



# PATIENT HISTORY

Name:	Date of Birth:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Occupation:
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**Have you ever had or now have problems with:**

	Yes	No		Yes	No		Yes	No
Anxiety / depression			Heart Trouble			Migraines		
Asthma / emphysema			Kidney Disease			Thyroid disease		
Bleeding Tendencies			Mental Illness			Bleeding disorder		
Blood clots			Valley fever			Chronic back pain		
Cancer			Arthritis			Other-		
Diabetes			Seizures					
Glaucoma			Tuberculosis					
High Blood Pressure			STD's					
High Cholesterol			Stroke					

Family History	Age(s)	Medical Problems:
Father		
Mother		
Brothers No: _____		
Sisters No: _____		

**Have you ever had any operations? Y  N  If yes, please list:**

Year	Operation	Year	Operation	Year	Operation

List other illnesses not requiring an operation for which you were hospitalized:

Do you have any **allergies** or sensitivities to medicines or other substances? Y  N  If yes, please list with type of reaction:

Do you have any religious or cultural beliefs which may affect your care with FamilyCare? Y  N  If yes, please explain:

**Medications**, name or otherwise identify over the counter, herbal, natural remedies or prescription medications, including oral contraceptives, now or recently used:

Do you have an Advance Directive (Living Will) in place? Y  N

Tobacco use now	Y <input type="checkbox"/> N <input type="checkbox"/>	Past	Y <input type="checkbox"/> N <input type="checkbox"/>	Type/amount:	How long:
Alcohol use now	Y <input type="checkbox"/> N <input type="checkbox"/>	Past	Y <input type="checkbox"/> N <input type="checkbox"/>	Type/amount:	How long:
Marijuana or street drug use now	Y <input type="checkbox"/> N <input type="checkbox"/>	Past	Y <input type="checkbox"/> N <input type="checkbox"/>	Type/amount:	How long:

Check the diseases against which you have been immunized: Hepatitis B  Hepatitis A  Pneumovax  MMR  Tetanus  Polio  Diphtheria  Influenza  Other:

Date of last Pap smear: \_\_\_\_\_ Date of last Mammogram: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_

Are you sexually active? Y  N  Have you ever experienced any form of abuse? Y  N

Have you ever had a blood transfusion? Y  N  Date: \_\_\_\_\_

Is there anything that you would like to discuss with your physician in confidence? Y  N

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician/Provider Signature: \_\_\_\_\_ Physician Name: Jyoti Patel M.D.F.A.A.P. Date: \_\_\_\_\_



From: Dr. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To: **Jyoti Patel, MD FAAP**  
**Fountain Hills Pediatrics & Internal Medicine**  
**13620 N. Saguaro Blvd, Suite 50**  
**Fountain Hills, AZ 85268**  
**Phone: (480) 837-6800**  
**Fax: (480) 837-6804**

**RELEASE OF MEDICAL RECORDS**

**Please release entire record.**

**I hereby consent to the release of records pertaining to treatment/diagnosis of the following.**

- Confidential Alcohol in Drug Abuse-Related information (as defined in 42 CFR Section 2.1 ET SEQ)
- Confidential HIV-Related Information (as defined in A.R.S. Section 36-611)
- Confidential Mental Health Diagnosis/Treatment information.
- Confidential Communicable Disease-Related information (as defined as A.R.S. Section 36-611)

I authorize the facsimile transmission of the above records.

Yes \_\_\_\_\_ No \_\_\_\_\_

I understand that this authorization shall expire, without my express revocation, six months from the Date written below (60 days for drug/alcohol abuse). I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Printed Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legally authorized Representative \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_



Doctor: Dr. Jyoti Patel

## Patient Profile

<b><u>PATIENT INFORMATION</u></b>	
Name _____	Sex: [ ]M [ ]F
Primary Address _____	Date of Birth: _____ Age: _____
City _____ State _____ Zip _____	Driver's License #: _____
Phone _____ Alt. Phone _____	Social Security #: _____
E-Mail _____	Marital Status: [ ]Married [ ]Single [ ]Divorced
Secondary Address _____	Referring Physician: _____
City _____ State _____ Zip _____	Primary Physician: _____

<b><u>PATIENT EMPLOYMENT INFORMATION</u></b>	<b><u>EMERGENCY CONTACTS</u></b>
[ ]Employed [ ]Retired [ ]Unemployed [ ]Other	Name Relationship Phone
Employer's Name: _____	_____
Employer's Phone: _____	_____
Occupation: _____	<input type="checkbox"/> OK to share my medical information with above person.

<b><u>RESPONSIBLE PARTY</u></b> <i>(If patient is under 18 years of age)</i>	
Name: _____	Employer: _____
Address: _____	Home Phone: _____
City, State, Zip: _____	Work Phone: _____
	SSN: _____
	Date of Birth: _____

<b><u>PRIMARY INSURANCE</u></b>	<b><u>SECONDARY INSURANCE</u></b>
Insurance Company Name: _____	Insurance Company Name: _____
ID #: _____	ID #: _____
Group/Policy #: _____	Group/Policy #: _____
Subscriber's Name: _____	Subscriber's Name: _____
Subscriber's Phone #: _____	Subscriber's Phone #: _____
Relationship to Patient: _____	Relationship to Patient: _____
Subscriber's Employer: _____	Subscriber's Employer: _____
Subscriber's SS #: _____	Subscriber's SS #: _____
Subscriber's Date of Birth: _____	Subscriber's Date of Birth: _____

**HIPPA AGREEMENT**

Fountain Hills Pediatrics and Internal Medicine staff and business associates will share information as needed to aid in continuing medical care for patients. Information is not sold or given to anyone other than physicians for referrals and billing. We also share information with SMIL, Lab Corp and Sonora Quest. I have received a copy of Fountain Hills Pediatrics & Internal Medicine Privacy Practices as required by HIPPA.

\_\_\_\_\_  
 PATIENT/GUARDIAN SIGNATURE DATE

**INSURANCE AUTHORIZATION AND ASSIGNMENT**  
(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

\_\_\_\_\_  
 PATIENT/GUARDIAN SIGNATURE DATE





## FHPIM Financial Policy

We are doing everything possible to hold down the cost of your medical care and provide good service. We appreciate your cooperation in this matter!

### All Payments Are Expected at the Time of Service

- Co-payments and self-payments are required at the time service. Fountain Hills Pediatrics and Internal Medicine accepts cash, VISA and MasterCard. We do not accept personal checks. If an exception is made, there is a **\$25.00 service charge for returned checks**.

### Insurance

- We need updated Insurance information and card at every visit. If there is non-payment due to incorrect information or lapse/change of current insurance, you will be responsible for all charges.
- We bill participating insurance companies and your secondary insurance but cannot guarantee coverage of services
- Please know your level of insurance coverage before your visit. Our provider cannot change the bill to your insurance with different codes. For example, some patients do not have benefits for mental health or physicals. We cannot change any documentation after it has been entered and signed in your electronic chart.
- Patients are responsible for :
  - verifying with your insurance companies your full coverage and benefits
  - insuring that our providers are In-Network
  - verifying all charges not covered by your insurance, deductibles or out of network charges
  - verifying laboratory/radiology services and location – we use Sonora Quest; please notify us if you need to use another lab ahead of time
  - If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from our office before seeing a specialist. This is the patient's responsibility to ensure a referral has been faxed. No retroactive referrals will be given.

### Billing

- If you need assistance or have any billing questions, please contact the Billing Department @ 1-877-638-3629

### No-Show Appointments/Late Cancellations:

- Missed appointments represent a loss to other patients who could have been seen in the time set aside for you
- Cancellations are requested 24 hours prior to the appointment
- You will be charged **\$25.00 for no-show or late-canceled appointments**
- Excessive abuse of scheduled appointments may result in discharge from the practice

### Medical Record/Forms Fee

- There is a **\$25.00 fee for obtaining a copy of your medical records.**
- We prefer you make an office visit if you need medical forms filled out. If you choose not to make an appointment, there is a **\$40.00 fee to fill out any and all forms.**

### Phone Charges

- If you request for the provider to call you back to provide medical services and advice over the phone, you will be assessed a phone charge which will be billed to your insurance. If charges are not covered by your insurance, you will be responsible for payment.

I have read and understand the FHPIM Financial Policy. I agree to assign insurance benefits to FHPIM whenever necessary. I also agree that if it became necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative \_\_\_\_\_ Date: \_\_\_\_\_