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: _____

CHILD HEALTH HISTORY FORM

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

Past Medical History: **Please circle any condition listed below that your child has now or has ever had:

Allergies Anemia Asthma Attention Deficit Disorder Bed Wetting
Chicken Pox Croup Ear Infections-Frequent Fractures Obesity
Pneumonia RSV Rotovirus Skin Dryness Urinary Tract Infection-Frequent

Hospitalizations: Please list any hospitalizations for your child and the dates

_____ Date _____

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

Y	N		When	Y	N		When
		Appendix				Joint Surgery	
		Biopsy				Pyloric Stenosis	
		Circumcision				Scoliosis Surgery	
		Ear Tubes				Strabismus	
		Frenulectomy				Tonsils	
		Hernia Repair		Other?			

Social History:

Parents marital status: **married** **separated** **divorced** **widowed** **unmarried-living together** **unmarried**

Name of Guardian/Person child lives with _____ Relationship _____

If child is not living with natural parents, what are the living arrangements? (circle one)

Adopted CPS Foster Care Other_____

Mother's occupation: _____ Father's occupation: _____

Is the child exposed to tobacco smoke on a regular basis? **Y** **N**

Which applies best to the child's daily activities? Daycare Preschool Grade Level _____

Date of last dental exam: _____

For children 12 yrs and older:

Do you currently smoke tobacco? **Y** **N** **Never smoked** If yes, how much per day? _____

Do you currently drink alcohol? **Y** **N** **Never drank** If yes, how often do you drink _____

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

Family History: Does the child have a parent or sibling with a history of the following?

Y	N		Relationship			
		Anxiety	Mom	Dad	Brother	Sister
		ADD	Mom	Dad	Brother	Sister
		Asthma	Mom	Dad	Brother	Sister
		Depression	Mom	Dad	Brother	Sister

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

Medication Allergies _____

Reaction _____

CONSENT FOR TREATMENT OF A MINOR

I, _____ who is legal guardian of _____ give permission for my child, who is under the age of 18, to be treated at Desert Grove Family Medical without myself being present. I authorize _____ (who is over the age of 18) to bring my child into the office to have medical treatment. I assume the responsibility of informing the above listed adult of any allergies or adverse reactions to any medications my child may have.

I also understand that it is up the discretion of the medical provider who is performing the care to determine if the instructions which are given to the patient necessitate the guardian being present and that the treatment of the minor child may deferred until I can be available.

_____ _____

Guardian Signature Date

This consent is valid for six months from the date of this signature.

For office use only: Initials & Date: _____

Patient Portal Agreement

Desert Grove Family Medical provides this portal site in partnership with /ŜℕyŜℕ 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 /ŜℕyŜℕ, our Electronic Health Record software vendor and provider. The data is on HIPAA compliant VPN with high fŜØŜf ŜyŎℕèLJűƛ2y˝úKl·ű ŜÈŎŜŜŘă IŁt!! ăűl·yŘl·ℕŘă¢ While we believe that the IT infrastructure and data are safe l·yŘ ăŜŎdzℕŜƶ ƛű Ř2Ŝă y2ű ∃dzl·ℕl·yűŜŜ űKl·ű 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: _____

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.