Patient Registration

PATIENT INFORMATION – PLEASE MAKE SURE EVERY LINE IS COMPLETE

Patient Name: ____________________________________ Preferred Name: ______________________ DOB: ___________

Address: ____ Zip: _____________

Cell phone: ________________________________ Home: ____________________________ SSN: _____________________

Email address for My Chart Patient Portal: ____

Birth sex: ___________ Current Gender: ____________ Gender Identity: ____________Preferred Pronoun:_______________

Marital Status: __________________________________ Spouse's Name: ____

Race: ____ Ethnicity: ____

Primary Care Physician: ____ Referred By: ___________________________

Other Providers Involved in Your Care:____

Employer: ____ Occupation: _______________________________________

Employment status: _____________________________________ Birth state: _______________________________________

Emergency Contact:______________________ Phone number:_________________Relationship:_____________________

I prefer to be contacted in the following manner (check all that apply):

☐ Cell Phone: ☐ Detailed Message OR ☐ Callback Number Only

☐ Home Phone: ☐ Detailed Message OR ☐ Callback Number Only

☐ Work Phone: ☐ Detailed Message OR ☐ Callback Number Only

☐ Written Communication: I give my consent to be contacted in the following ways:

☐ Mail to Home ☐ Email to: ____ ☐ Fax to: _________________________

Pharmacy Name:____Cross Streets:_______________________________

_____ (Initials) ACS providers may prescribe medications electronically.
By initialing, you give ACS permission to access your prescribed medications.

INSURANCE INFORMATION – PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST

Primary Insurance: ____ ID: ______________________ Group: _____________

Insurance Company Address:____

Policy Holder: __________________________________ **DOB**: _________ Relationship to patient: _____________________
(If other than the patient)

Secondary Insurance: ____ ID: _________________________ Group: ___________

Policy Holder: __________________________________ DOB: _____________ Relationship to patient: __________________
(If other than the patient)

Date of injury: _________________________________ Do you have AHCCCS? _____ Yes ____ No
(If Workers Comp)

PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Omnibus Rules of 2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or had the opportunity to review the Notice of Privacy Practices from Arizona Community Specialists ("ACS"), which contains a more complete description of the uses and disclosures of my health information. I understand that ACS has the right to change its Notice of Privacy Practices from time to time and that I may contact ACS at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that ACS restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand ACS is not required to agree to my requested restrictions, but if ACS does agree then ACS is bound to abide by such restrictions.

ACS does not discriminate based on race, age, sex, sexual orientation, or ethnicity.

REQUEST FOR CONFIDENTIAL COMMUNICATION

HIPAA privacy rules give certain individuals the right to request confidential medical information. In that regard, you may select the method in which this confidential medical information is communicated. Also, ACS may need to communicate with you regarding your confidential medical information. Please select your preferred method of contact. If you would like to change your contact information in the future, please provide your request in writing to the address contained within the Privacy Practice Notice.

I give permission to disclose my confidential medical information to the following individuals:

Printed Name: ____________________________________ Relationship: ______________________________________

Printed Name: ____________________________________ Relationship: ______________________________________

Printed Name: ____________________________________ Relationship: ______________________________________

I attest that the information provided above is true and accurate. I acknowledge that I have read, signed, and will abide by the Arizona Community Specialists, P.C. "Patient Payment and Financial Policies". I give ACS my consent to access my pharmacy/medication records.

Patient's signature: ____ Date: ______________ (Parent/guardian if patient is a minor)

____

Patient Printed Name

ACS OFFICE USE ONLY:
I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:
Date: ______________________________ Employee Name: ____
Reason: ____

Patient Registration

MEDICAL HISTORY

Please fill out the form in its entirety if not applicable please mark N/A

Age_____**Height__________Weight__________**

Reason for your visit today? __________________________________ Referring Doctor____________________

Is the reason for visit accident related (provide details):____

If needed, I consent to the transfusion of a Blood/Blood products: YES_____ NO_____

Have you ever been diagnosed with: **C-Diff** Y___N___ HIV Y___N___ **Hep B** Y____N____ **Hep C** Y____N____

Do you have an active or history of MRSA/VRE infection: YES ____ NO____ Current______ History of______

CURRENT MEDICAL PROBLEMS (e.g., high blood pressure, diabetes)

MEDICATIONS/SUPPLEMENTS TAKEN REGULARLY	**AND REASON**

MEDICINE/FOOD ALLERGIES	**AND REACTION**

PAST MEDICAL AND SURGICAL HISTORY

DISEASE/ILLNESS	YEAR DIAGNOSED	PROCEDURE/SURGERY	YEAR OF PROCEDURE

ARIZONA COMMUNITY SPECIALISTS

Patient Registration

FAMILY HISTORY

e.g. cancer, heart disease, diabetes for **maternal/paternal** grandparent, parent, sibling, children

FAMILY MEMBER	DISEASE

TOBACCO USE: YES NO FORMER Never Type________________ Years used_____ Units per day_____ **VAPING:** YES NO Never Frequency______________ **ALCOHOL USE:** YES NO FORMER Never: Frequency ___________	PHARMACY NAME CROSS STREETS PHONE NUMBER

ARIZONA COMMUNITY SPECIALISTS

Patient Registration

REVIEW OF SYSTEMS

Date/Year of Last Mammogram: ____________________ Date/Year of Last Colonoscopy: ______________________

Are you currently experiencing any of the following: Please mark **YES** or **NO** for each

Y	N	Constitution
		Activity Change
		Appetite Change
		Chills
		Diaphoresis (excessive sweating)
		Fatigue
		Fever
		Unexpected weight change

Y	N	HENT
		Congestion
		Dental problem
		Drooling
		Ear discharge
		Ear pain
		Facial swelling
		Hearing loss
		Mouth sores
		Nosebleeds
		Postnasal drip
		Rhinorrhea (runny nose)
		Sinus Pain
		Sinus pressure
		Sneezing
		Sore throat
		Tinnitus (ringing ears)
		Trouble swallowing
		Voice change

Y	N	Eyes
		Eye discharge
		Eye itching
		Eye pain
		Eye redness
		Photophobia (light sensitivity)
		Visual disturbance

Y	N	Respiratory
		Apnea (stop breathing)
		Chest tightness
		Choking
		Cough
		Shortness of breath
		Stridor (noise when breathing)
		Wheezing

Y	N	Cardio
		Chest pain
		Leg swelling
		Palpitations

Y	N	Endocrine
		Cold intolerance
		Heat intolerance
		Polydipsia (Increased thirst)
		Polyphagia (increased hunger)
		Polyuria (increased urination)

Y	N	GI
		Abdominal distention (swelling)
		Abdominal pain
		Anal bleeding
		Blood in stool
		Constipation
		Diarrhea
		Nausea
		Rectal pain
		Vomiting

Y	N	Musculoskeletal
		Arthralgias (stiffness)
		Back pain
		Gait problem
		Joint swelling
		Myalgias (muscle pain)
		Neck pain
		Neck stiffness

REVIEW OF SYSTEMS – 2

Y	N	Skin
		Color Change
		Pallor (paleness)
		Rash
		Wound

Y	N	GU
		Dysuria (difficulty urinating)
		Enuresis (involuntary urination)
		Flank pain (side pain)
		Frequency
		Genital sore
		Hematuria (blood in urine)
		Penile discharge
		Penile pain
		Penile swelling
		Scrotal swelling
		Testicular pain
		Urgency
		Urine decreased
		Dyspareunia (painful sex)
		Menstrual Problem
		Pelvic Pain
		Vaginal Bleeding
		Vaginal Discharge
		Vaginal Pain

Y	N	Alleg/Immuno
		Environmental Allergies
		Food Allergies
		Immunocompromised

Y	N	Neurological
		Dizziness
		Facial asymmetry
		Headaches
		Light headedness
		Numbness
		Seizures
		Speech difficulty
		Syncope (fainting)
		Tremors
		Weakness

Y	N	Hematologic
		Adenopathy (enlarged lymph nodes)
		Bruises/bleeds easily

Y	N	Psychiatric
		Agitation
		Behavior problem
		Confusion
		Decreased Concentration
		Dysphoric mood (unease)
		Hallucinations
		Hyperactive
		Nervous/anxious
		Self-injury
		Sleep Disturbance
		Suicidal Ideas

Patient Registration

SIGNATURE

Patient Name: ____Date of Birth:___________________________

Address:____

Arizona Community Specialists (ACS) Attestation
I acknowledge I have received the documents from Arizona Community Surgeons and consent to the following: (initials and signatures required):

_______ Notice of Privacy and HIPAA

_______ Prescriptions and Narcotics Agreement

_______ Code of Conduct for Patients, Parents and Visitors

_______ ACS Finance Policy I have read and agree to this Payment Policy, Assignment and Release of Information stated in the policy. I acknowledge my financial responsibility related to the services provided by Arizona Community Specialists.

_______ I give ACS permission to obtain my medication history

_______ I hereby consent to the clinical exam and treatment to be provided.

_______ I give ACS permission to bill my insurance company for services and/or product(s) received on my behalf. (if applicable).

My signature is acknowledgement of receipt of these documents. I understand I am responsible for reviewing and understanding the information provided by ACS and agree to comply. My signature confirms the information provided to ACS is true and accurate. I give ACS permission to bill my insurance company for services and/or product(s) received on my behalf. (if applicable). I acknowledge typing my name below constitutes an electronic signature.

____

Patient Signature   Date