to do so, we must implement a no show/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

A patient who does not show their appointment, and who does not notify the practice 24 hours in advance, will be subject to an administrative fee of $25.00. This fee is not payable by your insurance company and remains the responsibility of the patient. This fee will be due in full prior to your next appointment.

We do make courtesy reminder calls to patients, so please make sure we have current contact information for you.

Multiple no show, rescheduled or cancelled visits may result in being dismissed from Western Endocrine Associates.

- **Form Completion Fees**

There is an administrative fee charged for form completion requests. Our fees start at $25.00. The amount of time spent researching and completing the form dictates the ending cost. If you would like a quote prior to having the form completed, please let us know. This fee is not covered by insurance companies.

- **Medications**

Our physicians will only authorize prescription refills that they have prescribed for you. Your refill requests may be denied if you do not keep your follow up appointments. If you have any questions regarding this policy, please discuss this with your physician.

If you need a refill on your medication, please contact your pharmacy directly. We recommend you contact them at least 72 hours in advance to allow time for our staff to review and approve these requests.

- **Office Charges**

If you do not have insurance, payment is expected at the time of service.

If you have insurance, we will submit your charges to your insurance company. Since insurance companies will not guarantee us payment, we cannot guarantee that your charges will be covered. The term “covered” means your insurance company will process the charge according to your benefits. You will be responsible for any out of pocket expenses, such as co-insurance and deductibles. Please check with your insurance company if you have any questions about your coverage.

Failure to keep your account in good standing may result in you being dismissed from Western Endocrine Associates.

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5920 N. LaCholla Blvd Ste 150, Tucson, AZ 85741
Phone: (520) 547-5836 Fax: (520) 547-5841
Vinus Patel, DO Nora Barsony, MD

- **Lab Charges**

If we are contracted with your insurance carrier, we will send your lab specimens to our facility. Sometimes it is necessary to send some tests that our lab does not perform to an outside lab. You may receive a separate bill from them if your insurance does not completely cover the test being performed.

Some insurance plans negotiate coverage terms with employers and patients directly, and this can affect what you have to pay out of pocket. This can include sending you to another facility to get your labs drawn. Please make our staff aware of these terms at the check in window as our staff is not made aware of these exceptions by your insurance company. It is the responsibility of the patient to inform us of any special insurance requirements.

I, _____, have read and acknowledge the above information.

_____ _____
(Patient Signature) (Date)