☐ New Patient ☐ Updated Information

PATIENT INFORMATION

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Today's Date:_____Allergies:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Race: ☐Native American, Eskimo ☐Asian/Pacifier Islander ☐Black ☐Multi-Racial ☐White ☐Other ☐Unknown

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown ☐Other Interpreter Needed ☐Yes ☐No

Is this your Legal Name? ☐Yes ☐No

Mailing Address: _____ City: _____

State: _____ Zip Code:_____

Social Security Number: _____ Email Address (Optional): _____

Home Phone:_____ Cell Phone:_____

Referred to Clinic by: _____

Current Primary Care Provider: _____

EMPLOYMENT

Employment Status: ☐Full Time ☐Part-time ☐Not Employed ☐Self-Employed ☐Retired ☐Other _____

If Applicable, Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Student Status: ☐Full-time ☐Part-time ☐Not a Student

INSURANCE

Responsible Party to Pay: _____ Birth date of Responsible Party:_____

Address of Responsible Party, (if different):_____

Phone Number of Responsible party:_____

Primary Insurance Name of Insurance:_____

Subscriber's Name, if different: _____Subscriber's SSN: _____

Subscriber's Birth Date: _____ ID#:_____ Group #:_____

Patient's Relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance (If applicable) Name of Insurance:_____

Subscriber's Name, if different: _____Subscriber's SSN: _____

Subscriber's Birth Date: _____ ID#:_____ Group #:_____

Patient's Relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

EMERGENCY CONTACT

Name of Emergency contact person: _____ Relationship to Patient: _____

Home Phone Number:_____ Work Phone Number:_____

The above information is true to the best of my knowledge. I authorize Arizona Bleeding Disorders Health & Wellness Center to treat me. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance.

_____ _____

Patient/Guardian Date

MEDICAL HISTORY

If your answer is "Yes" to a question, please explain on the line following the question.

None	☐ Yes ☐ No	_____
Thyroid Problems	☐ Yes ☐ No	_____
Seizures	☐ Yes ☐ No	_____
Stroke	☐ Yes ☐ No	_____
Asthma	☐ Yes ☐ No	_____
C.O.P.D.	☐ Yes ☐ No	_____
Sleep Apnea	☐ Yes ☐ No	_____
Coronary Artery Disease	☐ Yes ☐ No	_____
Congestive Heart Failure	☐ Yes ☐ No	_____
Chest Pain	☐ Yes ☐ No	_____
High Blood Pressure	☐ Yes ☐ No	_____
Elevated Cholesterol	☐ Yes ☐ No	_____
Heart Attack	☐ Yes ☐ No	_____
Implantable Devices	☐ Yes ☐ No	_____
Cardiac Arrhythmia	☐ Yes ☐ No	_____
Rheumatic Fever	☐ Yes ☐ No	_____
Diabetes	☐ Yes ☐ No	_____
Liver Problems	☐ Yes ☐ No	_____
Stomach Problems	☐ Yes ☐ No	_____
Irritable Bowel Syndrome	☐ Yes ☐ No	_____
Reflux (G.E.R.D.)	☐ Yes ☐ No	_____
Kidney Problems	☐ Yes ☐ No	_____
Incontinence of Urine	☐ Yes ☐ No	_____
Genitourinary Problems	☐ Yes ☐ No	_____
Osteoporosis	☐ Yes ☐ No	_____
Back or Neck Problems	☐ Yes ☐ No	_____
Arthritis	☐ Yes ☐ No	_____
Skin Problems	☐ Yes ☐ No	_____
Anemia	☐ Yes ☐ No	_____
Blood Disorder	☐ Yes ☐ No	_____
M.R.S.A. / V.R.E	☐ Yes ☐ No	_____
Tuberculosis	☐ Yes ☐ No	_____
C-difficile	☐ Yes ☐ No	_____
Hepatitis	☐ Yes ☐ No	_____
HIV or AIDS	☐ Yes ☐ No	_____
STDs	☐ Yes ☐ No	_____
Depression	☐ Yes ☐ No	_____
Anxiety	☐ Yes ☐ No	_____
Eating Disorder	☐ Yes ☐ No	_____
Menstrual Problems	☐ Yes ☐ No	_____
Abnormal Pap Smear	☐ Yes ☐ No	_____
Cancer	☐ Yes ☐ No	_____
Other Medical Problems	☐ Yes ☐ No	_____
Hospitalizations	☐ Yes ☐ No	_____
Are immunizations on schedule	☐ Yes ☐ No	_____
Previous reaction to immunizations	☐ Yes ☐ No	_____

SURGICAL HISTORY

If your answer is "Yes" to a question, please explain on the line following the question.

None	□ Yes □ No	_____
Appendectomy	□ Yes □ No	_____
Breast Biopsy	□ Yes □ No	_____
Cholecystectomy	□ Yes □ No	_____
Coronary Artery Bypass	□ Yes □ No	_____
Hernia	□ Yes □ No	_____
Hip Replacement	□ Yes □ No	_____
Hysterectomy	□ Yes □ No	_____
Knee Replacement	□ Yes □ No	_____
Other surgical procedures	□ Yes □ No	_____

MEDICATIONS

Please list all the medications you are taking, including any vitamins, herbal medicines, and "over-the-counter" medication

HEALTH RISK PROFILE

If your answer is "Yes" to a question, please explain on the line following the question.

Latex Allergy Risk	□ Yes □ No	_____
Allergic to latex	□ Yes □ No	_____
Reaction to a medical procedure	□ Yes □ No	_____
Reaction to a dental procedure	□ Yes □ No	_____
Allergic to bananas	□ Yes □ No	_____
Allergic to kiwis	□ Yes □ No	_____
Allergic to avocados	□ Yes □ No	_____
Allergic to chestnuts	□ Yes □ No	_____

Smoking Status

Current every day smoker	□ Yes □ No	_____
Current some day smoker	□ Yes □ No	_____
Former smoker	□ Yes □ No	_____
Never smoker	□ Yes □ No	_____
Smoker current status unknown	□ Yes □ No	_____
Unknown if ever smoke	□ Yes □ No	_____
Exposure to secondhand smoke	□ No □ Yes (If "yes," who and where?):	_____
Other tobacco use	□ Yes □ No	_____
Alcohol Use	□ Yes □ No	_____
Recreational Drug Use	□ Yes □ No	_____
Caffeine Use	□ Yes □ No	_____

Family History:	Relationship to you		Relationship to you
Diabetes	_____	Alcoholism/Addiction	_____
Heart disease	_____	Depression/Anxiety	_____
High blood pressure	_____	Bleeding disorder	_____
High Cholesterol	_____	Strokes	_____
Prostate cancer	_____	Arthritis	_____
Breast cancer	_____	Thyroid disease	_____
Other cancers	_____	Osteoporosis	_____

Other Chronic Health Conditions _____

Please specify any specific issues or problems you would like to address today:

_____

_____