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/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 (SPA)
☐ 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

New Patient History

Name:_____

Date:_____

MRN:_____

Do you have allergies to any medications?

Medication	Reaction you had	Year
1.		
2.		
3.		
4.		
5.		

Please list all medications you are currently taking.

Medication	Dosage	How many times a day do you take it and how is it taken?	Year started
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Vitamins/supplements please list:

_____

_____

Employment:

Occupation	Employer	Full/Part time or Retired

Marital Status: Please circle one

Single Married Divorced Widowed Significant Other Legally separated

If applicable what is your spouse's name? _____

Number of children? _____

What do you do for exercise? _____How many times a week? _____

How much coffee, tea, or caffeinated soda consumed in a day? _____

Please check one. Do you consider your diet ☐LOW FAT ☐MODERATE FAT ☐HIGH FAT

What is your sexual orientation? _____

Who was your previous physician? _____

Do you have any medical history? Please **circle and date** when it started.

ADD/ADHD
Yes No Date:

Allergic rhinitis
Yes No Date:

Allergies
Yes No Date:

Anemia
Yes No Date:

Anxiety
Yes No Date:

Arthritis
Yes No Date:

Asthma
Yes No Date:

Cancer
Yes No Date:

Cataracts
Yes No Date:

CHF
Yes No Date:

Chronic pain
Yes No Date:

Clotting disorder
Yes No Date:

Colon polyps
Yes No Date:

COPD
Yes No Date:

Depression
Yes No Date:

Diabetes mellitus
Yes No Date:

Eating disorder
Yes No Date:

Eczema
Yes No Date:

GERD
Yes No Date:

Glaucoma
Yes No Date:

Gout
Yes No Date:

Headache
Yes No Date:

Hearing loss
Yes No Date:

Heart murmur
Yes No Date:

Hepatitis
Yes No Date:

HIV/AIDS
Yes No Date:

Hypertension
Yes No Date:

Inflammatory bowel disease
Yes No Date:

Kidney disease
Yes No Date:

Lupus
Yes No Date:

Memory loss
Yes No Date:

Heart Attack
Yes No Date:

Nerve / muscle disease
Yes No Date:

Osteoporosis
Yes No Date:

PVD
Yes No Date:

Rheumatoid arthritis
Yes No Date:

Seizures
Yes No Date:

Sleep apnea
Yes No Date:

Stroke
Yes No Date:

Substance abuse
Yes No Date:

Thyroid disease
Yes No Date:

Vision problems
Yes No Date:

OTHER PLEASE LIST:

Tobacco use. Please circle one of the following.

Current every day smoker Someday smoker Former smoker

Never smoker Passive smoke exposure-never smoker

If current/former smoker when was the start date? _____

If applicable when was the quit date? _____

Type of tobacco smoked. Please circle one. **Cigarettes Pipe Cigars**

How many packs per day? _____

For how many years? _____

E-cigarette/Vaping use. Please circle one of the following.

Current every day smoker Someday smoker Former smoker Never smoker Passive smoke exposure

What kind of E-cigarette/Vaping? Please circle one of the following.

1. Nicotine THC CBD Flavoring
2. Disposable Prefilled or refillable cartridge Refillable tank Pre-filled pod

Alcohol use. Please circle below

Yes currently Not Currently Never

What Kind of Alcohol consumed? Please circle below

Wine Beer Liquor

How many drinks per week? _____

Substance/Illicit Drug use. Please circle below

Yes currently Not Currently Never

What kind if used? _____

Do you have any surgical history? Please list below the type of surgery it was, date when it happened, where it took place and with what doctor.

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

Please list your Family History:

	TYPE↓	WHO↓	NAME↓	ALIVE↓	DECEASED↓
ARTHRITIS					
ASTHMA					
CANCER					
MELANOMA					
DIABETES					
HEART ATTACK					
HYPERTENSION					
STROKE					
ALTZHEIMER'S					
TB					
OSTEOPOROSIS					
THYROID					
OTHER					
OTHER					

CHECK HERE IF FAMILY HISTORY UNKNOWN ☐ CHECK HERE IF ADOPTED ☐

Do you see any specialist? Please name who you see and the specialty.

_____

_____