PATIENT INFORMATION

Name: ____ Date of Birth: ____

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

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

Mailing Address: ____ City: _________________________________

State: ________________________________ Zip Code:____

Social Security Number: ______________________ Email Address: ____

Home Phone:____________________________________ Cell Phone:____

EMPLOYMENT

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

If Applicable, Employer Name: ____

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

INSURANCE

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.

X____ ____________________________

Patient/Guardian Date

Surgical History

- __________________________________ Date : ____________________
- __________________________________ Date: _____________________
- __________________________________ Date: _____________________
- __________________________________ Date: _____________________
- __________________________________ Date: _____________________

Medical Past/ Present History

□Heart disease
□Diabetes
□Seizures
□Lung problems / cough
□Low blood pressure
□Arthritis
□Neurological problems
□Tonsillitis
□Swollen ankles
□Thyroid problems

□Shortness of breath
□High cholesterol
□Kidney / Bladder problems
□Stroke
□Sinus problems
□Heartburn (reflux)
□Cancer
□Depression / Anxiety
□Ear problems

□Eye disorder / Glaucoma
□Asthma
□High blood pressure
□Liver problems / Hepatitis
□Headaches / Migraines
□Seasonal allergies
□Anemia or blood problems
□Ulcers/colitis
□Psychiatric care

Other: ____

Preventative Health Maintenance

Flu Vaccine: _______________________

Pneumonia Vaccine: ________________

Tetanus Vaccine: ___________________

Hepatitis B Vaccine: _________________

Last Labs: ______________________________

Last PSA: _______________________________

Colonoscopy: ____________________________

Mammogram: ____________________________

Shingles Vaccine: ____________________ Bone Density: ___________________________

Gardasil Vaccine: _____________________ EKG: ____________________________________

Chest X-Ray: _________________________ Eye Exam: ________________________________

Last EKG: ___________________________ Heart Catheterization: _______________________

Endoscopy (EGD): ____________________ Heart Stress Test: ___________________________

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	□Yes □No	_________________	______________________
Father	□Yes □No	_________________	______________________
Sister's	□Yes □No	__________________	______________________
Brother's	□Yes □No	__________________	______________________
P-Grandmother	□Yes □No	__________________	______________________
P-Grandfather	□Yes □No	__________________	______________________
M-Grandmother	□Yes □No	__________________	______________________
M-Grandfather	□Yes □No	__________________	______________________

Other Family History

____

Social History

Do you currently smoke or chew tobacco: □Yes □No

If no, have you in the past: □Yes □No

How many packs per day ________________________

Do you drink alcohol, beer, or wine: □Yes □No

If no, have you in the past: □Yes □No

How many drinks per week _______________________

Do you currently drink coffee and/or tea : □Yes □No

If yes, how many cups per day _________________________

Do you exercise daily/weekly □Yes □No

Do you use seatbelts while driving □Yes □No

Do you wear a helmet while riding a bike □Yes □No

Females: Gynecological History

How many times have you been pregnant _______________

Date of last Pap smear: _____________________________

Have you had an abnormal Pap smear? □Yes □No

Diagnosis: ________________ Follow up: _______________

Have you had a sexually transmitted disease □Yes □No

Diagnosis: ____

Date of last mammogram: _____________________________

Mammogram results: ________________________________

Have you ever had a breast biopsy? □Yes □No

Biopsy results: _____________________________________

Medical Consent and Financial Agreement

Medical Treatment Consent:

I (the undersigned, and/or the parent or legal guardian) consent to the administration of reasonable and necessary services in connection with treatment of the above-mentioned patient at Arizona Bleeding Disorders Health & Wellness Center. This consent includes, but is not limited to, laboratory procedures, medication administration, infusions, procedures, and/or services rendered to a patient by members of the medical staff, their representatives, and/or associates, and employees under the instruction of the physician. I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the clinic.

Release of Information, Assignment of Insurance Benefits, and Financial Agreement:

Release of Information: I hereby authorize Arizona Bleeding Disorders Health & Wellness Center and any physician who has rendered services to release any and all information pertaining to my (or the patient's) treatment to enable the collection of benefits for the services rendered. The authorization includes release of information to insurance companies or healthcare providers, in whole or in part, for payment in exchange for services rendered, whether such payment is in exchange for services rendered by Arizona Bleeding Disorders Health & Wellness Center or by the physicians. Release of Information is also authorized to any providers for follow-up medical care.

Assignment of Benefits: I hereby authorize and assign payment directly to Arizona Bleeding Disorders Health & Wellness Center for benefits, including secondary benefits, due to me for medical services. I understand that I am financially responsible for charges not covered by any insurance or medical benefit payor. I further acknowledge that any benefits, when received by and paid to Arizona Bleeding Disorders Health & Wellness Center will be credited to my account in accordance with this assignment.

Financial Agreement: I understand and agree that I am financially responsible to Arizona Bleeding Disorders Health & Wellness Center, and/or physician for any charges not covered by the authorization below or charges not covered by insurance. In addition, with respect to future treatments at Arizona Bleeding Disorders Health & Wellness Center, this document is ongoing in nature and will remain in effect until revoked by me in writing. I hereby give permission to receive services and treatment by my physician (and/or associates) at Arizona Bleeding Disorders Health & Wellness Center. I authorize the release of information including protected health information as needed to file for payment for services incurred. I fully understand my Financial Responsibility for services rendered at Arizona Bleeding Disorders Health & Wellness Center.

I hereby give permission to receive services and treatment by my physician (and/or associates) at Arizona Bleeding Disorders Health & Wellness Center. I authorize the release of information including protected health information as needed to file for payment for services incurred. I fully understand my Financial Responsibility for services rendered at Arizona Bleeding Disorders Health & Wellness Center.

______________________________	______________________________
Signature of Patient or Personal Representative	Printed Name of Patient or Personal Representative
______________________________	______________________________
Date	* Relationship to Patient (if Personal Representative)

*If Personal Representative, the patient is unable to sign because (check one):

Other (explain):____

For Office Use Only: **Date received** __________________ **Received by:** ______________________

Check if applicable: ❑ **Patient refused to sign Consent and Agreement (explain):**______________________

Arizona Bleeding Disorders Health & Wellness Center
Acknowledgement of Privacy Practices and Instructions for Release of Personal Health Information / HIPAA

PATIENT NAME: ____

DATE OF BIRTH: ____

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES: __________

I give permission to AZ Bleeding Disorders Health & Wellness Center to communicate messages regarding APPOINTMENTS as follows:
______ You may leave a message on my voice mail /answering machine
______ You may leave a message with ____
______ You may communicate with me through the Patient Portal
______ Please communicate appointment messages as follows: __________________________

I give permission to AZ Bleeding Disorders Health & Wellness Center to communicate messages regarding REFERRALS TO ANOTHER PHYSICIAN as follows:
______ You may leave a message on my voice mail /answering machine
______ You may leave a message with ____
______ You may communicate with me through the Patient Portal
______ Please communicate appointment messages as follows: __________________________

I give permission to AZ Bleeding Disorders Health & Wellness Center to communicate messages regarding LAB RESULTS, X-RAYS AND OTHER TESTS as follows:
______ You may leave a message on my voice mail /answering machine
______ You may leave a message with ____
______ You may communicate with me through the Patient Portal
______ Please communicate Test Result messages as follows: __________________________

Names of individuals who we have permission to release your health information to:

____

____

Signature of Patient, Parent or Legal Guardian: ______________________________________

Date: ______________________________