

## 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)

**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? \_\_\_\_\_

## 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?

		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"/>
Ey	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"/>
EN TM	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:

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

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 \_\_\_\_\_