Medical History

Patient Name_____ **Date of Visit**_____

****PLEASE CHECK IN 15 MINUTES PRIOR TO APPOINTMENT WITH FORMS COMPLETED****

Other Physicians you see:

1.
2.
3.
4.

Medications			
(Please list all prescribed or over the counter medications)			
Name of Medication	**Dose (mg, ml)**	**# of tablets or capsules each dose**	**# of times per day**
Example- Drug A	*20 mg*	*One tablet*	*Twice a day*

Medication Allergies	
Have you had an allergic or adverse reaction to any medication? ☐ **Yes—complete details below** ☐ No	
Medication	**Type of Reaction**

Medical History

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Your Medical History

Check all that apply

☐ Hayfever (allergies)
☐ Hearing Loss
☐ Glaucoma
☐ Cataracts
☐ Other ear or eye disease_____

☐ Asthma
☐ COPD
☐ Valley Fever
☐ Lung Nodule
☐ Other lung disease_____

☐ High blood pressure (hypertension)
☐ Heart Attack (myocardial infarction)
☐ Congestive Heart Failure
☐ Atrial Fibrillation
☐ Elevated cholesterol (hypercholesterolemia)
☐ Other heart disease_____

☐ Acid reflux (GERD)
☐ Crohn's Disease
☐ Ulcerative Colitis
☐ IBS (irritable bowel syndrome)
☐ Hepatitis (type)_____
☐ Ulcer of stomach or esophagus
☐ Chronic constipation
☐ Other gastrointestinal illness_____

☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Fibromyalgia
☐ Lupus
☐ Osteoporosis
☐ Osteopenia
☐ Other rheumatologic disorder_____

☐ Cancer (type)_____

☐ Diabetes Mellitus
☐ Hypothyroidism (low thyroid)
☐ Hyperthyroidism (high thyroid)
☐ Menopause____age (women only)
☐ Polycystic ovarian disorder (women only)
☐ Other endocrine disease_____

☐ Kidney disease
☐ Kidney stones (nephrolithiasis)
☐ Enlarged Prostate (men only)
☐ Frequent urinary tract infections
☐ Other kidney disease_____

☐ Stroke or TIA
☐ Migraine Headaches
☐ Seizures
☐ Dementia
☐ Parkinson's Disease
☐ Other neurological disease_____

☐ Skin cancer
☐ Eczema
☐ Other skin disease_____

☐ Anemia
☐ Leukemia
☐ Lymphoma
☐ Blood clot
☐ Other blood disorder_____

☐ Depression
☐ Anxiety
☐ Eating Disorder
☐ Attention Deficit Disorder
☐ Bipolar Disease
☐ Other psychiatric illness_____

Medical History

Patient Name_____ **Date of Visit**_____

Surgical History		
☐ Appendectomy ☐ Removal of gallbladder (cholecystectomy) ☐ Colon surgery ☐ Breast surgery ☐ Prostate surgery	☐ Tubal ligation ☐ Vasectomy ☐ Hysterectomy ☐ Removal of ovaries (oophorectomy) ☐ Joint replacement-specify	☐ Cardiac Bypass ☐ Pacemaker ☐ Valve replacement ☐ Cardiac cath with stent ☐ Other (specify)_____

Family History			
Family Member	**Living**	**Deceased/Age**	**Medical Problems**
Mother			o Diabetes o Heart Disease o Breast cancer o Colon cancer o None
Father			o Diabetes o Heart Disease o Breast cancer o Colon cancer o None
	Number Living	**Number Deceased**	**Medical Problems**
Sister(s)			o Diabetes o Heart Disease o Breast cancer o Colon cancer o None
Brother(s)			o Diabetes o Heart Disease o Breast cancer o Colon cancer o None

Social History
Who do you live with? ☐ Self ☐ Spouse ☐ Family ☐ Other, please specify
Do you currently smoke? ☐ No ☐ Yes, How much do you smoke?_____ How many years have you been smoking? _____
Have you ever smoked? ☐ No ☐ Yes, How many years did you smoke?_____ What year did you quit?_____
Occupation: ☐ Check if retired and previous profession

Medical History

Patient Name_____ **Date of Visit**_____

Immunizations			
Immunization	**Date**	**Immunization**	**Date**
☐ Influenza		☐ Pneumovax	
☐ Shingles (Shingrix)		☐ Prevnar 13	
☐ Shingles(Zostavax)		☐ Gardisil	
☐ Hepatitis B		☐ Tetanus	
☐ Hepatitis A		☐ TDAP	

Screening Male and Female			
☐ Stool Cards	Date	☐ Normal	☐ Abnormal
☐ Colonoscopy	Date	☐ Normal	☐ Abnormal
☐ Bone Density	Date	☐ Normal	☐ Abnormal

Screening Male			
☐ PSA	Date	☐ Normal	☐ Abnormal
☐ Testicular Exam	Date	☐ Normal	☐ Abnormal

Screening Female			
☐ Pap Smear	Date	☐ Normal	☐ Abnormal
☐ Mammogram	Date	☐ Normal	☐ Abnormal

Medical History

Patient Name_____ **Date of Visit**_____

Review of Systems

Only circle any symptoms you are <u>currently</u> having or <u>have had</u> and are <u>concerned</u> about.

General	HEENT		Heart/Vascular	Respiratory
Weight loss	Visual changes	Nose congestion	Chest pain	Shortness of breath
Weight gain	Photophobia	Nose drainage	Rapid heart rate	Coughing
Fever	Eye itching	Nose bleeding	Irregular heart rhythm	Wheezing
Chills	Eye Redness	Sinus congestion	Leg swelling	Snoring
Fatigue	Loss of hearing	Sore throat	Pain in the legs when walking	
Insomnia	Ear infection	Hoarse Voice		

Gastrointestinal	Blood Disorder	Musculoskeletal	Skin
Stomach pain Nausea/vomiting Heartburn Trouble swallowing Diarrhea Constipation Blood in stool Stool incontinence Hemorrhoids	Bleeding disorder Easy bruising Anemia **Lymphatics** Enlarged lymph nodes Lymphedema	Joint pain Joint swelling Muscle pain Back pain Neck pain Fractures	Rash Hives Dry skin Eczema Skin cancer

Nervous System	Psychiatric	Genitourinary	Men
Dizziness Spinning Numbness/tingling Gait disturbance Balance difficulties Seizures Headaches	Depression Anxiety Phobias Eating disorder Substance Abuse	Burning with urination Frequent urination Nighttime urination Urinary incontinence Blood in the urine Sexual difficulties	Difficulties with urination Weak stream Scrotal/testicular lump STD.s

Pre Menopause	Post Menopause	Breast
Irregular menses	Vaginal dryness	Breast lumps
Painful menses	Hot flashes/night sweats	Nipple Discharge
Vaginal discharge	Vaginal Bleeding	
STD's	STD's	
LMP_____		

Patient Information

First Name_____ **Date of Birth** ____/_____/____

Last Name_____ **Social Security No.** _____-_____-____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____)-_____ **Cell Phone** (_____)-_____

Work Phone (_____)- _____

Best Number to Reach You? _____

Sex: Male Female

Marital Status: Single Married Divorced Widow Separated Partner

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Emergency Contact

Name_____

Relationship to Patient _____

Address _____

Home Phone (____)- _____**Cell Phone** (____)- _____

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hispanic
☐ Pacific Islander ☐ White ☐ Other ☐ Do not wish to respond

Ethnicity: ☐ Not Hispanic ☐ Hispanic, Latino/a ☐ Other ☐ Do not wish to respond

Language Preference: ☐ English ☐ Other _____ ☐ Do not wish to respond

Employment Status ☐ Working ☐ Student ☐ Retired ☐ Disabled

Email _____ (Please ask about our patient portal)

Last updated 3/3/2023

Primary Insurance

Name of Insurance Company_____

Claim Address _____

Policy/ ID No _____ **Group No** _____

Policy Holder Name _____

Relationship to Patient_____

Policy Holder's Address_____

_____

Employer _____

Policy Holder's Social Security No. (required) _____-_____-_____

Policy Holder's Date of Birth ____/_____/_____

Secondary Insurance

Name of Insurance Company_____

Claim Address _____

Policy/ ID No _____**Group No** _____

Policy Holder Name _____

Relationship to Patient_____

Policy Holder's Address_____

_____

Employer _____

Policy Holder's Social Security No. (Required) _____-_____-_____

Policy Holder's Date of Birth ____/_____/_____

Person Responsible for Bills (if different than patient)

Name _____

Relationship to Patient _____

Address

_____

_____

Phone (____)-_____ **Cell** (_____)-_____

Does patient have a Living Will or Medical Power of Attorney?

YES (If yes, please provide a copy.) NO

I acknowledge that all of the information given is true and correct and that it has been furnished to this office with full knowledge that, regardless of responsible party listed above, the person signing this document is ultimately liable for all said services rendered and that he/she is contractually bound to pay for said services.

Further, by signing below, I give Ocotillo Internal Medicine Associates permission to bill my insurance(s) on my behalf.

Patient or Guardian Signature

X_____ Date_____

HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Patient Name: _____ Date of Birth: _____

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient hereby waives his/her confidentiality rights should collection action become necessary. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office. However, we are not obligated to alter internal policies to conform to your request.

My protected health information can be released to the following people:

Name: _____ Relationship: _____Phone:_____

Name: _____ Relationship: _____Phone:_____

Name: _____Relationship: _____Phone:_____

HIV/AIDS/STD: This form authorizes release of medical information including HIV-related. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potential exposed to HIV. I **DO ___ DO NOT ___** consent to the release of any positive or negative test result for AIDS/ HIV or STD infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:____ Date: _____**

With this consent, I give Ocotillo Internal Medicine permission to call my home or other alternative location provided in patient information form and leave a detailed message on voice mail or in person to someone listed above in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care such as lab and test results.

_____ _____

Patient Signature [or parent, guardian or legal representative] **Date (expires in 1 year)**

Ocotillo Internal Medicine Financial Agreement

Insurance: Ocotillo Internal Medicine Associates (OIMA) is a primary care practice. Your insurance *may* require that you select a primary care physician. Failure to do so, prior to the office visit, will result in insurance denying full or partial payment of your claims. A copy of your insurance card is required. We are required by our insurance contracts to collect all co-pays at the time of service. This includes annual visits. Any co-pays not received on the day of the visit will be subject to a $10 processing fee.

It is your responsibility for knowing the benefits of the specific insurance plan(s) you have purchased. OIMA is not responsible for interpreting these benefits, or knowing how your insurance will process your claims. If your insurance requires a referral it is your responsibility to obtain the referral prior to your appointment with specialist, some insurances take a week to process referrals.

Claims Submission: OIMA will file a claim with your insurance company on your behalf. If OIMA is not contracted with your insurance company, you hereby authorize assignment of payment directly to our office for services provided.

Self-Pay Patients: Patients without insurance coverage, or coverage that cannot be verified prior to an appointment, shall be responsible for paying the balance in full at the time services are provided. A $65 deposit prior to the appointment is required (cash or credit card).

Balances: Unless other arrangements have been made in advance, the balance on accounts are due and payable at either the next appointment or upon the receipt of statement whichever is first. It is the patient's responsibility to update demographic information at each appointment. If an account becomes past due, OIMA will take the necessary steps to collect this debt. After having mailed three statements, a $20 fee will be added to your account balance. If your account is sent to our outside collections agency, OIMA will assess a $40 collection's fee. There is a $50 NSF fee for any returned checks. An account that is sent to collections may be discharged from our practice.

Patient initials:_____

Appointments: Patients arriving more than 10 minutes after their appointment time will be asked to reschedule. We require 24 hour advanced notice of cancellation. A $45.00 fee will be applied to your account for short-notice cancellations or missed appointments. A second offense will result in a $90 fee. Patients who miss several appointments without calling may be discharged from our practice.

Annual Exam: Ocotillo Internal Medicine provides comprehensive medical care. As such, an annual appointment is required yearly of every patient. A new patient appointment (initial visit) is considered an annual appointment.

Annual exams at OIMA consist of the preventive portion as well as the assessment or management of specific symptoms or problems, acute and/or chronic. Insurance companies require all services to be itemized and coded appropriately. These codes are standardized and follow commercial insurance and Medicare guidelines. In order to provide you with the optimal medical care and for your convenience we provide these services in one visit. Please understand that because our annual appointments cover both types of services, some fees may be subject to your plan's co-pay, deductible or coinsurance and it will be your obligation to pay those fees for which OIMA is contractually obligated to collect. If the preventative code is **not covered,** per your insurance, our office will charge a $65 fee.

Chronic Care Management Services:

As part of an ongoing effort to enhance care coordination we are pleased to offer chronic care management services which will help better coordinate your care. Care coordination consists of non-face-to-face care services which Ocotillo will furnish to assist in your care among your different care provider and help you better manage your care. There will no out of pocket cost for this service.

Patient initials:_____

By signing this agreement, you consent to have Ocotillo Internal Medicine Associates bill your insurance monthly for Chronic Care Management services provided to you by providers at Ocotillo Internal Medicine Associates. Please direct questions to our billing office. You may revoke this consent anytime by written request. There will be no out- of-pocket charges for the patient.

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT.

No changes to this policy by the patient will be acknowledged. Questions may be directed to the billing office.

Printed Name:

Patient Signature Date

RELEASE OF MEDICAL INFORMATION

Patient Name _____

Date of Birth_____ SSN# _____

I, _____, hereby authorize use or disclosure of protected health information about me.

I am authorizing the following location to release my records

Dr/Facility _____

Address _____

Phone_____Fax_____

To

Ocotillo Internal Medicine
245 S. Dobson Rd.
Chandler, AZ 85224
480-895-5870 480-895-0573 Fax

I understand that the information used or disclosed may be subject to re-disclosure by the person receiving it and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notification in writing of my desire to revoke it. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the provider to whom this authorization is furnished may not condition its treatment or me on whether or not I sign the authorization.

This authorization expires two (2) years from the date of execution.

Dated this _____ day of _____, 20___.

_____
Patient's signature