**East Valley Internal Medicine**

2081 W. Frye Rd Suite 200 Chandler, AZ 85224

**Please print and fill out completely**

New Patient/Update

**General Information**

Name:_____ Sex:_____ Martial Status:_____

Last First MI

Address:_____City:_____State:_____Zip:_____

Street Name

Home or Cell Phone: (_____)_____-_____ Date of Birth:_____/_____/_____

Work Phone: (_____)_____-_____ Social Security Number:_____-_____-_____

Place of Employment:_____Email Address:_____

Emergency Contact:_____-_____ (_____)_____-_____

Relation Phone Number

**Guarantor/Responsible Party Information (Primary insurance holder below if other than patient)**

Name:_____ Relation to Patient:_____

SSN:_____-_____-_____ Date of Birth: _____/_____/_____

**Insurance Information**

Primary Insurance Name:_____

I.D. #:_____ Group #:_____

Secondary Insurance Name:_____

I.D. #:_____ Group:_____

**Authorization to pay benefits to physicians**

I, hereby authorize payment directly to East Valley Internal Medicine, otherwise servicesw ill be payable to me or my dependent regarding my services and examination. I understand that I am financially responsible for the non-covered services.

**Authorization of release of medical information**

I, hereby authorize East Valley Internal Medicine or their agents, to release information acquired in the course of treatment or examination to my insurance company for billing purposes only.

Signature:_____ Date:_____

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**Patient Information**

Name:_____ Age:_____ Date of Birth _____/_____/_____

Place of Birth_____ Grade level Achieved_____ Martial Status_____

**Current Health Problems (reason for visit):**

_____

_____

**Current Medications:**

_____

_____

**Medication Allergies:**

_____

_____

**Hospitalizations (Including surgeries and childbirth):**

_____

_____

**Other medical problems (type and date):**

_____

_____

**Major Injuries (types and date):**

_____

_____

## Family History

List any of the following:

Stroke, Diabetes, Heart Disease, Heart Attack, Arthritis, Bleeding Problems, High Blood Pressure, Kidney Problems, Lung Problems, TB, Depression, Anxiety, or any other health issues.

| Family Members | Age | Living/Deceased | Illness/Cause of Death |
|---|---|---|---|

Father:_____

Mother:_____

Brother(s):_____

Sister(s):_____

Children:_____

Other family members with serious health problems/illnesses:

_____

## Social History

Circle the best answer that describes you.

Smoking/Tobacco use: Never Rare Quit Cigarettes/Pipe/Cigars/Snuff Amount per day_____

Alcohol: Never Rare Quit Occasional Weekends Daily_____

Street Drugs: Never Rare Quit Weekly Daily Type_____

Caffeine: Never Rare Quit Soda/Coffee/Tea Cans/Cups/Glasses per day_____

Exercise: Never Occasional Weekly Daily Type_____

Eating Habits: 3 meals daily / 2 meals daily / Occasionally skip meals / Frequently skips meals

Sleep Habits: 9,8,7,6, Hours of sleep per night/Frequent Insomnia/Loud snoring/Sleep Apnea

Employment: Retired Unemployed Homemaker Student Type of Work_____

## For Women Only:

How many pregnancies_____ Miscarriages_____

Stillbirth's_____ Abortions_____

Premature_____ Last pap smear_____

Last day of menstrual cycle_____ Last mammogram_____

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Chandler, AZ 85224

## Statement of Patient Financial Responsibility

East Valley Internal Medicine appreciates you in choosing our practice to provide you with all your healthcare needs. This Financial responsibility obligates to ensure you that your payments are in full, as a courtesy we will verify coverage and bill your insurance on your behalf. However, you are ultimately responsible for your payments at time of service.

I, hereby agree to pay all collection fees and non-sufficient fees determined by East Valley Internal Medicine

As determined, you are responsible for any deductibles, co-payments, and/or coinsurance as contracted with your insurance carrier, at time of service

## Consent of Treatment

I hereby authorize East Valley Internal Medicine, through its appropriate person to perform or have performed upon me appropriate assessment and treatment procedures.

## Cancellation Policy

Any appointments you cannot make we ask you to call and cancel or reschedule at least 24 hours in advance. I hereby agree to pay the following No-show/Same day Cancellation fee when applied.

Following fees will apply: New Patient: $65.00  Established: $45.00

I understand if I no-show for three or more appointments I will be discharged from East Valley Internal Medicine.

I, hereby have read and agree with all terms showed by East Valley Internal Medicine.

_____  _____

Signature  Date

**East Valley Internal Medicine**

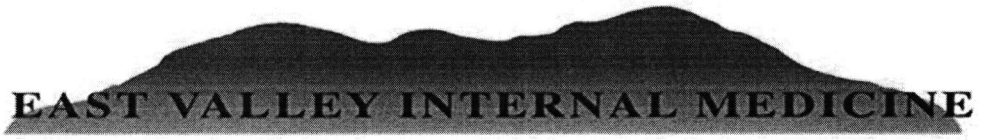
**Acknowledgment for Notice of Privacy Practice**

I, _____ Acknowledge that I have received a copy of East Valley Internal Medicine P.C "Notice of Privacy Practice". This notice describes how East Valley Internal Medicine P.C may use and disclose my protected health information, certain restriction to use and disclose my information and right I may have regarding my protected health information.

I give _____, (Spouse, Family member, Friend, Etc.) permission to my health records, until further notice from myself or power of attorney.

_____ _____

Signature Date




2081 W. Frye Rd Ste 200, Chandler, AZ 85224

Phone: 480-821-3821 • Fax: 877-799-4622

**Medical Records Request**

Please fill out completely

To (doctor requesting records from): _____

Address: _____

City: _____ State:_____ Zip Code: _____

Phone: (_____)_____-_____ Fax Number: (_____)_____-_____

I hereby authorize the release of my medical records including psychiatric and/or substance abuse and dependency, and request they be sent to:

East Valley Internal Medicine, PC

2081 W Frye Rd, Suite 200

Chandler, AZ 85224

Phone: (480) 821.3821 Fax: (877) 799-4622

Please fax the following records (please check at least one):

| | | |
|---|---|---|
| ____ALL records in my chart | ___Progress Notes | ____Psychiatric |
| ____Laboratory Reports | ___Pathology Reports | ____Substance Abuse |
| ____Imaging/Radiology Reports | ___Discharge | ____Medications |

Print Patient's Name:_____

Patient's Signature:_____

Patient's DOB:_____ Date of Signature:_____

This authorization to release confidential information may be revoked by me, in writing at any time, except to the extent that action has already been taken; shall be effective only long enough to answer the purpose for which it is given, and no further confidential information will be release without execution of an additional written authorization.

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form in not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.