Sierra Vista Medical Group

PATIENT

Patient name (Last, First, M.I.)	Gender M or F	Date of Birth	Age	Marital Status S M D W

Mailing Address: City State Zip Code

Street Address *(if different)*:

Social Security #	Home Phone	Cell Phone	Work Phone

Contact Preference: (circle one)	Email Address
Home phone Cell phone Work phone Mail Email	

Race: *(Optional)*

_____White/Caucasian _____Black/African American
_____American Indian _____Other (Specify) _____

Ethnicity: *(Optional)*

_____ Mexican _____ Not Hispanic or Latino
_____ Hispanic or Latino/Spanish _____ Latin American/Latin,Latino
_____ Puerto Rican _____ Central American _____Spaniard
_____South American _____ Dominican _____ Cuban

Language Preference	Primary Care Physician	HOW DID YOU HEAR ABOUT US?

Contact name if different from patient	Phone

Person to notify in case of EMERGENCY	Relationship	Phone

Person RESPONSIBLE FOR PAYMENT of services	Address

Social Security #:	Date of Birth	Phone

GUARDIAN

Parent/Guardian Name	Relationship to Child:	Non-Custodial Name	Home Phone

Home Address	Home Address	Work/Cell Phone

INSURANCE

PRIMARY Insurance Name		**SECONDARY** Insurance Name	
Policy Holder's Name	Date of Birth	Policy Holder's Name	Date of Birth
Policy Holder's Address		Policy Holder's Address	
Policy ID # - Suffix #	Group #	Policy ID # - Suffix #	Group #
Group Name	Relationship to Patient	Group Name	Relationship to Patient

Social Security #	Subscriber Suffix #	Effective Date	Social Security #	Subscriber Suffix #	Effective Date

NOTE: ***For Treatment Purposes*** – If any special Parental or Custodial relationships exist, please describe below.

Please bring paperwork with you a day prior or the day of your appointment.

What Pharmacy do you use? _____
Home Health? _____
Referring Physician? _____

Please bring a current list of medications at each visit.

Sierra Vista Medical Group

Patient Name: _____ Date of Birth: _____

Consent to Treatment: I hereby give my consent for medical treatment by the physicians or under the direction of the physicians of SVMG. I may refuse or withdraw consent for treatment before treatment is rendered.

Payment Policy: I understand that I am financially responsible for all charges, co-payments and deductibles remaining after insurance payments, and all charges not covered by my insurance company (ies), Medicare or third party payor.

Assignment of Benefits: I assign to the treating physician of SVMG. all payments for medical services rendered to my dependents or myself for services filed to insurance on my behalf.

Privacy Policy: I hereby acknowledge that I have received the Notice of Privacy Practices for SVMG.

Authorization for Release of Medical Information: I authorize SVMG to release medical information acquired in the course of my, or the above named patient, examination or treatment necessary to process all claims.

_____ _____
Patient or Guardian Signature Date

I authorize that messages may be left for the patient about appointment reminders and/or medical information regarding patient care:

At work ____ On home answering machine ____ With spouse or other family member ____
Initial Initial Initial

On a cell phone____ Number of cell phone_____ Initial

I authorize disclosure of my medical information and may speak to the following person(s):

Name _____ Relationship _____Phone #_____

Name _____ Relationship_____Phone #_____

Name _____ Relationship_____Phone # _____

I may revoke consent for any or all of the above initialed items at any time in writing. I certify that all information provided to SVMG. is correct.

_____ _____
Patient or Guardian Signature Date

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by SVMG and its associated physicians, clinicians and other personnel. I/We may refuse or withdraw treatment before treatment is initiated. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations

Assignment of Insurance Benefits

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and SVMG. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that SVMG can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

_____ _____
Signature of patient or responsible adult Date

Sierra Vista Medical Group

Acknowledgement of Medication Risks

Medications are drugs. They are prescribed because of their intended benefit. However all drugs may cause unwanted side effects. Fortunately, most patients experience no side effects or minor side effects. Medication side effects can occur with the start, dosage change and or cessation of a medication.

Medication side effects can range from minor to severe. These side effects can even result in death and/or serious problems in extreme cases. Fortunately, side effects are rarely life threatening. The doctor will inform you of the most likely and serious side effects when he starts you on the medication.

Medication can also have very serious interactions with other medications. It is very important that you keep all your doctors informed of all current medications.

There are numerous possible rare and usually mild side effects to medications. When your prescription is filled your pharmacist should give you a printout about the medication including possible side effects. These can include bone thinning, blood abnormalities, rash, and liver dysfunction.

Your likelihood of having side effects may be related to your age, weight, sex, disease, medical condition and other drugs you are taking.

Pregnancy is a unique condition in that most medications can affect the normal course of development of the embryo/fetus. Many women are not aware of their pregnancy in its early stages.

Unfortunately, this is when the embryo/fetus is most vulnerable to harm. This harm can be extreme resulting in the loss of the pregnancy or fetus malformations resulting in permanent birth defects.

Therefore it is essential that you tell the doctor if there is any possibility of pregnancy. This includes any changes in that risk of pregnancy, at any time during treatment by your provider.

Changes in medications prescribed by other physicians while under the care of your provider:

1. If you are having suspected medication side effects you should talk to provider or the nurse.
2. Do not stop taking your medication without talking to your physician first.
3. If you think you are having a serious reaction to your medication call 911 or go to the local emergency room

I have read the above statement of risk and understand the risks of taking medications. I agree to follow its conditions.

Your provider may withhold treatment if you do not agree.

If you have any questions about any of the above, please discuss them with your provider or the nurse.

_____	_____	_____
Signature of patient or guardian	Date of Birth	Date

Sierra Vista Medical Group
75 Colonia De Salud, Suite 100C
Sierra Vista, Az. 85635
Phone 520-452-0144
Fax 520-452-0075

Authorization for Release of Protected Health Information (PHI)

I hereby authorize _____ to release health records information on:
(Name of Provider)
Patient Name:_____ DOB _____

Address: _____ Phone _____

City/State/Zip _____ SS# _____

For Healthcare covering the period(s) from: _____ to _____

This information is to be released to:
Doctor_____Phone #_____Fax #_____
Address_____
_____

Information to be disclosed:
__ Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records
__Copy of all health records to **exclude** HIV testing/results, mental health and/or alcohol or drug abuse records
__ Specific records: Laboratory test ___ Progress Notes ___ X-ray Reports ___ Other _____

The purpose of this disclosure is for:
__ Continuance of Medical Care ___ Attorney
__ Other _____

I understand that the information released as a result of this Authorization may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of revocation.

Unless, otherwise indicated, this Authorization will expire twelve (12) months from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of the authorization upon request.

_____ _____
Signature Date

_____ _____
Witness Date

Sierra Vista Medical Group

Authorization for Release of Protected Health Information (PHI)

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via: fax, E-mail, Internet, or Data Transfer System. _____ (please initial)

I understand that my prescriptions will be electronically transmitted by my physician or his/her staff to my pharmacy. Additionally, my physician or his/her staff may also receive a complete active medication list from pharmacy. _____ (please initial)

I understand that SVMG cannot require me to sign this Authorization as a condition to providing services to me. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact my physician or the SVMG Privacy Officer.

Signature: _____ Date :_____

Sierra Vista Medical Group
75 Colonia De Salud, Suite 100C
Sierra Vista, AZ 85635
520-452-0144

PATIENT NAME: _____ **DOB**: _____

Please complete **ALL** sections on all the forms that you have received with **BLACK** ink. Please return forms to our office or fax forms to: 520-452-0075 prior to your appointment. Please review forms to make sure they have been completed and are signed. We must receive forms prior to your appointment date

On:_____ **With Doctor**:_____

Primary Care Provider:	**Date of Last Exam:**
Reason for Visit:	**Date of Onset:**

Pharmacy Preference: _____

MEDICATION LOG- TO INCLUDE PRESCRIPTION AND ANY OVER THE COUNTER MEDICATION YOU ARE CURRENTLY TAKING

MEDICATION NAME	DOSAGE	INSTRUCTIONS ON USAGE

If too many to list here, please attach personal list of medications.

MEDICATION ALLERGIES YES_____ NO_____

IF YES PLEASE LIST BELOW

MEDICATION ALLERGY	REACTION

If too many to list here, please attach personal list of medications.

HEALTH HISTORY

Confidential

Patient Name: _____DOB:_____

Symptoms – Please check (✓) symptoms you currently have or have experienced within the last year.

Constitutional: ☐ Fever ☐ Chills ☐ Night Sweats ☐ Fatigue ☐ Weight Loss

Eye: ☐ Recent visual changes ☐ Eye Discharge

ENMT: ☐ Decreased hearing ☐ Ear Pain ☐ Nasal Congestion ☐ Sore Throat

Respiratory: ☐ Shortness of breath ☐ Cough ☐ Coughing up blood ☐ Wheezing

Cardiovascular: ☐ Chest pain/pressure ☐ Palpitations ☐ Swollen Ankles

Gastrointestinal: ☐ Stomach Pain ☐ Blood in Stools ☐ Change in Bowel Habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Loss of Appetite ☐ Nausea ☐ Vomiting

Genitourinary: ☐ Painful Urination ☐ Blood in Urine ☐ Urinary Frequency ☐ Urinary incontinence

Breast: ☐ Lumps / Masses ☐ Nipple Discharge / Bleeding ☐ Breast Pain

Skin: ☐ Rash ☐ Itching ☐ Abrasions ☐ Changes in Moles

Neurologic: ☐ Dizziness ☐ Headaches/Migraine ☐ Memory Loss

Psychiatric: ☐ Anxiety ☐ Depression ☐ Sleeping problems

Endocrine: ☐ Cold Intolerance ☐ Heat Intolerance ☐ Excessive Thirst ☐ Excessive Hunger

Musculoskeletal: ☐ Back Pain ☐ Joint Pain ☐ Muscle Weakness ☐ Neck Pain

Heme/Lymph: ☐ Easy Bruising ☐ Easy Bleeding ☐ Swollen Or Painful Lymph Nodes

HOSPITALIZATIONS / SURGERIES:

Year	Hospital, City, State, Country	Reason for Hospitalization / Surgical Procedure

If too many to list here, please attach personal list of surgeries.

Medical Conditions - Please check (✓) medical conditions you currently have or have had in the past.

Glaucoma		Cataracts		Hernia	
AIDS/HIV		Measles		Coronary Artery Disease	
Anemia		Mumps		High Blood Pressure	
Bleeding Disorder		Chicken Pox		Heart Failure	
Blood Clots		Rheumatic Fever		Elevated Cholesterol	
Cancer***		Polio		Pacemaker	
Anorexia/Bulimia		Renal failure		Breast Cyst	
Suicide Attempt		MRSA		Kidney Disease	
Hepatitis:		STD/STI		PCOS	
Cirrhosis		Diabetes		Prostate Problem	
Ulcers		Thyroid Disease		Gout	
Asthma		Lupus		Guillan-Barre's	
Bronchitis		Epilepsy		Other:	
Emphysema		Migraine			
COPD		Stroke			

Tuberculosis		Multiple Sclerosis			

***If yes for Cancer What Type?:_____

Patient Name: _____DOB:_____

FAMILY HISTORY:

Relative	Current Age	Age at Death	Health Problems / If cancer need type.
Mother			
Father			
Sons			
Daughters			
Sisters			
Brothers			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Maternal Aunts&Uncles			
Paternal Aunts&Uncles			

Social Habits		
Substance	**Daily Amount**	**Years Used**
Coffee/Tea/Soda		
Alcohol		
Drugs		
Tobacco		
Date Quit Smoking:		

Current Occupation: _____ **Education Level**: _____

Marital Status: _____ **Lives With**: _____

For Females only:

Pregnancies: Yes or No
Number of pregnancies _____ Number of abortions _____ Number of Miscarriages_____ Vaginal Deliveries_____
Caesarean Section Deliveries_____ Complications:_____
Last Menstrual Period: _____ Birth control: _____

****If being seen for a <u>Breast Problem</u> please answer the following questions for Gail Model Risk Assessment.**

1. **Race: _____ 2. Current Age _____ 3. Age at first menses _____**
4. **Age at first live birth _____ 5. Number of mother/ sisters/ daughters with breast cancer _____**
6. **Number of previous breast biopsies _____ 7. Abnormal results? ___ Yes ___No ____Unknown**

To be filled out by Medical Staff / Risk Assessment 5 years _____ Lifetime _____

ANY PERTINENT INFORMATION NOT LISTED ABOVE:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature / Relationship to Patient Date/Time