Scottsdale Family Physicians
New Patient Registration Form

PERSONAL INFORMATION

Name: ____ Date of Birth: ________________
Last First MI

Address: ____ Gender: M or F Age: __________
Street

____ Marital Status: S M D W
City State Zip

Phone numbers: Home __________________ Cell __________________ Work __________________

Email: ____ Occupation: ____________________________

Primary Language: __________________ Race: ____________________ Ethnicity: ________________

How did you hear about our office? ____

INSURANCE INFORMATION

Primary Insurance: ____________________ Policy Holder/Guarantor______________ D.O.B: ________

ID/Policy #: __________________________________ Group #: __________________

Address: ____ Phone ______________
Street City State Zip

Secondary Insurance: ____________________ Policy Holder/Guarantor______________ D.O.B: ________

ID/Policy #: __________________________________ Group #: __________________

Address: ____ Phone ______________
Street City State Zip

Emergency Contact Person:

Name: ______________________ Phone: ______________ Relationship to Patient: __________________

Pharmacy Information (optional):

Name: __________________ Cross streets: ______________________________ Phone ______________

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to ask you:
Do we have permission to discuss your case with certain specified relatives and/or friends of your choosing:

Spouse? YES NO Name: ______________ Others? Name/Relationship: ____________________

Do we have your permission to leave messages on your voicemail at home/work or cell phone? YES NO

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release record of my treatment to my insurance company or other third parties responsible for payment of my medical charges.

Patient /Guardian Signature: ____ Date: ____________________

Financial Policy
Scottsdale Family Physicians, PLLC

_____ Initial Please carefully read each statement and sign below. This policy has been put in place to ensure that the financial payments due are recover so that we may continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straight forward as possible. Our staff will be glad to discuss these policies with you.

_____ Initial I understand that if I do not have my insurance card, referral, and/or co-payment that my appointment may be rescheduled until such time that I can provide the required documents or payments.

_____ Initial I understand that reminder appointments calls from the office are a courtesy only, and that I am responsible for keeping track of my appointment and being on time.

_____ Initial I understand I am financially responsible for any co-payments, deductibles, co-insurance and all charges which are not covered by my insurance. ***I understand that verification of coverage is not a guarantee of payment of benefits.*** My insurance company determines benefit payments, I understand I will be responsible for the portion not covered by my insurance.

_____ Initial I understand that if I am unable to make a scheduled appointment I need to contact the office at least 24 hours prior to my scheduled appointment. A $24-$75 FEE MAY BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 1 BUSINESS DAY WITH A 24 HOUR NOTICE.

_____ Initial I understand that there is a $25 charge for a Non-Sufficient Funds (NSF) check.

_____ Initial I understand there may be a $10-$40 charge for all forms deemed appropriate, filled out by the physician (e.g. Disability, FMLA, ect.). When dropping forms off, I must allow 5-7 business days for completion.

_____ Initial I understand if my account is not paid in full within 90 days, I may be turned over to a collection agency for further processing and incur an additional 35% fee. Legal action fee will be 50%. In addition, I will be discharged from the practice.

I have read and I understand the above Financial Policy and I agree to abide by its terms.

_______________________________________ Signature of the Patient or the Patients Legal Representative

_______________ Date

_______________________________ Print Name

_______________________________ If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.

Scottsdale Family Physicians, PLLC
Acknowledgment of Privacy Pratices and Instructions for Release of Personal Health Information/HIPPA

PATIENT NAME: ____

DATE OF BIRTH: ____

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES: __________

I give permission to Scottsdale Family Physicians, PLLC to communicate messages regarding APPOINTMENTS as follows (check all that apply):
____ You may leave a message on my voice mail/answering machine.
____ You may leave a message with ______________________________
____ You may communicate with me through the Patient Portal.

I give permission to Scottsdale Family Physicians, PLLC to communicate messages regarding REFERRALS TO ANOTHER PHYSICIAN as follows (check all that apply):
____ You may leave a message on my voice mail/answering machine.
____ You may leave a message with ______________________________
____ You may communicate with me through the Patient Portal.

I give permission to Scottsdale Family Physicians, PLLC to communicate messages regarding LAB RESULTS, X-RAYS AND OTHER TESTS as follows (check all that apply):
____ You may leave a message on my voice mail/answering machine.
____ You may leave a message with ______________________________
____ You may communicate with me through the Patient Portal.

Please list the names of individuals whom we have permission to release health information to:

Name:	Phone Number:	Relation:
______________	____________	__________
______________	____________	__________
______________	____________	__________

Signature of Patient, Parent, Legal Guardian: ______________________ Date: __________

Updated 03/20/2018

Patient Name: ______________________________ **Age:** ________ **Date:** ____________________

MEDICATIONS: List all current prescription and non-prescription medications, vitamins, and herbal products. Please INCLUDE even occasional use of aspirin or anti-inflammatory medication for arthritis.

Name of Medication	Strength	Frequency Taken
______________________	______________	__________________
______________________	______________	__________________
______________________	______________	__________________
______________________	______________	__________________
______________________	______________	__________________
______________________	______________	__________________

MEDICAL HISTORY (active or inactive) Check those that are applicable

☐ Angina	☐ Gallstones	☐ Kidney Stones
☐ Anemia	☐ Heart Attack	☐ Chronic Kidney Disease
☐ Coronary Artery Disease	☐ Congestive Heart Failure	☐ Migraine Headaches
☐ High Blood Pressure	☐ Colitis	☐ Diabetes/High Sugar
☐ Stomach Ulcers	☐ Heart Valve Disease	☐ Seizures
☐ Acid Reflux, GERD	☐ Atrial Fibrillation	☐ Pancreatitis
☐ Thyroid disease	☐ Osteoporosis	☐ Hepatitis
-CANCER-	☐ Stroke	☐ Colon polyps
☐ Breast	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Skin	☐ Hay Fever	☐ Degenerative arthritis
☐ Prostate	☐ Asthma	☐ Glaucoma
☐ Colon	☐ COPD; Emphysema	☐ Depression
☐ Other: ______________	☐ Sleep Apnea	☐ Bipolar Disorder

Other medical problems not listed above:

____

____

____

Preventive Medicine Screening Tests (check all that apply – most recent month and year):

____ Colonoscopy __________ (month & year) ____ PAP Smear __________ (month & year)
____ Mammogram __________ (month & year) ____ PSA /Prostate Exam __________ (month & year)
____ Cholesterol test __________ (month & year) ____ Exercise Stress Test __________ (month & year)

Adult Immunizations:

____ Pneumonia __________ (month & year)
____ Chicken Pox / Shingles __________ (month & year)
____ Hepatitis A __________ (month & year)
____ Hepatitis B __________ (month & year)
____ Tetanus __________ (month & year)
____ Flu __________ (month & year)
____ Meningococcal __________ (month & year)

ALLERGIES ☐ NONE (INCLUDE allergies to medications and other medical products (examples: tape, latex, and iodine).

Name of Medicine or Product:	Description of Reaction:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

SURGICAL HISTORY ☐ None

Type of Surgery and Reason	Year

For women: PREGNANCY HISTORY # of pregnancies: _______ # of children: ________

FAMILY HEALTH HISTORY	AGE	HEALTH PROBLEMS/cause of death		AGE	HEALTH PROBLEMS/cause of death
Father		Living: ☐ Y ☐ N	**Children**		M F
Mother		Living: ☐ Y ☐ N			M F
Sibling		Living: ☐ Y ☐ N M F			M F
		Living: ☐ Y ☐ N M F			M F
		Living: ☐ Y ☐ N M F	**Grandmother** *Maternal*		Living: ☐ Y ☐ N
		Living: ☐ Y ☐ N M F	**Grandfather** *Maternal*		Living: ☐ Y ☐ N
		Living: ☐ Y ☐ N M F	**Grandmother** *Paternal*		Living: ☐ Y ☐ N
		Living: ☐ Y ☐ N M F	**Grandfather** *Paternal*		Living: ☐ Y ☐ N

HEALTH HABITS AND PERSONAL SAFETY Occupation: ______________________________

EXERCISE: How often: ____________________ Which Activities: ______________________________

Do you drink alcohol? ☐Yes ☐ No If yes, what kind? __________________________ How many drinks per week? _________

Do you use tobacco? ☐ Yes ☐No ☐ Cigarettes – pks./day ____ # of years ______ ☐ or year quit ________________

☐ Chew - #/day ______ Do you currently use recreational or street drugs? ☐ Yes ☐ No

I have received and read the clinic's Privacy Notice: ____________________ (initials)