ArizonaPreferredSurgeons
UNITING SCIENCE AND COMPASSION

Brian P. Lipton, M.D., Ph.D., F.A.C.S.
Debora J. McClary, M.D., F.A.C.S., F.A.S.C.R.S.
Kara M. Villareal, M.D., F.A.C.S.

www.AZPreferredSurgeons.com
(602) 995-0822 OFFICE
(602) 995-0825 FAX

PATIENT DEMOGRAPHICS

PATIENT INFORMATION

Patient: First Name_____ Middle Initial_____ Last Name_____

Date of Birth_____ Last 4 of SSN___XXX-XX-_____ Gender: ☐Male ☐Female

Address_____ Email_____

City_____State_____ Zip Code_____

Home Phone___(_____)_____ Cell Phone ___(_____)_____

Occupation_____ Employer_____ Work Phone_____

Marital Status: ☐Married ☐Single ☐Widowed/er ☐Divorced Significant Other's Name_____

Preferred Language_____ Race_____Ethnicity_____

PHYSICIAN/PHARMACY INFORMATION

Primary Care Provider_____ Phone Number ___(_____)_____

Referring Provider (if different)_____ Phone Number ___(_____)_____

Cardiologist's name_____ Endocrinologist's name_____

Pulmonologist's name_____ Gastroenterologist's name_____

Pharmacy Name_____ Pharmacy Phone___(_____)_____

Pharmacy Location: Cross Streets, City and Zip Code_____

CONTACT INFORMATION

Under current privacy laws, we cannot disclose information regarding your medical condition, treatment plans, or test outcomes to anyone except you, the patient (or a responsible adult in the case of a minor), without your permission. If you choose, you can give us permission to leave information regarding tests and results with another person such as a spouse, significant other, or friend, if we are unable to reach you. Please provide the name and relation of that person here:

Name_____ Relationship_____ Phone_____

How can we contact you? (Please check all that apply): ☐Home Phone ☐Cell Phone ☐Work Phone ☐Voicemail

You must initial here to provide us permission to call your cell phone or leave messages on your cell phone. _____ (Initials)

I understand and agree that if I have NOT heard from this office within 2 weeks of ANY testing/pathology, it is my responsibility to call AZPS and obtain the results. _____ (Initials)

IN CASE OF EMERGENCY NOTIFICATION

In case of an emergency, please notify:

Name_____ Relationship_____

Home/Cell Phone___(_____)_____ Work Phone___(_____)_____

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FINANCIAL/INSURANCE

Patient Name_____ Date_____

PRIMARY INSURANCE

Patient's relationship to policy holder: ☐Self ☐Spouse ☐Parent ☐Child ☐Other_____

Policy Holder's Name_____

Policy Holder's DOB_____ SSN_____

Employer_____

Subscriber #_____ Group #_____

Plan Name_____ Plan Address_____

Plan Phone____(_____)_____

SECONDARY INSURANCE

Patient's relationship to policy holder: ☐Self ☐Spouse ☐Parent ☐Child ☐Other_____

Policy Holder's Name_____

Policy Holder's DOB_____ SSN_____

Employer_____

Policy #_____ Group #_____

Plan Name_____

Plan Name_____ Plan Address_____

Plan Phone____(_____)_____

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT/SELF

Name of Responsible Party_____ Date of Birth_____ SSN_____

Address_____ Relationship to Patient_____

City_____ State_____ Zip Code_____ Employer_____

Home Phone____(_____)_____ Address_____

Work Phone____(_____)_____ City_____ State_____ Zip Code_____

BENEFIT ASSIGNMENT/ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby authorize the staff of Arizona Pref (AZPS) to provide such medical services, either regular or emergency, as may be determined by my physician to be in my best interest (or the best interests of my dependent if I am signing as parent or guardian).

I authorize payment of medical benefits to AZPS. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. I hereby authorize AZPS to release the necessary information regarding me to my health plan in order to complete and process my insurance claims.

I hereby acknowledge that I have been presented with a copy of the Arizona Preferred Surgeons' NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient/Responsible Party Date

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MEDICAL AND SURGICAL HISTORY

Name: _____ Gender_____ Date of Birth: _____

Why are you here to see a surgeon today? _____

MEDICAL HISTORY: (include medical conditions and problems, illnesses) (☐check if additional history on separate sheet of paper)

Past Medical History (include hypertension, diabetes, hypothyroidism, high cholesterol)	Month/Year

Do you have sleep apnea? ☐Yes ☐No Do you use a CPAP Mask? ☐Yes ☐No

OPERATION HISTORY: include all operations/procedures and month/year (☐check if additional info on separate sheet of paper)

Operations	Month/Year	City/State

CURRENT MEDICATIONS: (☐check if additional medications on separate sheet of paper)

Do you take aspirin in any form, including a regular baby aspirin? ☐Yes ☐No Date of last dose?_____

Do you take any other medications that thin your blood (coumadin, Plavix, Xarelto, etc) ☐Yes ☐No Date of last dose?_____

Name	Dose	Frequency	Reason for Use

Have you taken steroids in the last 12 months? ☐Yes ☐No When? How given?_____

Do you take herbal supplements? ☐Yes ☐No Which supplements?_____

ALLERGIES TO MEDICATIONS/LATEX/IV DYE (☐check if additional allergies on separate sheet of paper)

Medication	Type of Reaction	Date of Reaction

SOCIAL HISTORY:

Do you use nicotine/tobacco/vaporizers? ☐Never ☐Rare ☐Weekly ☐ Daily ☐Former/Quit If quit, when?_____

Do you drink alcohol? ☐Never ☐Rare ☐Weekly ☐ Daily ☐Former/Quit If quit, when?_____ How many per day?_____

Do you use drugs (recreational, illegal, nonprescribed)? ☐Never ☐Rare ☐Weekly ☐ Daily ☐Former/Quit If quit, when?_____ Which drugs?_____

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MEDICAL AND SURGICAL HISTORY (Page 2)

Name: _____ Gender_____ Date of Birth: _____

FAMILY HISTORY:

	Age	Disease/Condition	If deceased, cause of death?
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
BROTHER	_____	_____	_____
SISTER	_____	_____	_____
SPOUSE	_____	_____	_____
CHILDREN	_____	_____	_____

REVIEW OF SYSTEMS

Are you experiencing any of the following signs or symptoms?

		Yes	No			Yes	No
Co	Recent weight change? Fevers or night sweats? Problems with anesthesia?	☐ ☐ ☐	☐ ☐ ☐	In	Any changing moles or freckles? Rashes?	☐ ☐	☐ ☐
Ey	Whites of your eyes turn yellow? Vision changes?	☐ ☐	☐ ☐	Ne	Dizziness or light-headed feeling? Memory loss? Lose balance easily?	☐ ☐ ☐	☐ ☐ ☐
EN TM	Bleeding from mouth/gums/nose? Difficulty swallowing?	☐ ☐	☐ ☐	Mu	Muscle or joint pain Need assistance walking (cane, walker, wheelchair, aide)	☐ ☐	☐ ☐
Br	Lump(s) in breast? Painful breasts? Discharge from nipples?	☐ ☐ ☐	☐ ☐ ☐	En	Hormone problems? Thyroid problems? Diabetes poorly controlled?	☐ ☐ ☐	☐ ☐ ☐
CV	Chest pain or angina? Shortness of breath when walking or lying flat? Swelling of feet, ankles, or hands?	☐ ☐ ☐	☐ ☐ ☐	Ps	Memory loss or confusion? Insomnia?	☐ ☐	☐ ☐
Re	Coughing or wheezing? Difficulty breathing?	☐ ☐	☐ ☐	Bl	Anemia current or in the past? Blood clots too easily? Family history of hereditary bleeding problems? Enlarged lymph nodes/glands?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
GI	Change in bowel movements? Nausea or vomiting? Bleeding with bowel movements or in stools? History of stomach ulcer? Accidents losing bowel movements/incontinence?	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	Al	HIV? Hepatitis?	☐ ☐	☐ ☐
GU	Kidney disease/poor function? Difficulty starting to urinate? Accidents losing urine/incontinence?	☐ ☐ ☐	☐ ☐ ☐				

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Name: _____ Gender_____ Date of Birth: _____

CONSENT FOR OPIOID THERAPY TREATMENT

Your surgeon may prescribe an opioid/narcotic for the treatment of painful conditions such as incisional pain after surgery.

Narcotics are dangerous medications and should only be taken under direction of a physician. Negative effects of narcotics include:

Addiction	**Physical dependence**
Death	**Nausea or vomiting**
Impaired judgment	**Excessive drowsiness**
Impaired reasoning	**Urinary retention (inability to urinate)**
Respiratory depression (stop breathing)	**Low blood pressure**
Constipation	**Insomnia (inability to sleep)**
Itching	**Depression**
Birth defects in a fetus	**Impotence**

Please ***initial*** acknowledging each of the following, and sign below:

_____We will retrieve a report from the Arizona Board of Pharmacy Prescription Monitoring Program prior to prescribing or refilling any opioid medication. Please notify us of any prescriptions for narcotics or benzodiazepines you have received or taken in the last 30 days. Any discrepancies between this report and your record may make you ineligible for narcotic prescription(s) for post-surgical pain.

_____If you participate in a pain management service for chronic or acute pain management, you must disclose the name of your physician/provider. Failure to do so may make you ineligible for narcotic prescription(s) for post-surgical pain.

_____The above risks, especially death, are much higher if you are also taking a benzodiazepine such as Ativan or Valium, commonly known as sedatives or sleeping agents. You must disclose to us if you are using these medications.

_____The above risks, especially death, are much higher if you are using marijuana or illegal drugs. You must disclose to us if you are using marijuana or illegal drugs.

_____Female patients must disclose to us if they are pregnant or become pregnant during treatment with opioid medications, as narcotics can cause severe birth defects in the first trimester of pregnancy.

_____Do not drink alcohol while taking opioid medications.

_____Do not drive a motor vehicle while taking opioid medications.

I have read and understand the above.

Signature_____ Date_____

Name _____ Date of Birth_____

CONSENT FOR E-PRESCRIBING AND PHARMACY BENEFITS MANAGER INTERFACE

AZPS requires your signed permission to request and use your prescription medication history from other healthcare providers and/or pharmacy benefit payors for treatment purposes, including retrieval of your prescription history and to e-prescribe medications you may need.

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to your pharmacy. Our federal government has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Pharmacy Benefits Management are business entities, either inside or outside of your insurance company, responsible for processing and paying prescription drug claims and verifying prescription coverage.

By signing this consent form, you are agreeing that Arizona Preferred Surgeons can request and use your prescription medication history from other healthcare providers, pharmacies and/or pharmacy benefit manager services for treatment purposes.

Signature_____ Date_____

Name _____ Date of Birth_____