

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 () _____

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

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)

<u>Past Medical History (include hypertension, diabetes, hypothyroidism, high cholesterol)</u>	<u>Month/Year</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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)

<u>Operations</u>	<u>Month/Year</u>	<u>City/State</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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? _____

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Reason for Use</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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)

<u>Medication</u>	<u>Type of Reaction</u>	<u>Date of Reaction</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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? _____

MEDICAL AND SURGICAL HISTORY (Page 2)

Name: _____ Gender _____ Date of Birth: _____

FAMILY HISTORY:

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

REVIEW OF SYSTEMS

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

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 _____