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Internal Medicine

New Patient Registration Form

Please Print

Today's Date:	

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)				Name Normally Used (Nickname)
Address	Apt. No.	City	State	Zip
E-mail	Home Phone	Work Phone	Cell Phone	
Social Security No.	Sex	Marital Status	Date of Birth	Driver's License No. / State Issued
Employer Name	Employer City	Employer State	How Did You Hear About Us?	

List anyone you authorize this office to share your medical information with (name and relationship to you)

Permitted Contact Method(s) (circle all that apply) home phone cell phone work phone mail e-mail	Ok to leave message on answering machine/voicemail? Yes___ No___

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work phone	Cell Phone

INSURANCE INFORMATION

Primary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name/Parent's Name (if patient a child) D.O.B.	Policy Holder's Social Security No.	
Secondary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name		

EMERGENCY INFORMATION

Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone

INFORMATION FOR THE PATIENT

I have read and agree to the payment policy. I understand that payment is my responsibility regardless of insurance coverage. I understand that all co-pays and deductible amounts (if known) are due at the time of service and that any deductible amounts remaining will be billed to me as stated on the explanation of benefits provided by my insurance company for services rendered. I hereby assign to edicineIM all money to which I am entitled for medical expenses related to the services performed from time to time by edicineIM, but not to exceed my indebtedness to edicineIM. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to edicineIM. I authorize any holder of medical information about me to release to CMS and its agents any information

Patient/ Guarantor Signature: _____Date:_____

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General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Payment Agreement

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to edicineIM, all insurance or third party payments that I receive for services rendered to me immediately upon receipt. **Patient Initial:** _____

Medicare Lifetime Authorization - I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to edicineIM. **Patient Initial:** _____
I request this authorization also apply to all other insurance. **Patient Initial:** _____
I acknowledge that I have been given edicineIM's Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the edicineIM Office Manager at 480-488-8020. **Patient Initial:** _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

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A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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Name _____ Date _____

Health History for New Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit:_____

Other concerns: _____

What are your health goals for the next year?_____

Where were you getting your care before?_____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? □ No □ Yes
Feeling down, depressed or hopeless? □ No □ Yes

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
___Unexplained weight loss / gain
___Unexplained fatigue / weakness
___ Fall asleep during day when sitting
___ Fever, chills
___ No problems

Skin
___ New or change in mole
___ Rash / itching
___ No problems

Breast
___ Breast lump / pain / nipple discharge
___No problems

Ears/Nose/Throat
___ Nosebleeds, trouble swallowing
___ Frequent sore throat, hoarseness
___ Hearing loss / ringing in ears
___ No problems

Eyes
___ Change in vision / eye pain / redness
___ No problems

Cardiovascular
___Chest pain / discomfort
___ Palpitations (fast or irregular heartbeat)
___ No problems

Respiratory
___ Cough / wheeze
___ Loud snoring / altered breathing during sleep
___ Short of breath with exertion
___ No problems

Gastrointestinal
___ Heartburn / reflux / indigestion
___ Blood or change in bowel movement
___ Constipation
___ No problems

Genitourinary
___ Leaking urine
___ Blood in urine
___ Nighttime urination or increased frequency
___ Discharge: penis or vagina
___ Concern with sexual function
___ No problems

Musculoskeletal
___ Neck pain
___ Back pain
___ Muscle / joint pain _____
___ No problems

Endocrine
___ Heat or cold sensitivity
___ No problems

Hematologic/Lymphatic
___ Swollen glands
___ Easy bruising
___ No problems

Neurological
___ Headache
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness / tingling
___ Unsteady gait
___ Frequent falls
___ No problems

Allergic/Immune
___ Hay fever / allergies
___ Frequent infections
___ No problems

Psychiatric
___ Anxiety / stress / irritability
___ Sleep problem
___ Lack of concentration
___ No problems

Women only
___ Pre-menstrual symptoms (bloating cramps, irritability)
___ Problem with menstrual periods
___ Hot flashes / night sweats
___ No problems

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. □

Tetanus (Td) _____ With Pertussis (Tdap)_____Varicella (Chicken Pox) shot *or* illness_____Pneumovax (pneumonia) _____

Influenza (flu shot)_____Hepatitis A_____Hepatitis B_____MMR_____Meningitis _____ Zostavax (shingles)_____HPV _____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

□ TAKE NO MEDICATIONS

Medication Dose (e.g. mg/pill) How many times per day?

_____

_____

_____

Allergies or intolerance to medications (include type of reaction): _____

_____ □ NONE

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)	Date _____	Abnormal?	□ No	□ Yes
Sigmoidoscopy or Colonoscopy (circle one)	Date _____	Polyp?	□ No	□ Yes
Women only:				
Mammogram	Date _____	Abnormal?	□ No	□ Yes
Pap Smear	Date _____	Abnormal?	□ No	□ Yes
Bone Density Test	Date _____	Abnormal?	□ No	□ Yes

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions? □ NONE

Condition	*Code*	*Current*	*Past*	*Comments*
Alcohol / Drug abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder / Kidney Problems				
Blood Clot (leg)	453.40			
Blood Clot (lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulosis	562.10			
Emphysema	492.8			
Fractures (broken bones)				Where?
Gallbladder Disease	574.20			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			
Glaucoma	365.9			

PERSONAL MEDICAL HISTORY Continued: *Condition*	*Code*	*Current*	*Past*	*Comments*
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Gynecological Conditions (Other)				
Heart Attack	410.90			
Hepatitis – Type A	070.1			
Hepatitis – Type B	070.30			
Hepatitis – Type C	070.51			
Hepatitis – Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease / Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive) / Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (list)				
Other (list)				

SURGICAL HISTORY – Please check off any procedure or surgeries. List any abnormal finding or complications. □ NONE

Surgical Procedure	*Code*	*Yes*	*Year*	*Comments*
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal

SURGICAL HISTORY Continued: *Surgical Procedure*	*Code*	*Yes*	*Year*	*Comments*
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation ("Tubal")				
Ovary Removal				Circle: Right Left Both
Vasectomy				
Sigmoidscopy				
Sinus Surgery				
Other (list)				

Adopted – Yes No (Please Circle) If yes and you do <u>not</u> know your family history skip this section and continue to page 5 (Other Health Issues)

FAMILY HISTORY – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

OTHER HEALTH ISSUES:

Tobacco Use
Smoke cigarettes: □ Never □ No □ Yes
(If you never smoked please go to alcohol use question now)

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

Approximately how many packs a day did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____

Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use
Do you drink alcohol? □ No □ Yes

# of drinks/week: _____ □ Beer □ Wine □ Liquor

Drug Use

Do you use marijuana or recreational drugs? □ No □ Yes
Have you ever used needles to inject drugs? □ No □ Yes

Sexual Activity
Sexually involved currently: □ No □ Yes
Sexual partner(s) is/are/have been: □ male □ female
Birth control method (circle below all that apply): □ None needed
Condom, pill, diaphragm, vasectomy, other _____

Exercise: Do you exercise regularly? □ Yes □ No
What kind of exercise? _____
_____

How long (minutes)?_____How often? _____

Diet: How would you rate your diet? □ Good □ Fair □ Poor
Would you like advice on your diet? □ No □ Yes

Safety: Do you use a bike helmet? □ No bike □ Yes □ No
Do you use seatbelts consistently? □ Yes □ No
Does your home have a working smoke detector? □ Yes □ No

If you have guns in your home, are they locked up?
□ Not applicable □ Yes □ No
Is violence at home a concern for you? □ No □ Yes

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?
(Circle above all that apply) □ Yes □ No

SOCIAL HISTORY:

Occupation (or prior occupation):_____retired/unemployed/leave of absence/disabled (circle one)

Employer:_____Years of education or highest degree: _____

Marital status (circle one): single, partner, married, divorced, widowed, other: _____

Spouse/partner's name:_____Number of children:_____Ages if under 18 years: _____

Number of grandchildren: _____ Number of great grandchildren: _____

Who lives at home with you? _____

Leisure activities, group involvement, religion, volunteer work, recent travel: _____

_____

_____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

Thank-you for taking the time to complete this form.

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FINANCIAL POLICY

Patient Name: _____ **Account #:** _____
Social Security #: _____

Name of Guarantor (if different from Patient): _____
Social Security #: _____

It is edicineIM's policy to inform you of our patient payment policy. Please review the section below that is applicable to you.

Patient Without Insurance (Private Pay):
Please make payment for your care at each patient visit. If payment cannot be made at each visit, the front desk staff will assist you in completing the form below for other edicineIM approved financial arrangements.

edicineIM Does Not Participate With All Healthcare Plans: (Please ask if edicineIM is in-network with your Health Plan)

Insurance Deductible: Each year many patients have to pay their annual deductible amount before their insurance pays for medical services provided. These payments are due at the time of service.

I have read and agree to the financial policy stated above that applies to me and I agree to the financial arrangements as outlined on the form below.

X _____
Patient or responsible party signature **Date**

_____
Signing on behalf of patient (please print name) and list reason why patient cannot sign themselves.

_____
Relationship to patient **Address** **Phone**

FINANCIAL ARRANGEMENT STATEMENT

I agree to make_____equal payments on the 1st or 15th of each month in the amount of $_____, for a total of $_____. If I am unable to make my payment(s), I will call edicineIM patient accounts at (480) 488-8020 to inform them and discuss my next payment.

I authorize edicineIM to charge my credit card monthly on or about the 1st or 15th in the amount of $_____(and/or less for the remaining balance) for dates of service from____/____/____to ____/____/____.

_____
Cardholder signature **Date**

Patient Name_____
Cardholder Name_____
_____ Cardholder Address_____
_____ City_____
State_____ZIP _____

_____
Credit Card Number **Expiration Date** **3 Digit Security Number**

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Commercial

Patient: _____ Insurance Company: _____

- You are receiving this notice because your insurance company may not pay for all of the services that you received during your visit to our office.

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask questions.

Supplies and services	Reason insurance may not pay	Estimated cost

_____YES, I want to receive these services. If my commercial insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for non-payment by my insurance carrier.

_____NO, I have decided not to receive these services.

_____OTHER, Should I decide to request these services in the future, I understand I will be charged and am responsible for payment in full.

By signing this notice you agree to take financial responsibility for the cost of the supplies and services listed above should your insurance company deny coverage for the listed items.

_____ _____/_____/_____

Patient / Responsible Party Signature **Date**

edicineIM
34597 N 60th Street, Suite 110
Scottsdale, AZ 85266-5240
Ph: 480.488.8020 Fx: 480.264.6404

Initial _____