WestValley InternalMedicine WestValley UrgentCare

PATIENT INFORMATION

Last Name:		Middle Name:	
First Name:		DOB:	Sex: Male/Female
SS#	Marital Status: married/single/divorced/widowed		

HOME ADDRESS

Address (include apt. #):		City:	State: Zip:
Home Phone:	Cell:	Other:	
Email:			

EMPLOYER

Employer Name:	Work Phone:

PRIMARY CARE PHYSICIAN

Physician Name:	City:	State:	Phone:

RESPONSIBLE PARTY

Name:	Phone:
Relationship to Patient:	

EMERGENCY CONTACT

Name:	Phone:
Address:	Relationship to Patient:

COMPANY

□Internal Medicine □Walk In Clinic

NO INSURANCE/ SELF PAY

□Cash □Credit/Debt

INSURANCE INFORMATION

Primary Insurance:		Insurance subscriber:
Subscriber DOB:	Sex:	Subscriber SS#
Subscriber's employer:		
Policy#/Subscriber ID#		Relationship to Patient:
Secondary Insurance:		Insurance subscriber:
Subscriber DOB:	Sex:	Subscriber SS#
Subscriber's employer:		
Policy#/Subscriber ID#		Relationship to Patient:

LANGUAGE

Primary Language:	Secondary Language:

ETHNICITY

____ Not Hispanic, Latio/a, or Spanish orgin	____Cuban
____ Mexican, Mexican American, Chicano/a	____ Another Hispanic, Latino/a or Spanish
____ Puerto Rican	____ Prefer not to disclose

RACE

____ American Indian	____ Asian	____ Other Specify:_____
____ Caucasian	____ Pacific Islander	____ Prefer not to disclose
____ Black/African Amer.	____ Indian	
____ Chinese	____ Native Hawaiian	
____ Filipino	____ Multiracial	

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FINANCIAL AGREEMENT

I understand that West Valley Care participates in a variety of insurance plans and that in order to ensure appropriate insurance billing it is my responsibility for the following:

*Provide my insurance card at each visit.

*Be prepared to pay my co-pay or deductible responsibility at time of service.

*If the patient is a minor (under 18 years of age) I am financially responsible for services provided.

*It is my responsibility to contact my insurance company with questions regarding specific coverage issues.

*Be aware that some of the services you receive may be non-covered or not considered reasonable or necessary. There are legitimate reasons your provider may order items or services that are not covered. By signing this form, you are agreeing to pay for services rendered that are not covered by your insurance company.

*Payment for any additional services provided/prescribed by WVC is due at check out.

*If my insurance eligibility can not be varified by WVC, I may be required to make a monetary deposit and upon receipt of payment from my insurance company, I will be reimbursed minus any co-pays, co-insurance and/or deductibles if any.

*If I do not have insurance, the initial office visit payment is due prior to services rendered.All other payments for services due at check out.

* 24 hour notice is required for any cancellations or reschedule of appointment. A $25 fee will be charged to all patients that are in violation of this policy.

*After 30 days of WVC bill submission date to my insurance company has not responded, my account balance will be transferred to patient responsibility.

*In the event that I fail to pay the outstanding balance of my account to WVC for services provided to me, I understand that my account will be turned over to a collection agency and I will be responsible for an additional 35% collection fee.

ACKNOWLEDGEMENT OF UNDERSTANDING

I acknowledge that I have read and fully understand the Patient Financial Agreement as outlined above.

Patient Name:_____

Patient Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's notice of Privacy Practices

Patient Name(responsible party):_____

Patient Signature(responisble party):_____ Date:_____

CONSENT FOR MEDICAL TREATMENT

I agree to examination and treatment by West Valley Care personnel, including but not limited to injections, local anesthetics, minor surgical procedures or other procedures discussed with me and recommended by West

Signature:_____ Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign ____ Communication barriers

____ Emergency Situation ____ Other Specify:_____

RELEASE OF MEDICAL INFORMATION AND RECORDS				
I hereby authorize West Valley Care, L.L.C. to discuss my medical records with				
The following individuals:				
Name:		Relationship to Patient:		
Name:		Relationship to Patient:		
Name:		Relationship to Patient:		
____ I wish to release all aspects of my records to the above mentioned person(s).				
____ I DO NOT wish to authorize WVC to discuss my records with anyone other than myself.				
ADVANCED DIRECTIVES				
Formal advance directives are documents written in advance of serious illness that state your choices for health care or name someone to make those choices, if you become unable to make decisions. Through advance directives such as: living wills and durable power of attorney for health care, you can make legally valid decisions about your future medical treatment. ____ I already have an advance directive on file with the state of AZ and will bring in a copy for your files. ____ I do not have an advance directive on file and would like more information on how to put one into place. ____ I do not currently have an advance directives on file but would NOT like to complete one at this time.				
Patient Signature/Legal Guardian:				Date:
Office Staff Signature:				Date:
HEALTH HISTORY				
Patient Name:			DOB:	
Last physical exam:		Name of Doctor:		
Dr. Phone #		Marital Status: Married Divorced Single Widow Seperated		
Exercise Yes/No	Smoker Yes/No	Alcohol Yes/No	Caffeine Yes/No	
# per week:	Packs per week:	# per week:	# per week:	
Type:	Date quite:	Type:	Type:	
Drugs Yes/No	**LIST ALL MAJOR SURGERIES OR INJURIES**			
# per week:	1)	4)		
Type:	2)	5)		
	3)	6)		

HEALTH HISTORY					
Patient Name:				D.O.B.	
Reason for visit:				Date Illness began?	
Medication and other allergies and reactions:					
Medication Name:				Dose:	
Medication Name:				Dose:	
Medication Name:				Dose:	
Medication Name:				Dose:	
_____ See Attached Medication List					
PAST MEDICAL HISTORY					
Measles	Yes/No	Smallpox	Yes/No	High Cholestrol	Yes/No
Mumps	Yes/No	Pneumonia	Yes/No	Cancer	Yes/No
Chickenpox	Yes/No	Rheumatic Fever	Yes/No	Pollo	Yes/No
Whooping Cough	Yes/No	Heart Disease	Yes/No	Glacoma	Yes/No
Scarlet Fever	Yes/No	Arthritis	Yes/No	Hernia	Yes/No
Diptheria	Yes/No	Verneral Disease	Yes/No	Back Pain	Yes/No
Bladder Infection	Yes/No	Anemia	Yes/No	Hives	Yes/No
Epilepsy	Yes/No	Hemorrhoids	Yes/No	Asthma	Yes/No
Migraines	Yes/No	Mitral Value Prolaps	Yes/No	Eczema	Yes/No
Tuberculosis	Yes/No	Kidney Disease	Yes/No	Bronchitis	Yes/No
Blood Transfusion	Yes/No	Thyroid Disease	Yes/No	Stroke	Yes/No
Hypertension	Yes/No	Bleeding Tendency	Yes/No	Hepatitis	Yes/No
Hypotension	Yes/No	AIDS or HIV	Yes/No	Diabetes	Yes/No

FAMILY MEDICAL HISTORY					
Relationship	Mother	Father	Grandmother	Grandfather	
Diabetes	Yes/No	Yes/No	Yes/No	Yes/No	
High Blood Pressure	Yes/No	Yes/No	Yes/No	Yes/No	
Heart Disease	Yes/No	Yes/No	Yes/No	Yes/No	
Cancer	Yes/No	Yes/No	Yes/No	Yes/No	
Tuberculosis	Yes/No	Yes/No	Yes/No	Yes/No	
Stroke	Yes/No	Yes/No	Yes/No	Yes/No	
Epilepsy	Yes/No	Yes/No	Yes/No	Yes/No	
Allergies	Yes/No	Yes/No	Yes/No	Yes/No	
Anemia	Yes/No	Yes/No	Yes/No	Yes/No	
Blood Tendency	Yes/No	Yes/No	Yes/No	Yes/No	
High Cholestrol	Yes/No	Yes/No	Yes/No	Yes/No	

Patient Name_____DOB_____

DO YOU HAVE NOW OR WITHIN THE PAST YEAR					
Weakness or Paralysis	Yes/No	Difficulty Swallowing	Yes/No	Depression	Yes/No
Weight Change	Yes/No	Heartburn	Yes/No	Memory Loss	Yes/No
Change in appetite	Yes/No	Abdominal Cramps	Yes/No	Poor Coordination	Yes/No
Sensitive to cold/heat	Yes/No	Nease/Vomiting	Yes/No	Dizziness	Yes/No
Persistent Fever	Yes/No	Chonic Diarrhea	Yes/No	**Men Only:**	
Night sweats/flashes	Yes/No	Chronic Constipation	Yes/No	Discharge from Penis	Yes/No
Skin rash	Yes/No	Rectal Bleeding	Yes/No	Pain in Testicles	Yes/No
Change in nails/hair	Yes/No	Dark Urine	Yes/No	Impotence	Yes/No
Headaches	Yes/No	Jaundice	Yes/No	Last Colonscopy:	
Bleeding or bruising	Yes/No	Frequent Urination	Yes/No	**Women Only:**	
Blurred Vision	Yes/No	Increased Thirst	Yes/No	Age of Period:	
Eye Pain	Yes/No	Painful Urination	Yes/No	Days Period last:	
Infected eye	Yes/No	Blood in Urine	Yes/No	Flow heavy:	
Wear glasses/contacts	Yes/No	Difficulty Urinating	Yes/No	Date of last period:	
Ringing in the ears	Yes/No	Lack of Sex drive	Yes/No	Last Pelvic Exam:	
Discharge from ears	Yes/No	Hemorrhoids	Yes/No	Last Mammogram:	
Ear Pain	Yes/No	Backaches	Yes/No	Last Colonscopy:	
Frequent nose bleeds	Yes/No	Joint pain/stiffness	Yes/No	# of Pregnancies:	
Frequent colds	Yes/No	Muscle cramps	Yes/No	# Full term Pregnancies:	
Sinus issues	Yes/No	Sleeplessness	Yes/No	# Full term births:	
Loss of smell	Yes/No	Seizures	Yes/No	# preterm births:	
Shortness of Breath	Yes/No	Chest Pain/discomfort	Yes/No	Flow Heavy	Yes/No
Bloody Sputum	Yes/No	Purple fingers/lips	Yes/No	Vaginal itching	Yes/No
Wheezing	Yes/No	Swelling of Extremities	Yes/No	Pain during Sex	Yes/No
Leg pain/cramps	Yes/No	Heart Palpatations	Yes/No	Birth Control	Yes/No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my/or my childs health. It is my responsibility to inform the doctor's office of any changes in my/my childs medical status. I also authorize the health care staff to perform necessary health care services I or my child may need.

Signature of patient/ parent : Date:

PERMISSION TO CONTACT

I understand that West Valley Care uses multiple methods to contact their patients with any information pertaining to their health care such as test results, referral status, and appointment stauts. Methods used to inform patient's are emil, text, phone calls, and online patient portal.

_____ I have read the above and give WVC permission to contact me using these methods

_____ I DO NOT give WVC permission to contact me by way of unsecure communication

Signature of patient/parent:

Patient Name_____DOB_____