DESERT BLOOM FAMILY PRACTICE
PATIENT HEALTH INFORMATION

Name: _____________________________________ Date of Birth: _____________________________________

HEALTH HISTORY

Answers on this form will assist your health care provider in understanding your medical concerns and condition(s). If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

Primary Care Provider: ____

Main reason for today's visit:____

Last physical exam: ___________________________ Name of Provider:__________________________________

(For women only) Last well women exam:__________________________ Name of Provider: __________________

Preferred Pharmacy: ____

List any medical conditions you have and approximately when you were diagnosed with the condition:

____

____

____

Allergies or reactions to medications: ____

MEDICATIONS

Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day

Have you had any hospitalizations in the last year, if yes, approximate date:_________________________________

Why were you hospitalized: ____

Have you gone to the emergency room in the last year, if yes, why and when:_____________________________

____

Check any of the following that applies to you:

_ Arthritis
_ Diabetes
_ Cancer
_ Depression
_ Heart Disease
_ Chronic Fatigue
_ Painful Menstruation

_ Epilepsy
_ AIDS
_ Allergies
_ Frequent Illnesses

INTAKE or *USE*
_ Alcohol
_ Recreational Drugs
_ Pain Relievers
_ Tobacco

Check any problem that you have had in the past 6 months:

Muscles-Skeleton
_ Low Back Pain
_ Pain Between Shoulders
_ Neck Pain
_ Arm Pain
_ Joint Pain/Stiffness
_ Problems Walking
_ Difficulty Chewing - TMJ
_ General Stiffness

Circulation-Breathing
_ Chest Pain
_ Shortness of Breath
_ Blood Pressure Problems
_ Irregular Heart Rate
_ Heart Problems
_ Lung Problems
_ Stroke

Eye-Ear-Nose-Throat
_ Visual Disturbances
_ Dental Problems
_ Sore Throat
_ Ear Aches
_ Difficulty Hearing
_ Stuffy Nose
_ Sinus Drainage/Pain
_ Pain - Forehead or Face

Nerve System
_ Headaches
_ Nervousness
_ Numbness/Tingling
_ Muscular Weakness
_ Dizziness
_ Forgetfulness
_ Depression
_ Fainting
_ Convulsions/Seizures
_ Cold Hands Feet
_ Stress
_ Shaking/Tremors

Digestion-Elimination
_ Poor Appetite
_ Excessive Thirst
_ Frequent Nausea
_ Diarrhea
_ Constipation
_ Hemorrhoids
_ Weight Loss/Gain
_ Gas/Bloating
_ Heartburn
_ Change in Stools

Urinary-Genitals
_ Pain with Urination
_ Infrequent Urination
_ Frequent Urination
_ Weak Urine Stream
_ Loss Of Bladder Control
_ Pain in Genitals

Female Only
_ Menstrual Pain/Irregularity
_ Low Back Pain w/ Periods
_ Breast Pain/Lumps

Have you ever had any surgeries/Operations, if yes, please list reason and year of occurrence:

____

FAMILY HISTORY

Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

__Alcoholism
__Cancer, specify type _____________
__Heart disease
__Depression/suicide
__Genetic disorders
__Diabetes Type I: _____ Type II: ______
__Other: ______________________

__High cholesterol
__High blood pressure
__ Stroke
__Bleeding or clotting disorder
__Asthma
__COPD

SOCIAL HISTORY

Tobacco Use

__Cigarettes:	__Current	__Former	__Social	__Never	Packs/day: _____
__Cigars/Pipe:	__Current	__Former	__Social	__Never	
__Other (Chew/Snuff):	__Current	__Former	__Social	__Never	

If former: Start Date_________ Quit Date _______ (*approximate dates*)
If current: Are you interested in quitting? __ Yes __ No

WOMEN'S HEALTH HISTORY

pregnancies: ________________ # deliveries: _____________ # abortions: __________ # miscarriages: _____

Age at start of periods: _______ LMP: _________________ Age at end of periods: ______ B/C: ___________

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

As a patient, you have the right to:

- Considerate and respectful care.
- Knowledge of the name of the healthcare provider who has primary responsibility for coordinating the care, and the names and professional relationships of other healthcare providers who may see you.
- Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the provider who will carry out the procedure or treatment.
- Participate actively in any decisions regarding your medical care; to the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning your medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual.
- Confidential treatment of all communications and records pertaining to your care.
- Reasonable continuity of care and to know, in advance, the time and location of appointment as well as the identity of persons providing the care.
- Be advised if the healthcare provider proposes to engage in or perform human experimentation affecting care or treatment, you have the right to refuse to participate in such research projects.
- Have all your rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Have complaints forwarded to Administrative personnel for appropriate response.
- Know that all the Clinic/Office personnel will observe your rights.

The care a patient receives depends partially on the patient. Therefore, in addition to patient rights, you as the patient have certain responsibilities as well.

- You are responsible to provide accurate and complete information concerning your present complaints, past medical history, and other matters relating to your health.
- You are responsible for making it known whether you clearly comprehend the course of your medical treatment and what is expected of you.
- You are responsible for following the treatment plan established by your healthcare provider, including the instructions of nurses and other health professionals as they carry out the healthcare providers orders.
- You are responsible for keeping appointments and for notifying the office within 24 hours to cancel your appointment. We understand emergency situations occur, however, we reserve the right to initiate a $25.00 missed appointment fee per occurrence, with the possibility of dismissal after three occurrences.
- You are responsible for your actions should you refuse treatment or not follow the healthcare providers orders/recommendations.
- You are responsible for assuring that the financial obligations of your care are fulfilled.
- You are responsible for being considerate of the rights of other patients and office personnel.

I understand my rights and responsibilities as a patient of *Desert Bloom Family Practice*:

Patients Signature:____ Date:___________________
Witness: ____ Date:___________________

DESERT BLOOM FAMILY PRACTICE

FINANCIAL POLICY

Thank you for choosing Desert Bloom Family Practice for you and your family's medical care. Our purpose is to provide quality healthcare for every patient. The following is a statement of the financial policies of Desert Bloom Family Practice, which we require you to read and sign prior to the initiation of medical care. If you would like a copy, please feel free to speak with one of our associates, and we will be happy to assist you.

FULL PAYMENT, CO-PAYMENT, OR ANY OUTSTANDING BALANCE IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, PERSONAL CHECKS, AND MASTERCARD/VISA.

Insurance

In most cases we will accept your insurance benefits. Please check with your insurance company prior to being seen to discover if we are a contracted provider. Your portion of the bill (also known as co-payments/co-insurance) is to be paid at the time of service. This fee cannot be waived or discounted.
***The balance is your responsibility whether your insurance company pays or not.**

Please present your insurance card at the time of check-in so that we may file a claim to your insurance company. Therefore, it is necessary for us to keep a copy of the card in your medical records chart.

Your insurance policy is a contract between you and your insurance company. Desert Bloom Family Practice is not a party to this contract. *Please understand that some, and sometimes all, of the procedures, vaccines, and services provided may not be covered by your insurance*.

If a charge is not covered by your insurance plan**,** *you will be billed the balance* after we receive an Explanation of Benefits from your insurance carrier. Our practice is committed to providing the best medical treatment for our patients and we charge the usual and customary fees for the services rendered. Therefore, outstanding charges are due upon receipt.
Accounts with unpaid charges 120 days from the original date a claim has been filed, are placed with a collection agency.
You will be responsible for any collection cost with Desert Bloom Family Practice and the affiliated collection agency.

Uninsured Patients

Desert Bloom Family Practice understands the healthcare situation of its community. We welcome those patients whose insurance companies are not contracted with this office or wish to pay out of pocket for services rendered. Our policy is for payment to be made at the time of service for all office visits and surgical procedures.

Returned Checks

There will be a $35.00 service charge for all returned checks.

By signing this form, you understand and agree to Desert Bloom Family Practice's financial policy.

Date:______________________

Patient or Guardian's Signature:____

DESERT BLOOM FAMILY PRACTICE

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I authorize Desert Bloom Family Practice to obtain my medical information as directed below.

Patient's Full Name:_______________________________ Date of Birth:______________________________

I hereby authorize Desert Bloom Family Practice P.L.L.C. to obtain Protected Health Information from:

Name: ____

Address: ____

____

Phone Number: ____

Please specify the Protected Health Information to be released: (i.e.; lab or x-ray results, progress notes, all):____

Dates of care include:__________to __________

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that the information may include sensitive information such as alcohol and drug usage, child abuse/neglect, sexual assault/abuse, sexually transmitted disease, termination of pregnancy, sexual preference, history of behavioral health counseling/family interaction problems.
3. EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now):______

Please forward my Protected Health Information to:

Desert Bloom Family Practice P.L.L.C.
1925 W. Orange Grove Road
Suite 201
Tucson, AZ 85704
Phone: (520) 202-5820 Fax: (520) 638-6861

____________ ____
Date Signature of patient or guardian

DESERT BLOOM FAMILY PRACTICE

CONSENT TO LEAVE DETAILED MESSAGE

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Name____ DOB _____________________

I authorize the associates of Desert Bloom Family Practice to leave detailed messages (as I have marked below) on any or all phone numbers I have listed below.

____
____
____

☐ Desert Bloom Family Practice can leave NORMAL results on the phone number(s) listed above.

☐ Desert Bloom Family Practice can leave detailed messages regarding ANY results on the phone number(s) listed above.

☐ Desert Bloom Family Practice can leave detailed messages regarding my medical care on the phone number(s) listed above.

☐ Desert Bloom Family Practice may ONLY leave call back information on the phone number(s) listed above, with **NO** details.

I understand that it is my responsibility to contact Desert Bloom Family Practice regarding any changes to the phone numbers I have listed above.

Signature___________________________________Date_________________________

Witness____________________________________ Date__________________________

We value your business; in order to serve you better please provide the requested information. Please print clearly and complete all information listed below.

PATIENT INFORMATION

Date:_____________ Patient Name:____

Address: ______________________________________ City:______________________________

State:______________ Zip:_____________ Employer_______________________________________

Home Telephone Number:________ Work Number: ________ Cell Number__________ Religion:___________ Race:___________

Spouse Name: ____________________________ Spouse Work Number: ______________ Spouse Cell:______________________

Emergency Contact/Nearest Relative:__________________________________ Telephone Number:_________________________

Marital Status: Single o Married o Divorced o Widowed o Social Security Number: ________________________________

Date of Birth:_______________________ Primary Care Provider: ____

E-mail address:

____

PRIMARY INSURANCE INFORMATION

Insurance Company: ____

Insurance Identification #: ____ Group #:__________________

Address: ____________________________________ City:__________________ State:______________ Zip:_________________

Subscriber:____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Subscriber SS#:________-_______- __________ Date of Birth:____ Sex: ☐ M ☐ F

Employer:____ Work # ______________________________

Employer's Address:_________________________________City:__________________State:_______________ Zip:__________

SECONDARY INSURANCE INFORMATION

Insurance Identification #: ____ Group #:__________________

Address: ____________________________________ City:__________________ State:______________ Zip:_________________

Subscriber:____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Subscriber SS#:________-_______- __________ Date of Birth:____ Sex: ☐ M ☐ F

Employer:____ Work # ______________________________

Employer's Address:_________________________________City:__________________State:_______________ Zip:__________

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I HEREBY AUTHORIZE DESERT BLOOM FAMILY PRACTICE TO RELEASE ANY INFORMATION CONCERNING MY HEALTH INFORMATION TO MYSELF:________________MY PARENT/GUARDIAN:_______________________OTHER:___________________

I UNDERSTAND THAT MY PERSONAL HEALTH INFORMATION WILL BE USED BY DESERT BLOOM FAMILY PRACTICE ACCORDING TO ARIZONA STATE & HIPAA.

By signing this form I agree and consent to Desert Bloom Family Practice's use and disclosure of my protected health information to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, and to conduct normal healthcare operations such as quality assessments and healthcare provider certifications as stated in the notice of privacy practices, and that I have been provided or offered a copy of this notice.

I agree that all of the above demographic and insurance information is accurate and up-to-date. If there is an error in the information above, I understand I am responsible for the charges related to the error(s). I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/ procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services. I hereby assign all medical and/or treatment benefits including major medical benefits to Desert Bloom Family Practice for services rendered.

Patient Consent:____

Parent/Legal Guardian's Consent:____