Welcome to our office. Please fill out the information requested as completely as possible.
A copy of your driver's license or a photo ID and your insurance card is required for identification.

PATIENT DATA

Name _____ **Birthdate** _____ **Age** _____

S.S. # _____ **Male** **Female**

Race (circle one): Am. Indian Asian White Black/African American Native Hawaiian/Pacific Islander

Ethnicity (circle one): Hispanic Latino Other

Address _____ **City** _____ Zipcode _____

Phone # _____ **Wk. #** _____ **Cell#** _____

Email Address: _____

I prefer to be contacted by **(circle one)** **email** **phone** **cell phone** for my messages.

Marital Status: MARRIED DIVORCED SEPARATED SINGLE WIDOWED CHILD

RESPONSIBLE PARTY INFORMATION (For insurance and billing purposes)

Name _____ Date of Birth _____

Relationship to patient: SELF FATHER MOTHER CHILD GUARDIAN SPOUSE--Male or Female

Address _____ City _____ St._____ Zipcode _____

Name of guarantor on ins. card if different from resp. party name: _____

EMERGENCY CONTACT

Name _____ Relation: _____ Phone #:_____

How did you find out about our office? (Mark one please)

___Picked name from ins. book
___Auto assigned by ins. co.
___Heard Dr. speak at program
___Found our name on internet
___Referred from a friend
___Saw staff/physician at health fair
___Saw our providers at a sports physical event
___Received a flier in the mail
___From our website
___Referred from hospital
___Drove past our office

Preferred Pharmacy - Name and Cross streets _____

_____ _____
Signature of patient or parent/guardian Date

For office use only: Initials & Date: _____

ADULT HEALTH HISTORY FORM

NAME: _____ **DOB:** _____ **DATE:** _____

Past Medical History: **Please circle if YOU have now or have ever had any of these medical conditions**

Allergies Alzheimers Anemia Arthritis Asthma Breast Cancer Carotid Artery Blockage

Colon Cancer Coronary Artery Disease Congestive Heart Failure COPD Diabetes

Enlarged Prostate Fractures Gallstones GERD Headache-Migraines Heart Attack

Heart Palpatations High Cholesterol Hypertension Hypothyroid Lung Cancer Obesity

Osteoporosis Peptic Ulcer Disease Prostate Cancer Seizures Skin Cancer Stroke

Urinary Tract Infections-Frequent

Hospitalizations: **Please circle if YOU have ever been hospitalized for any of these medical conditions**

Asthma Congestive Heart Failure Coronary Artery Disease Diabetes COPD

Pneumonia Stroke Headache-migraine DVT

Preventative exams and tests:

When was your last colonoscopy?_____ Any history of an abnormal colonoscopy? Y N

When was your last EKG?_____ Any history of an abnormal EKG? Y N

When was your last DEXA Scan?_____ Any history of an abnormal DEXA? Y N

Men only:

When was your last PSA labwork done?_____ Any history of an abnormal PSA? Y N

Women only:

# of pregnancies _____ # of live births _____ Currently preganant? Yes or No

Birth control method now? _____ Age of 1st period _____ Age at menopause _____

When was your last pap smear?_____ Any history of an abnormal pap? Y N

When was your last mammogram?_____ Any history of an abnormal mammogram? Y N

Past Surgical History: Have you ever had surgery for the following (If yes, please state when)

Y	N		When	Y	N		When
		Appendix				Hernia Repair	
		Back				Hysterectomy	
		Biopsy				Joint Replacement	
		Cataract				Orthopedic Surgery	
		C-Section				Prostate removal--full	
		D & C				Prostate removal--partial	
		Gallbladder				Tonsils	
		Heart Bypass				Vasectomy	
		Heart Stent Placement				Other?	

Social History:

Occupation: Retired Not employed Never worked Current job: _____

Marital Status: Married Divorced Separated Single Widowed Child

Do you exercise regularly? **Y N** What kind of exercise?_____

How many days per week? _____ For how long each time? _____

CURRENT SMOKER? Y N If yes, please circle one below to indicate how much you smoke.

<10 cigarettes (1/2 pack/day) 10-20 cigarettes (1 pack/day) >20 cigarettes/day (2 pack/day)

How many years have you smoked?_____ Pk year calc (# of packs/day **X** yrs smoked)_____

PAST SMOKER? Y N If yes, <10 cigarettes or 10-20 cigarettes per day

<10 cigarettes (1/2 pack/day) 10-20 cigarettes (1 pack/day) >20 cigarettes/day (2 pack/day)

How many years did you smoke?_____ Quit date: _____

Pk year calc (# of packs/day **X** yrs smoked)_____

Do you currently drink alcohol? **Y N Never drank**

If yes, how much do you drink? #/day _____ #/week _____ #/month _____

Females: How many times in the past yr have you had more than 4 drinks in one day? _____

Males: How many times in the past yr have you had more than 5 drinks in one day? _____

Are you a recovering alcoholic? **Y N** Approx. quit date? _____

Do you use ilicit drugs (cocaine, marijuana, methampheatmines etc)? **Y N** If yes, how often? _____

If no, have you ever used ilicit drugs? **Y N** What kind? _____

Communicable Disease Please circle if YOU have now or have ever had any of these medical conditions

STDs: AIDS Chlamydia Condyloma (HPV) Gonorrhea Herpes HIV

Pelvic Inflammatory Disease Syphilis

Diseases: Cocci E. Coli Hepatitis A Hepatitis B Hepatitis C Influenza A

Influenza B Legionellosis Lyme Disease Measles Meningitis MRSA

Mumps Pertussis Shigellosis Trichinosis Tuberculosis Varicella(Chicken Pox)

Over the last month, how often have you been bothered by the following problems?

Little interest or pleasure in doing things Not at all Several days Nearly every day

Feeling down, depressed or hopeless Not at all Several days Nearly every day

Are you currently experiencing pain? YES NO

If yes, what is your pain on a scale of 1 - 10 with 10 being the worst _____

Family History: Do you have a parent or sibling with a history of the following?

Y	N		Relationship			
		Alcoholism	Mom	Dad	Brother	Sister
		Alzheimer's Disease	Mom	Dad	Brother	Sister
		Anxiety	Mom	Dad	Brother	Sister
		ADD	Mom	Dad	Brother	Sister
		Asthma	Mom	Dad	Brother	Sister
		Breast Cancer	Mom	Dad	Brother	Sister
		Colon Cancer	Mom	Dad	Brother	Sister
		Coronary Artery Disease	Mom	Dad	Brother	Sister
		Depression	Mom	Dad	Brother	Sister
		Diabetes	Mom	Dad	Brother	Sister
		Heart Attack	Mom	Dad	Brother	Sister
		Hepatitis C	Mom	Dad	Brother	Sister
		High Cholesterol	Mom	Dad	Brother	Sister
		Hypertension	Mom	Dad	Brother	Sister
		Lung Cancer	Mom	Dad	Brother	Sister
		Obesity	Mom	Dad	Brother	Sister

Review of Systems

Please circle below anything that you have experienced **REGULARLY or FREQUENTLY**.

General: fever chills fatigue general weakness

Eyes: visual disturbances eye irritation

Ears, Nose & Throat: runny nose sore throat nosebleeds ear pain trouble hearing

Heart: chest pain chest palpitation difficulty breathing on exertion passing out

Lungs: trouble breathing coughing spitting up phlegm wheezing

Breast: lumps skin changes drainage from the nipple

Abdomen: abdominal pain diarrhea constipation nausea vomiting

Urinary: urinating more than usual burning when urinating trouble holding urine retaining urine

Rectal: rectal bleeding black stools constipation change in firmness of stools

Genitals: vaginal discharge vaginal irritation irregular periods pain during intercourse testicular pain

Skin: rash moles that have recently appeared or changed in size or color

Neuro: headaches numbness or tingling weakness in one body part dizziness speech problems

Musculosketal: joint pain joint swelling neck pain joint deformity

Psych: trouble sleeping conflict in family or personal relationships that is sometimes handled by pushing/hitting/cruelty feeling depressed feeling anxious thoughts of hurting yourself/anyone else

Medication Allergies _____

Reaction _____

Medications Currently Taking:_____

_____

_____

_____

_____

Patient Portal Agreement

Desert Grove Family Medical provides this portal site in partnership with Cerner for the exclusive use of its established patients. The patient portal is designed to enhance patient-physician communications. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information.

The patient portal currently provides the following services: Communication of lab and other results from staff to patient, Ability for patient to review their Medical summary, Medication list, Treatment history and Visit Summaries. We will be considering adding other services in the future; this agreement will cover those services as well.

The patient portal is not intended to provide internet based diagnostic medical services. We currently are not accepting electronic communication from patients to Desert Grove Family Medical (emails). This service may be added at a later date in a limited capacity.

The patient portal is provided in partnership with Cerner, our Electronic Health Record software vendor and provider. The data is on a HIPAA compliant VPN with high level encryption that exceeds HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee that unforeseen adverse events cannot occur.

Please read our HIPAA policy for information on how private health information (PHI) is used at Desert Grove Family Medical. All new and established patients have signed HIPAA agreement forms and have been offered copies of our policies. These policies are also available on our website. If you would like a copy in another form, please let us know.

I acknowledge that I have read and fully understand this consent form. I am aware of the risks and benefits of patient portal and understand the risks of online communication between physician and patient. I consent to the conditions as outlined herein. I acknowledge that use of the portal is entirely voluntary and will not adversely affect the care I receive at Desert Grove Family Medical if I decide against using the portal. In addition, I agree to adhere to the policies set forth herein and on the Desert Grove Family Medical website as well as any other instructions or guidelines that my physician may impose on this online communication. I have been allowed to ask questions related to this consent agreement to my satisfaction. All of my questions have been answered to my satisfaction. My sign-on and continued use of the patient portal reflects my consent and agreement to this document in a continuing manner.

Email Address _____

Patient Signature _____ Date _____

For office use only:
Initials & Date: _____

Promise to pay note

- All patients are required to sign this form upon the first visit and it will remain in place as long as you are a patient in this office.

- We will send claims to all insurance companies that we are contracted with. If you have an insurance company that we are not contracted with, we will let you know before you are seen by a provider so you can make other arrangements for payment.

- We verify the eligibility of every patient on an HMO or AHCCCS plan at every visit. If you are on a PPO, POS, Indemnity or any other type of plan, we will make every attempt to verify your eligibility at each and every visit. However, if at a later date you become ineligible and the claim is denied by your health plan, you will be responsible for the bill. Ultimately, it is the responsibility of the patient to be sure they have adequate insurance for doctor's office visits.

- We expect that your account will be paid in full within 90 days of the date of service. We expect that you will be actively involved in facilitating the claims being processed by watching for statements from our office and from your insurance company.

My signature below indicates that I have read and understand the above changes in policy and consider this form to be a promise to pay note.

Printed patient name _____ Patient DOB _____

Patient/Guardian Signature _____

Relationship to patient _____

Date _____

For office use only:
Initials & Date: _____

DESERT GROVE
FAMILY MEDICAL

AUTHORIZATION FORM

Notice to patient regarding collection from insurance companies:

- We are authorized by HCFA, Champus, and OWCP to ask you for insurance information needed in the administration of the Medicare, Champus, FECA and black lung programs. Authority to collect information is in sections 205(A), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CPR 101 ET SEQ And 10 USC 1079 and 1086, 5 USC 8101 ET SEQ; And 30 USC 901 RT SEQ.

- The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies received are covered by these programs and to insure that proper payment is made.

- The information may also be given to other providers of service, carriers, and medical review boards within the HIPPA guidelines.

It is mandatory that you tell us if you are being treated for an employment related injury before you are seen.

Please initial each line and sign below to indicate your understanding of this process

_____ I authorize my insurance benefits be paid directly to Desert Grove Family Medical Group.

_____ I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

_____ I understand that it is ultimately my responsibility as a patient to ensure I am eligible with the insurance company that I have given to Desert Grove Family Medical Group. If my claim comes back as ineligible, I understand that I will be responsible for the bill. **(DGFM will verify eligibility each visit for patients on an HMO or AHCCCS plan. We will verify eligibility on all other insurances only at the first visit or the first time the patient is seen with a new insurance card)**

_____ I understand that it is ultimately my responsibility as a patient to make sure that my bill is paid by the insurance company. I understand that if I receive statements from DGFM or from my insurance company with unpaid balances that I will contact my insurance company and DGFM to help facilitate getting the claims paid.

_____	_____	_____
Printed Patient Name	Patient/Guardian Signature	Date

For office use only: Initials & Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE READ CAREFULLY

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

Uses and Disclosures of your protected health information:

• Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual.
• Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person.
• Protected health information contains specific information that identifies a person or can be used to identify a person.
Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. Desert Grove Family Medical, can act as each of the above business types. This medical information is used by Desert Grove Family Medical, in many ways while performing normal business activities.
• Your protected health information may be used or disclosed by Desert Grove Family Medical, for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. Desert Grove Family Medical, may use or disclose your health information for case agreement and services. Desert Grove Family Medical, may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.
• Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.
• Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

Reporting abuse of children, adults, or disabled persons.
Investigations related to a missing child.
Internal investigations and audits by the department's divisions, bureaus, and offices.
Investigations and audits by the state are Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
District medical examiner investigations.
Research approved by the department.
Court orders, warrants, or subpoenas.
Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Individual Rights

You have the right to request Desert Grove Family Medical, to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The DGFM privacy department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. Desert Grove Family Medical, may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the DGFM privacy department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. Desert rove Family Medical, may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department,
- Is not protected health information,
- Is by law not available for your inspection, or
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures Desert Grove Family Medical, may have made of your protected health information. This summary does **not** include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures for health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to [Practice decides date here].

This summary **does** include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6-year period from the date of your request. If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

Complaints

You have the right to express complaints to the provider and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the provider by contacting the provider's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The provider's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. Complaints against the provider can be mailed to Desert Grove Family Medical - Privacy Officer:
1855 N. Stapley Dr. Mesa, AZ 85203

Effective Date

This Notice of Privacy Practices is effective beginning March 28, 2011, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

By signing below you acknowledge that you have read and understand the privacy practices of Desert Grove Family Medical.

Patient Printed Name: _____

Patient Date of Birth: _____

Patient or Guardian Signature: _____

Today's Date: _____

For office use only:
Initials & Date: _____

DESERT GROVE FAMILY MEDICAL

I hereby authorize the doctor to perform indicated and necessary procedures, diagnostic studies or treatment. I understand that it is my responsibility to either pay the fees or to be sure that my insurance is not more than 60 days delinquent in paying the bill. I agree to pay the necessary co-pay or percent at the time of the service.

_____ _____

Signature of patient or parent/guardian Date

The Arizona Department of Health Services licenses this office.

As required by Arizona Department of Health rules and other statutes, rules and requirements, this office has provided you with a copy of your Patient Rights. By your signature below, you acknowledge receipt of your Patient Rights.

Per my request, I read the laminated copy of the patient rights in the office and do not want to take a copy home with me._____

Per my request, I was given a paper copy of the patient rights to take home with me_____

Printed Name: _____

DOB: _____

Relationship to Patient: _____

Signature: _____

Date: _____

For office use only:
Initials & Date: _____

Release Form for Individuals Involved in Care of Patient

I, _____ give Desert Grove Family Medical permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans, and payment for health services I receive.

This consent is valid until such time as I provide a written revocation of it.

This office may speak with:

Name: _____

Relationship: _____

Information to be released:

☐ Treatment ☐ Diagnosis ☐ Schedule ☐ Payment ☐ Other:_____

Name: _____

Relationship: _____

Information to be released:

☐ Treatment ☐ Diagnosis ☐ Schedule ☐ Payment ☐ Other:_____

Patient Signature: _____

Date: _____

Account #: _____

For office use only:

Initials & Date: _____

ADVANCE DIRECTIVES

Please choose one:

[ ] I brought my Living Will/Durable Power of Attorney today and I would like a copy put in my medical record.

[ ] I do not wish to have any advance directives on file.

[ ] Please give me the following forms to review. I will read the information and decide if I want to bring them back into the office and keep on file.

_____Advanced Directives Info and FAQ

_____Power of Attorney Form

_____Mental Power of Attorney Form

_____Living Will Form

_____DNR (Do Not Resuscitate) Form (leave this one filled out and in plain sight at home).

_____	_____	_____
Printed Name	Signature	Date

For office use only:
Initials & Date: _____