PATIENT INFORMATION

Name: _____ _____ _____
Last First Middle

Status: (check box)
☐ Single
☐ Married
☐ Other

Name you prefer to be called: _____

Sex: ☐ Male ☐ Female

Date of Birth: _____

Social Security Number (SSN): _____

Race: ☐American Indian/Alaskan Native ☐Black or African American ☐Patient Declined to Disclose
☐Asian ☐Native Hawaiian or other Pacific Islander ☐White

Ethnicity: ☐Hispanic or Latino ☐Non Hispanic or Latino ☐Patient Declined to Specify

ARIZONA ADDRESS

Mailing Address: _____ Apt / Space #: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Emergency: _____

Text appointment reminders to my cell phone? **YES** / **NO**

Email Address: _____

Do you leave the valley for the summer? ☐ YES ☐ NO

From what months do you leave? _____ (Month) to _____ (Month)

NOTE: If you leave for the summer, complete the following information. Otherwise leave it blank.

OUT OF STATE ADDRESS

Mailing Address: _____ Apt / Space #: _____

City/State: _____ Zip Code: _____

Home Phone: _____

EMPLOYMENT

Place of Employment: _____

Employer Address: _____
(Street) (City) (State/Zip)

Work Phone: _____

PATIENT MEDICAL HISTORY ***Please check all that apply***

☐ AIDS/HIV	☐ Gout	☐ Liver Disease
☐ Arthritis	☐ Heart Disease	☐ Lung Disease
☐ Bleeding Problems	☐ Hypertension/High Blood Pressure	☐ Ulcers
☐ Diabetes	☐ Kidney Problems	☐ Other

LIST ALL SERIOUS INJURIES, ILLNESSES, OR SURGERIES

Injury/Illness/Surgery & Reason	Hospitalized (Y/N)	Year

CURRENT MEDICATIONS

1.

2.

3.

MEDICATION ALLERGIES

1.

2.

3.

4.

PERSONAL HABITS

- **Do you smoke?** ☐ Yes ☐ No If yes, how much? # of packs/day _____ # of years _____
- **Do you use smokeless or chewing tobacco?** ☐ Yes ☐ No If yes, how often and for how long?_____
- **Do you drink alcohol?** ☐ Yes ☐ No If yes, how long and how much?_____
- **Are you currently pregnant?** ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

	Deceased	Age	Cause of Death
Father	☐ Yes ☐ No		
Mother	☐ Yes ☐ No		
Siblings	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Family Physician: _____ **Phone Number:** _____
Pharmacy: _____ **Phone Number:** _____

Are you Diabetic? ___ **No** ___ **Yes** **A1C**_____ **Cross Streets:** _____
Height: _____ **Weight:** _____ **Shoe Size:** _____

Patient Name: _____ **Date of Birth:** _____

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Ins Co Name:		Ins Co Name:	
Insured Patient Name		Insured Patient Name:	
ID# Group#		ID# Group#	
Claim Mailing Address:		Claim Mailing Address	
*HMO___ PPO___ Other ____ Specialist Co-Pay $_____		*HMO___ PPO___ Other ____ Specialist Co-Pay $_____	
Relationship to Patient:	☐ M ☐ F	Relationship to Patient:	☐ M ☐ F
Insured's Date of Birth:		Insured's Date of Birth:	
Insured's Employer:		Insured's Employer:	
Insured's SSN:		Insured's SSN:	

*****PLEASE ALLOW US TO MAKE A COPY OF YOUR INSURANCE CARD(S) AND PHOTO ID*****

***If you have an HMO Plan – your insurance requires you to have a referral from your Primary Care Physician (PCP). Each visit verify that we have a current referral on file to avoid being billed for your services.**

Some insurance companies and plans require a Prior Authorization before certain services are provided. Be familiar with your coverage and let us know if a prior authorization is needed for your services.

How did you hear about our office? _____

I certify that the above information provided is accurate to the best of my knowledge.

Printed Name of Patient/Guardian: _____

Patient/Guardian Signature: _____ **Date:** _____

Patient Name: _____ **Date of Birth:** _____