Gilbert Center
For Family Medicine

Registration

Patient Information

_____ _____ _____
Last Name **First Name** **Middle Name**

_____-_____-_____ _____/_____/_____ ☐ Female ☐ Male
Social Security **Birth Date** **Gender**

Marital Status ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Race ☐ Caucasian/White ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian *Government Regulation*
☐ Hispanic/Latino ☐ Middle Eastern ☐ Pacific Islander ☐ Other ☐ Declined TO Specify

Ethnicity ☐ No Hispanic/ Latino Origin ☐ Hispanic/ Latino Origin ☐ Unknown ☐ Declined TO Specify *Government Regulation*

_____ _____ _____ _____
Address **Apt#** **City** **State** **Zip**

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home Phone ☐ **Primary** **Day Phone** ☐ **Primary** **Alternative Phone** ☐ **Primary**

_____
Email Address

_____ _____ _____
Emergency Contact Last Name **Emergency Contact First Name** **Relationship**

(_____)_____-_____ Home ☐ Work ☐ Cell ☐ _____
Emergency Contact Phone **Phone Type** **How did you hear about our office?**

Guarantor Information

_____ _____ _____
Guarantor Last Name **Guarantor First Name** **Guarantor Middle Name**

_____-_____-_____ _____/_____/_____ ☐ Female ☐ Male
Social Security **Birth Date** **Gender**

_____ _____ _____ _____-_____
Address **Apt#** **City** **State** **Zip**

_____ (_____)_____-_____ (_____)_____-_____
Guarantor Relationship **Home Phone** **Primary** **Day Phone** **Primary**

Insurance Information

_____ _____ _____
Policy Holder Last Name **Policy Holder First Name** **Policy Holder Middle Name**

_____-_____-_____ _____/_____/_____ ☐ Female ☐ Male
Social Security **Birth Date** **Gender**

_____ _____ _____ _____-_____
Address **Apt#** **City** **State** **Zip**

_____ (_____)_____-_____ (_____)_____-_____
Policy Holder Relationship **Home Phone** **Primary** **Day Phone** **Primary**

_____ _____ _____
Primary Insurance Company **Policy Number** **Group Number**

_____ _____ _____
Secondary Insurance Company **Policy Number** **Group Number**

Acknowledgement

I certify that the above information is true and correct. I hereby authorize release of any and all medical information that may be requested by the above named insurance carrier(s) in order to process claim for benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all charges accumulated from any missed appointments that were not cancelled by the patient at-least 24 hours prior to my scheduled appointment. In the event of default and account is placed with a collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of the outstanding balance at the time the account is placed the agency and interest accrual of 10% per year on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs that occur.

_____ _____/_____/_____
Patient Signature **(If Minor: Parent/ Legal Guardian)** **Date**

Gilbert Center For Family Medicine

Patient Information

Name _____ Birth Date _____/_____/_____

Medical History 1

Pharmacy

Primary _____ **Cross Streets** _____

Secondary or Mail Order _____ **Cross Streets** _____

Advanced Directives

Type □ None □ Refuse □ Do Not Resuscitate
□ Living Will □ Do Not Place On Life Support □ Power of Attorney

Effective Date ____/____/_____

Allergies

□ **No Allergies**

Please Specify Allergy & Reaction

_____ _____ _____

_____ _____ _____

Medications

□ **No Medications**

Medication Name	Strength	Directions

Past Medical/Surgical History

□ **No Relevant History**

Past Medical History

	Year		Year		Year
□ Allergies	_____	□ COPD	_____	□ Liver Disease	_____
□ Anemia	_____	□ Coronary Artery Disease	_____	□ Migraine Headaches	_____
□ Angina	_____	□ Crohn's Disease	_____	□ Myocardial Infarction	_____
□ Anxiety	_____	□ Depression	_____	□ Osteoarthritis	_____
□ Arthritis	_____	□ Diabetes	_____	□ Osteoporosis	_____
□ Asthma	_____	□ Gallbladder Disease	_____	□ Peptic Ulcer Disease	_____
□ Atrial Fibrillation	_____	□ GERD	_____	□ Renal Disease	_____
□ Benign Prostatic Hypertrophy	_____	□ Hepatitis C	_____	□ Seizure Disorder	_____
□ Blood Clots	_____	□ Hyperlipidemia	_____	□ Thyroid Disease	_____
□ Cancer *Type* _____	_____	□ Hypertension	_____		
□ Cerebrovascular Accident	_____	□ Irritable Bowel Disease	_____		

Past Surgical History

	Year		Year	Females Only	Year
□ Angioplasty	_____	□ Gastric Bypass	_____	□ Augmentation Mammoplasty	_____
□ Angio w/stent	_____	□ Hernia Repair *Site* _____	_____	□ Bilat. Tubal Ligation	_____
□ Appendectomy	_____	□ Hip Replacement *Side* ___	_____	□ Breast Biopsy *Side* _____	_____
□ Arthroscopy Knee *Side* ___	_____	□ Knee Replacement	_____	□ Cesarean Section	_____
□ Back Surgery	_____	□ Lasik	_____	□ D and C	_____
□ CABG	_____	□ Liver Biopsy	_____	□ Hysterectomy	_____
□ Carpel Tunnel Release	_____	□ ORIF	_____	□ Mastectomy	_____
□ Cataract Extraction *Side* __	_____	□ Pacemaker	_____	□ Myomectomy	_____

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Medical History 2

☐ Cholecystectomy	_____	☐ Small Bowel Resection	_____	☐ Reduction Mammoplasty	_____
☐ Colectomy	_____	☐ Thyroidectomy	_____	☐ TAH/BSO	_____
☐ Colostomy	_____	☐ Tonsillectomy	_____	☐ Vaginal Hysterectomy	_____

Additional History

System	Disease	Year
Management	**Outcome**	**Year**

Males Only **Year**

☐ Prostate Biopsy _____
☐ TURP _____
☐ Vasectomy _____

☐ **Patient Adopted** **Family History** ☐ **No Relevant History**

Diagnosis	Family Member(s) Immediate Family/Blood Relatives *Please Specify Side Of Family (Mother or Father)*	Age Onset	Death Cause
ADD/ADHD			☐ Yes
Alcoholism			☐ Yes
Allergies			☐ Yes
Alzheimer's Disease			☐ Yes
Asthma			☐ Yes
Blood Disease			☐ Yes
CAD (Coronary Artery Disease)			☐ Yes
CAD - Premature			☐ Yes
Cancer *Type* _____			☐ Yes
CVA (Stroke)			☐ Yes
Depression			☐ Yes
Developmental Delay			☐ Yes
Diabetes			☐ Yes
Eczema			☐ Yes
Hearing Deficiency			☐ Yes
Hyperlipidemia			☐ Yes
Hypertension			☐ Yes
Irritable Bowel Disease			☐ Yes
Learning Disability			☐ Yes
Mental Illness			☐ Yes
Migraines			☐ Yes
Obesity			☐ Yes
Osteoarthritis			☐ Yes
Osteoporosis			☐ Yes
PVD			☐ Yes
Renal Disease			☐ Yes
Seizure Disorder			☐ Yes
Other_____			☐ Yes

Social History

Statuses

Race
☐ African American/Black ☐ Caucasian/White ☐ Pacific Islander/Native Hawaiian
☐ American Indian/Alaska Native ☐ Hispanic/Latino ☐ Other
☐ Asian ☐ Middle Eastern ☐ Do Not Wish To Disclose

Ethnicity ☐ Hispanic/Latino Origin ☐ No Hispanic/Latino Origin ☐ Unknown

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____
Language Spoken At Home ☐ English ☐ Spanish ☐ Other _____

Country Of Birth ☐ USA ☐ Other _____ **Hand Dominance** ☐ Right ☐ Left ☐ Ambidextrous

Employer (Name) _____ **Occupation (Type Of Work)** _____

Employment Status
☐ Full Time ☐ Self-Employed ☐ Retired *Date* ___/___/___
☐ Part Time ☐ Unemployed ☐ Other _____

Work Restrictions
☐ avoid dust/fumes ☐ no heavy lifting
☐ no climbing ☐ Other _____

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Medical History 3

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Legally Separated ☐ Annulled ☐ Other _____

Previously Widowed ☐ No ☐ Yes

Previous Divorce ☐ No ☐ Yes

Has Children ☐ No ☐ Yes **Number of Sons** _____ **Number of Daughters** _____

Tobacco / Alcohol / Caffeine

Uses Tobacco ☐ Current ☐ Former ☐ Never ☐ Unknown

Tobacco Type ☐ Chewing ☐ Cigar ☐ Cigarettes ☐ Pipe ☐ Smokeless ☐ Snuff

Units / Day _____
Years Used _____
Pack Years _____

Ever Tried To Quit? ☐ No ☐ Yes **Year Quit** _____ **Longest Tobacco Free** _____

Relapse Reason _____ **Passive Smoke Exposure** ☐ No ☐ Yes

Smoker Status ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Smoker, Status Unknown ☐ Never Smoker ☐ Former Smoker ☐ Unknown If Ever Smoked

Drinks Alcohol ☐ No ☐ Yes ☐ Formerly **Caffeine** ☐ No ☐ Yes

Lifestyle – Other

Activity Level ☐ Moderate ☐ Sedentary ☐ Vigorous

Health Club Member ☐ Now ☐ Previously ☐ Never

Type Of Exercise _____

Exercise Frequency _____

Hours / Week _____

Hobbies / Activities _____

Diet History ☐ Diabetic ☐ Vegan ☐ Vegetarian ☐ High Fiber ☐ Low Sodium ☐ High Protein ☐ Other

Animals In The Home ☐ No ☐ Yes *Type* _____

Lifestyle – Home Environment / Safety *(For Insurance Company Purposes)*

Smoke Detectors In Home ☐ No ☐ Yes

Pool / Spa At Home ☐ No ☐ Yes

Carbon Monoxide Detectors In Home ☐ No ☐ Yes

Seat Belt Use ☐ No ☐ Yes

Falls In The Last Year ☐ No ☐ Yes Number/Falls _____

Home Heating Method ☐ Gas ☐ Electric

Radon In The Home ☐ No ☐ Yes ☐ Treated ☐ Untested

Firearms At Home ☐ No ☐ Yes ☐ No Answer

Disease Management

Health Maintenance

	Date		Date	Females Only	Date
☐ H&P (Physical Exam)	___/___/___	☐ Influenza Vaccine	___/___/___	☐ GYN Exam	___/___/___
☐ Lipid Panel	___/___/___	☐ Tdap Vaccine	___/___/___	☐ Breast Exam	___/___/___
☐ EKG	___/___/___			☐ Pap	___/___/___
☐ Colonoscopy	___/___/___	**Males Only**	**Date**	☐ Mammogram	___/___/___
☐ FOBT	___/___/___	☐ PSA	___/___/___	☐ Dexa Scan	___/___/___

DIRECTIONS

Our preferred method to receive forms is via email. Please send forms at least 24 hours prior to your appointment. Not having these in advance may delay your appointment time.

Email: **Save this PDF file to your computer after completion.**
Go to emailyourdoc.com for secure emailing.
Upload the file and email it to office@mdofficemail.com.

Fax: **(480) 539-1763.**

Hand Carry: **Bring a copy with you to your appointment (if possible) at least 24 hours prior.**

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

652 E. Warner Rd, Suite 107 Gilbert, AZ 85296
Phone: *480-539-8680* Fax**:** *480-539-1763*

Privacy Practices & HIE Acknowledgement

_____ _____/_____/_____
Patient Name Birth Date

Acknowledgement

I hereby acknowledge that I have been presented with a copy of Gilbert Center for Family Medicine's Privacy Practice Notice.

_____ _____/_____/_____
Patient Signature Date

Release Information to Relative/ Friend

I, _____, give my consent and authorization to the staff of Gilbert Center for Family Medicine to relay medical information to the following persons listed below. This information may include but is not limited to scheduled appointments and/ or surgeries, lab results, radiological results, medications, all confidential aids, communicable disease, HIV related information, confidential alcohol or drug abuse related information, confidential mental health, and diagnosis/treatment information.

Authorized Person _____ Relationship to Patient _____
Authorized Person _____ Relationship to Patient _____
Authorized Person _____ Relationship to Patient _____

Health Information Exchange

By signing below, you are consenting to Gilbert Center for Family Medicine participates in the Health Current (HC) Health Information Exchange (HIE) to facilitate the secure exchange of your health information, including information related to mental health diagnoses and procedures, between and among your health care providers for purposes related to treatment, payment, healthcare operations, and secondary use. Through our connection to the HC-HIE, we will share your health information with other participating health care providers to provide faster access, facilitate better coordination of care, and enable more informed care decisions. You may choose to "opt out" and not have any of your health information shared through the HIE by completing and submitting the HIE Opt Out Request Form to your GCFM medical provider. Please allow up to 30 business days to process your request.

_____ _____
Patient Signature Legal Representative Signature

_____ _____
Date Relationship to Patient

Gilbert Center
For Family Medicine
652 East Warner Road, Suite 107, Gilbert, AZ 85296
Phone (480)539-8680 Fax (480)539-1763

Records Request

_____ _____/_____/_____
Patient Name **Birth Date**

_____ _____-_____-_____
Address **Social Security Number**

Authorization

- o I authorize the release of my medical records **from another provider/facility to Gilbert Center for Family Medicine.** (Provider/Facility→ GCFM)

Records To Be Released **Medical records shall include all confidential aids, communicable disease, HIV related information, confidential alcohol or drug abuse related information, and confidential mental health diagnosis/treatment information. Release the following described medical records only (specify types and dates).**

- o All medical records authorized to be released.
- o Other medical records authorized to be released:_____

Provider /Facility Information	
_____ Provider/ Facility Name	(_____)_____-_____ Phone
_____ Address	(_____)_____-_____ Fax

Consent: **This consent will expire sixty (60) days after the signed date below.** I may revoke this authorization at any time providing I notify Gilbert Center For Family Medicine in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I **herby release Gilbert Center For Family Medicine from all legal responsibility or liability that may arise from the act** I **have authorized above.**

_____ _____/_____/_____
Patient Name **(If Minor: Parent / Legal Guardian)** **Date**

_____ _____/_____/_____
Patient Signature **(If Minor: Parent / Legal Guardian)** **Date**

Gilbert Center
For Family Medicine

NOTICE TO PATIENTS

Gilbert Center for Family Medicine has a **NO NARCOTICS** policy.

We will no longer prescribe long term/chronic narcotics or other addictive medications to new patients.

(ie: **Adderall, Norco, Vicodin, Xanax, Clonazepam, Ambien** etc…)

In addition, Gilbert Center for Family Medicine does **NOT** write letters for emotional support animals. Patients seeking a letter for an emotional support animal will be referred to psychiatry/psychology.

I acknowledge that I have read and understand the above content.

_____

Name (Printed)

_____ _____

Signature Date

Gilbert Center
For Family Medicine
652 East Warner Road, Suite 107, Gilbert, Arizona 85296
Phone (480) 539-8680 Fax (480) 539-1763

Consent to Leave Detailed Voicemail

By signing this "Consent to Leave Voicemails", you consent to Prime Medical Group staff leaving voice mail message containing detailed medical information on the phone number(s) listed on file. This information may include, but not limited to, demographic information (partial or full name, date of birth, address, etc.), billing information, appointment information, medical information (diagnosis, medications, test results, etc.).

Name: _____ Date of Birth: _____

Signature: _____ Date: _____