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
____State Prohibited
____ Hispanic, Latino/a
Other :____________________
____ Prefer not to disclose

RACE

____ Caucasian/White	___ Indian	____ Black/African American
____ Japanese	___ Native Hawaiian/Other Islan	____ American Indian or Alaska Native
____ Asian	___ Chinese	____ Multiracial
____ Filipino	___ Hispanic	Other: ____________________
___ State Prohibited	___ Prefer not to disclose	

Update:10/2018

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 verified 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 $50 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 Signature(responsible party):_____________________________ 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 status. Methods used to inform patient's are email, 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_______________

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:___________________________

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 Previous Doctor:		
Clinic Address:		Telephone:	Fax:	
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)

HEALTH HISTORY

Reason for visit:	Date Illness began?
Medication and other allergies and reactions:	
Medication Name:	Dose:
Medication Name:	Dose:
_______ See Attached Medication List	

Men Only:		**Women Only:**			
Discharge from Penis	Yes/No	Age of Period:		Last Mammogram:	
Pain in Testicles	Yes/No	Days Period last:		Last Colonscopy:	
Impotence	Yes/No	Flow heavy:		# of Pregnancies:	
Last Colonscopy:		Date of last period:		# Full term Pregnancies:	
Last Mammogram:		Last Pelvic Exam:		# Full term births:	
		Flow Heavy	Yes/No	# Preterm births:	
		Vaginal itching	Yes/No	Birth Control	Yes/No
		Pain during Sex	Yes/No		

WestValley InternalMedicine WestValley UrgentCare

PAST MEDICAL HISTORY					
Arthritis	Yes/No	Heart Disease	Yes/No	Polio	Yes/No
Back Pain	Yes/No	Hernia	Yes/No	Rheumatic Fever	Yes/No
Cancer	Yes/No	High Cholestrol	Yes/No	Scarlet Fever	Yes/No
Chickenpox	Yes/No	Measles	Yes/No	Smallpox	Yes/No
Diptheria	Yes/No	Mumps	Yes/No	Venereal Disease	Yes/No
Glaucoma	Yes/No	Pneumonia	Yes/No	Whooping Cough	Yes/No

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

DO YOU HAVE NOW OR WITHIN THE PAST YEAR					
Abdominal Cramps	Yes/No	Change in nails/hair	Yes/No	Eye Pain	Yes/No
AIDS or HIV	Yes/No	Chest Pain/discomfort	Yes/No	Frequent colds	Yes/No
Anemia	Yes/No	Chonic Diarrhea	Yes/No	Frequent nose bleeds	Yes/No
Asthma	Yes/No	Chronic Constipation	Yes/No	Frequent Urination	Yes/No
Backaches	Yes/No	Dark Urine	Yes/No	Headaches	Yes/No
Bladder Infection	Yes/No	Depression	Yes/No	Heart Palpatations	Yes/No
Bleeding or bruising	Yes/No	Diabetes	Yes/No	Heartburn	Yes/No
Bleeding Tendency	Yes/No	Difficulty Swallowing	Yes/No	Hemorrhoids	Yes/No
Blood in Urine	Yes/No	Difficulty Urinating	Yes/No	Hepatitis	Yes/No
Blood Transfusion	Yes/No	Discharge from ears	Yes/No	Hives	Yes/No
Bloody Sputum	Yes/No	Dizziness	Yes/No	Hypertension	Yes/No
Blurred Vision	Yes/No	Ear Pain	Yes/No	Hypotension	Yes/No
Bronchitis	Yes/No	Eczema	Yes/No	Increased Thirst	Yes/No
Change in appetite	Yes/No	Epilepsy	Yes/No	Infected eye	Yes/No

Name:____ Date of birth:_____________________

WestValley InternalMedicine WestValley UrgentCare

DO YOU HAVE NOW OR WITHIN THE PAST YEAR					
Jaundice	Yes/No	Night sweats/flashes	Yes/No	Skin rash	Yes/No
Joint pain/stiffness	Yes/No	Painful Urination	Yes/No	Sleeplessness	Yes/No
Kidney Disease	Yes/No	Persistent Fever	Yes/No	Stroke	Yes/No
Lack of Sex drive	Yes/No	Poor Coordination	Yes/No	Swelling of Extremities	Yes/No
Leg pain/cramps	Yes/No	Purple fingers/lips	Yes/No	Thyroid Disease	Yes/No
Loss of smell	Yes/No	Rectal Bleeding	Yes/No	Tuberculosis	Yes/No
Memory Loss	Yes/No	Ringing in the ears	Yes/No	Weakness or Paralysis	Yes/No
Migraines	Yes/No	Seizures	Yes/No	Wear glasses/contacts	Yes/No
Mitral Value Prolapse	Yes/No	Sensitive to cold/heat	Yes/No	Weight Change	Yes/No
Muscle cramps	Yes/No	Shortness of Breath	Yes/No	Wheezing	Yes/No
Nausea/Vomiting	Yes/No	Sinus issues	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 :__________________________ 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 Valley Care providers.

Signature:_______________________________________ Date:_________________

Authorization for the Release of Patient Information

I hereby authorize West Valley Care, L.L.C. to use or disclose the specific information below, only for the purposes and parties also described below:

The following individual/s:

Name:_______________________________ Relationship:________________________

___ All Aspects of Medical Record ___ Appointment Date/Time
___ Lab Test/Results ___ X-ray Results
___ Summary of Medical Record ___ Medications and Pharmacy records
___ Diagnosis ___ Billing Record
___ Other (specify):____

Name:_______________________________ Relationship:________________________

___ All Aspects of Medical Record ___ Appointment Date/Time
___ Lab Test/Results ___ X-ray Results
___ Summary of Medical Record ___ Medications and Pharmacy records
___ Diagnosis ___ Billing Record
___ Other (specify):____

Name:_______________________________ Relationship:________________________

___ All Aspects of Medical Record ___ Appointment Date/Time
___ Lab Test/Results ___ X-ray Results
___ Summary of Medical Record ___ Medications and Pharmacy records
___ Diagnosis ___ Billing Record
___ Other (specify):____

This authorization shall remain in effect from the date signed below until (please check one):

□___________ (Specify expiration date or event)

□ NO EXPIRATION DATE

I understand that:

* I may inspect or copy the protect health information to be used or disclosed
* I may revoke this authorization in writing by contacting WVC at anytime
* This authorization is giving WVC the right to discuss my medical information with the one or more people listed above

Signature:____ Date:_____________________

Relationship to patient:____

(If signed by representative)