Phoenix Family Medical Care **Patient Registration**
1002 E McDowell Rd, Suite A
Phoenix, AZ 85006

Patient Name: _____ Responsible Party Name: _____

Birthdate: _____ Age: _____ Sex: Male Female

Mailing Address: _____ City, State Zip: _____

Email Address: _____ Pharmacy Info: _____

Home Phone: _____ Work: _____ Cell: _____

Pt Soc Sec #: _____Resp Party SS#: _____ Relationship to Responsible Party: Self Spouse Child Other

Referring Doctor Name & Address: _____
Primary Care Doctor Name & Address: _____
How did you hear about us? Zoc -Doc, Patient Pop, Spanish Ads, Other? _____

Marital Status Single Married Other Is Patient: Employed Full-Time Student Part-Time Student Other

Employer Name/ Address/Phone: _____

Emergency Contact Name/Address/Phone:_____

Advance Directive: Do you have a power of attorney? Yes No If Yes Please List Name and Provide Legal Document:
Power of Attorney Name: _____

What are you being seen for: _____ First date of symptoms: _____

Allergies: _____ Are you pregnant: Yes No

Insurance Information:

Primary Insurance:
Insurance Co. Name: _____

Insurance Co. Address: _____

Policy Holder Name: _____

Relationship to Insured:_____

Policy # _____ Group No: _____

Policy Holder Sex: F or M Birthdate: _____
Employer: _____

Secondary Insurance:
Insurance Co Name:

Insurance Co. Address:

Policy Holder Name:

Relationship to Insured:

Policy #_____ Group No:

Policy Holder Sex: F or M Birthdate:
Employer:

AUTHORIZED TO RELEASE/OBTAIN INFORMATION: I hereby authorized this physician/clinic to release or obtain any information required in the course of my examination or treatment which could include HIV, Communicable disease, drug abuse information, external drug history. We/or our delegate may contact you by phone at any number you have provided including wireless numbers, by text or email using pre-recorded/artificial voice message and/or automatic dialing and messaging device, as applicable. **AUTHORIZED TO PAY:** I hereby authorized payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services provided I understand that I am financially responsible for the charges not covered by my insurance.

Signed (Patient or Parent if minor): _____ Date: _____

HEALTH DATA BASE

Name_____ DATE

AGE _____HEIGHT_____WEIGHT_____

1. PRESENT PROBLEM: DESCRIBE BREIFLY YOUR PRESENT COMPLAINTS:

2. PAST ILLNESS: (PLEASE CIRCLE THOSE YOU HAVE HAD IN THE PAST)

ASTHMA	**THYROID**	**HEART DIEASE**	**BLEEDING TENDENCY/TRANSFUSION**
CANCER	**DIABETES**	**RHEUM. FEVER**	**LUNG DISEASE/TUBERCULOSIS**
JAUNDICE	**STROKE**	**KIDNEY DISEASE**	**NERVOUS DISORDER/SEIZURES**
ULCERS	**ARTHRITIS**	**HYPERTENSION**	**VENEREAL DISEASE**

SURGIRES: _____

HOSPITALIZATIONS: _____

3. ARE YOU ALLERIC OR SENSEITIVE TO ANY MEDICATIONS?

4. COMPLICATIONS OF ANY MEDICAL THERAPY OR TREATMENTS:

5. PERSONAL HABBITS: SMOKING_____ DRINK ALCOHOL_____ ILLICIT DRUGS_____ CAFFIENE_____

6. IMMUNIZATIONS: (PLEASE CIRCLE THOSE YOU HAVE HAD IN THE PAST 10 YRS)
TETANUS **INFLUENZA** **PNEUMONIA** **OTHERS:**

7. LIST OF MEDICATIONS:

8. FAMILY HISTORY:

A.	FAMILY MEMBERS	ALIVE	PRESENT HEALTH	CAUSE OF DEATH	AGE
	FATHER	Y/N			
	MOTHER	Y/N			
	SPOUSE	Y/N			
	BROTHERS	Y/N			
	SISTERS	Y/N			
	CHILDREN	Y/N			

B. CIRCLE ILNESS THAT HAVE OCCURRED IN YOUR BLOOD RELATIVES

CANCER	HIGH BLOOD PRESSURE/STROKE	BLEEDING TENDENCY
HEART	NERVOUS DISORDERS	DIABETES
ALCOHOLSIM	KIDNEY DISEASE/GALLSTONES	COLON/BOWEL
THRYOID	CHOLESTEROL	ASTHMA/HAYFEVER

C. NUMBER OF DEPENENTS_____ OCCUPATION_____

HEALTH REVIEW

A. GENERAL HEALTH

1. HAVE YOU HAD A RECENT CHANGE IN YOUR WEIGHT OF MORE THAN 10 POUNDS? YES_____NO_____
2. HAVE YOU NOTICED RECURRENT FEVER? YES_____NO_____

B. HEAD, EYES, EARS, NOSE, THROAT

1. DO YOU HAVE FREQUENT HEADACHES? YES_____NO_____
2. DO YOU HAVE ANY SIGNIFICANT VISION PROBLEM? YES_____NO_____
3. DO YOU HAVE HEARING LOSS THAT AFFECTS YOU DAILY? YES_____NO_____
4. HAVE YOU NOTICED ANY CHANGES IN YOUR VOICE? YES_____NO_____
5. DO YOU HAVE SEASONAL ALLERGIESOR HAYFEVER SYMPTOMS? YES_____NO_____

C. RESPIRATORY

1. ARE YOUR ABNORMALLY SHORT OF BREATH? YES_____NO_____
2. DO YOU COUGH UP BLOOD? YES_____NO_____
3. DO YOU PROVUDE PHLEGM OR SPUTUM DAILY? YES_____NO_____

D. CARDIOVASCULAR

1. DO YOU HAVE IRREGULAR HEART RHYTHM? YES_____NO_____
2. DO YOU REGULARLY HAVE PALPITATIONS/SKIPPING OF YOUR HEART YES_____NO_____
3. DO YOUR LEGS SWELL? YES_____NO_____
4. WITH EXERCISE, DO YOU FEEL PRESSURE OR DISCOMFORT IN YOUR CHEST? YES_____NO_____
5. HAVE YOU BEEN TOLD YOU HAVE A HEART MURMUR? YES_____NO_____
6. DO YOU HAVE ABNORMAL SHORTNESS OF BREATH WITH EXERCISE? YES_____NO_____

E. GASTROINTESTINAL

1. DO YOU HAVE HEARTBURN OR SWALLOWING PROBLEMS? YES_____NO_____
2. DO YOU HAVE BLEEDING FROM YOUR STOMACH OR RECTUM? YES_____NO_____
3. DO YOU TAKE LAXATIVES REGULARLY? YES_____NO_____
4. HAVE YOU HAD JAUNDICE OR GALLBLADDER DISEASE? YES_____NO_____

F. GENITOURINARY

1. DO YOU HAVE DIFFICULTY CONTROLLING YOUR URINE? YES_____NO_____
2. IS YOUR URINE STREAM WEAK/DIMINISHED? YES_____NO_____
3. DO YOU URINATE MORE THAN ONCE AT NIGHT? YES_____NO_____
4. DO YOU HAVE PAIN OR BURNING WITH URINATION? YES_____NO_____
5. DO YOU HAVE ABNORMAL VAGINAL OR PENILE DISCHARGE? YES_____NO_____

G. MUSCULOSKELETAL

1. HAVE YOU FALLEN DUE TO WEAKNESS/BALANCE PROBLEM? YES_____NO_____
2. DO YOU HAVE ARTHRITIS? YES_____NO_____
3. DO YOU HAVE MUSCLE WEAKNESS? YES_____NO_____
4. DO YOU HAVE BACK PAIN THAT INTERFERES WITH ACTIVITIES? YES_____NO_____

H. NEUROSPSYCHIATRIC

1. HAVE YOU EVER HAD A NERVOUS BREAKDOWN? YES_____NO_____
2. DO YOU FEEL TENSE, ANXIOUS OR NERVOUS? YES_____NO_____
3. DO YOU HAVE TROUBLE SLEEPING? YES_____NO_____
4. DO YOU HAVE DIFFICULTIES IN YOUR SEX LIFE? YES_____NO_____
5. DO YOU ABUSE DRUGS OR ALCOHOL? YES_____NO_____

F. FOR WOMEN ONLY

1. LAST MENSTRUAL PERIOD_____ ARE YOUR PERIODS REGULAR YES/N0

2. DATES BETWEEN CYCLES_____ NUMBERS OF PREGNANCIES_____

3. ARE YOU USING ANY CONTRACEPTION? _____IF YES, PLEASE NAME_____

HIPPA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

Background: in 1996, congress recognized the need for national patient privacy standards and, as part of the Health Insurance Portability and Accountability Act, abbreviated HIPPA, ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for back accounts, credit cards and even video rentals.

- By law consent is not required to discuss your medical treatment with your other doctors or healthcare providers. This also allows for a prescription to be called into your pharmacy and for scheduling of surgery in a hospital.
- Additionally, none is needed in the course of carrying out healthcare operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign in sheets.
- However, this office has always gone one step further in protecting you and does not believe on releasing specific information about you to any business or governmental entity without your written consent.
- Specific authorization is required to disclose protected information in a non-routine circumstance such as to your employer or for use in marketing a product to you.
- Medical information about you may be released for research and public health uses, as long as you are not individually identified.
- You are guaranteed access to review your medical record, and you may amend the record if you believe it to be incomplete or inaccurate.
- You have the right to review when and to whom your information was released.
- You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.
- Portions of this notice may be modified as long as you are notified.
- Should you believe that your privacy rights have been compromised, you may report the violation without penalty to you, to this office, or the Secretary of Health.
- The law requires that you acknowledge receipt of this notice; this has been included on the signature release on your registration form.

_____ _____

Signature of patient or responsible party Date

Privacy Release of information

Phoenix Family Medical Care PLLC
Josef Khalil MD
Josefina Castelo FNP

Patient Name: _____

I permit that the following person may be contacted with regards to my health information.

Name	Relationship to patient	Phone

(You must list your spouse and/or children's name separately- if they are not listed, we will not be able to authorize any information regarding your health, appointments and specialist information ect.)

_____

Signature of patient or responsible party Date

_____

Printed name of signed patient or responsible party Date

Phoenix Family Medical Care
Financial Policy

Thank you for choosing Phoenix Family Medical Care. Our office is committed to providing excellent healthcare for you and your family. The following Financial Policy has been established to avoid and reduce any confusion regarding your healthcare treatment. Your signature signifies that you have read this policy and have had your questions answered.

As the patient, you are responsible for payment of services rendered at the time of the appointment. **All co-payments, co-insurance, deductibles** must be paid at the time of service. This is part of your contract with your insurance company. Failure on our part to collect from patients can be considered **FRAUD.** It is the patient's responsibility to check with their health plan provider for coverage of any additional services provided. The patient is responsible for all non-covered services in the event your insurance does not cover the services ordered and provided.

Insurance Information. It is your responsibility to provide Phoenix Family Medical Care with all the correct and updated insurance information at every visit. Failure to do so may result in denied claims and any balance become your responsibility.

Automobile Accidents. Phoenix Family Medical Care does not bill third party insurance companies for automobile accidents.

Claims submission. As a courtesy, Phoenix Family Medical Care will submit your claims and assist you in any reasonable way to help get your claims paid.

Statements. Statements are sent out monthly. It is expected that any balances due be paid within 15days of receipt of the bill. If your account is over **90 days past due,** you will receive a letter stating that you 10days to pay your account in full. **Phoenix Family Medical Care has the right to refuse treatment to patients with outstanding balances.**

Return checks. A $35 fee for non-sufficient funds will be required from the patient as well as the balance due. No further checks will be accepted.

Appointment Policy. As a courtesy, our office will call prior to your appointment to remind you of your appointment. **We require 24 hours notice for all cancellation and/or reschedule appointments, failure to do so will result in a $50 charge. Automatic NO SHOW will be charge the same fee of $50.** Our office will make every effort to see patients on time and we expect the same respect from our patients.

_____ _____

Signature of patient or responsible party Date