East Mesa Orthopedics & Sports Medicine

Patient Information

Patient Name:______________________________ Date:______________

DOB:______________________ Age:______ Gender: [ ] Male [ ] Female

SSN:______________________ [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Employment: [ ] Employed [ ] Not Employed [ ] Retired [ ] Active Military [ ] Student

Employer:____

Home Phone:____________________ Work Phone:____________________

Mobile Phone:____________________ Other Phone:____________________

Local Address:____

City:__________________________ State:_____ Zip Code:______________

Mailing Address:____

City:__________________________ State:_____ Zip Code:______________

E-mail Address:____

Emergency Contact:______________________ Relationship:______________

Phone:____________________ May speak to about medical care: [ ] Yes [ ] No

Insurance Information

Primary:__________________________ ID#:____________________

Secondary:__________________________ ID#:____________________

Guarantor Information (Policy Holder)

Guarantor Name:____

DOB:______________________ SSN:__________________________

Relationship to patient: [ ] Self [ ] Spouse [ ] Child [ ] Other

Family Physician:______________________ Phone:__________________

Specialty Doctors:____

Type: [ ] Cardiology [ ] Pulmonology [ ] Oncology [ ] Neurology [ ] Pain Management

[ ] Other:____

Pharmacy:______________________ Phone:____________________

Location (crossroads):____

East Mesa Orthopedics & Sports Medicine
Patient Medical History

Patient Name:____ Date:________________
Height:__________ Weight:__________(lbs)

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to specify
Race:____ [ ] Decline to specify

Do you smoke? [ ] No [ ] Yes - Number of packs/day:__________ For how long:____________
Do you drink alcohol? [ ] No [ ] Yes - How often:______________ How much:____________
Do you currently use illicit drugs or have so in the past? [ ] Yes [ ] No
Please list illicit drugs currently being used:____

Are you allergic to any of the following?
[ ] Adhesive Tape [ ] Latex [ ] Iodine [ ] Sulfa [ ] Aspirin [ ] Codeine [ ] NSAIDS [ ] PCN
[ ] Other:____
Reactions:____

Reactions to Anesthesia:____

Past Medical History

[ ] Anemia	[ ] Cancer	[ ] Infections (MRSA, etc)
[ ] Arthritis	[ ] Diabetes	[ ] Kidney Disorder
[ ] Asthma	[ ] Depression	[ ] Liver Disorder
[ ] AIDS / HIV	[ ] Epilepsy	[ ] Lung Disease
[ ] Bleeding Disorder	[ ] Gastritis	[ ] Neurological Disease
[ ] Blood Clots	[ ] Gout	[ ] Osteoporosis
[ ] Blood Pressure	[ ] Heart Disease	[ ] Stroke
[ ] Blood Transfusion	[ ] Heart Problems	[ ] Thyroid Disorder
[ ] Bronchitis	[ ] Hepatitis - A, B or C	[ ] Ulcers

Other / Comments:____
____

Family History

Has anyone in your family ever had any of the conditions above?
Condition:____ Relation:________________
Condition:____ Relation:________________
Condition:____ Relation:________________
Condition:____ Relation:________________

East Mesa Orthopedics & Sports Medicine
Patient Medical History

Patient Name:______________________________ Date:__________

Reason for Visit:______________________________

Follow-up from the hospital: [ ] Yes [ ] No

Body Parts of Complaint:______________________________

____

Date of Onset/Injury:______________

Were you involved in a motor vehicle accident? [ ] Yes [ ] No
Were you injured on the job? [ ] Yes [ ] No
Are you filing for Workman's Comp? [ ] Yes [ ] No
Do you have an attorney on your case now or plan on getting one? [ ] Yes [ ] No

Describe how injury occurred:______________________________

____

____

Place of Injury: [ ] Home [ ] Work [ ] Other______________

Did you receive medical treatment anywhere? [ ] Yes [ ] No
What treatment did you receive and where?______________________________

____

Hospitalizations & Surgeries

Reason:______________________________ Date:__________
Reason:______________________________ Date:__________
Reason:______________________________ Date:__________
Reason:______________________________ Date:__________

Current Medications

Name	Dosage	Frequency	Name	Dosage	Frequency

East Mesa Orthopedics & Sports Medicine
Patient Health Questionnaire
Please check all that apply

Patient Name: ______________________________
Date: ______________________________

- ☐ Good General Health
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Night Sweats
- ☐ Fever
- ☐ Headaches
- ☐ Fatigue
- ☐ Chills

- ☐ Skin Rash
- ☐ Dry Skin

- ☐ Trouble Breathing
- ☐ Seasonal Allergies
- ☐ Immune Deficiency

- ☐ Trouble Hearing
- ☐ Hearing Loss
- ☐ Earaches
- ☐ Nasal Congestion
- ☐ Sinusitis

- ☐ Vertigo
- ☐ Lightheadedness

- ☐ Chest Pain
- ☐ Heart Murmurs
- ☐ Edema
- ☐ Swelling in Feet and Ankles
- ☐ Hypertension
- ☐ Heart Palpations

- ☐ Dry Cough
- ☐ Wheezing
- ☐ Shortness of Breath

- ☐ Nausea
- ☐ Diarrhea
- ☐ Loss of Appetite

- ☐ Hormonal Therapy
- ☐ Diabetes

- ☐ Weakness or Numbness in Extremities
- ☐ History of Stroke

- ☐ Pain
- ☐ Muscle Cramps
- ☐ Stiffness/Swelling
- ☐ Limited ROM
- ☐ Night Cramps
- ☐ Difficulty Walking
- ☐ Joint Pain
- ☐ Back Pain

- ☐ Seizures
- ☐ Loss of Memory
- ☐ Parathesias (nerve pain)
- ☐ Tremors
- ☐ Light headed or dizzy

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Suicidal Thoughts
- ☐ Confusion

- ☐ Bruising
- ☐ Swollen Glands
- ☐ History of Blood Clots
- ☐ History of Blood Transfusion
- ☐ Anemia

East Mesa Orthopedics & Sports Medicine

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, East Mesa Orthopedics & Sports Medicine, may use and disclose protected health information about me to carry out medical treatment, payment, and healthcare operations.

With my consent, East Mesa Orthopedics & Sports Medicine, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out my healthcare treatment, such as appointments, insurance claims, and any call pertaining to my clinical care, including laboratory results or x-ray results.

With my consent, East Mesa Orthopedics & Sports Medicine, may mail to my home or other designated location any items that assist the practice in carrying out my healthcare treatment, such as appointment information, prescriptions, or patient statements.

I have the right to request that East Mesa Orthopedics & Sports Medicine, restrict how it uses or discloses my health information. If the patient has specific restrictions they must provide them in writing at the time this form is signed. However, the practice is not required to agree to my requested restrictions, but if we do, we will abide by our agreement.

By signing this form, I am consenting to East Mesa Orthopedics & Sports Medicine, for use and disclosure of my health information for treatment and healthcare operations. I am also consenting to allow my information to be shared with our billing company Revmd for billing purposes. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, East Mesa Orthopedics & Sports Medicine may decline to provide treatment to me.

Upon request patients may ask to review and read our entire privacy policy before signing this form.

_______________________________________ ____________________

Signature of Patient or Legal Guardian Date

____

Print Name of Patient or Legal Guardian

4850 E. Baseline Road Suite 118 Mesa, Arizona 85206
Tele: 480 461 0047

East Mesa Orthopedics & Sports Medicine
Financial Policy

Thank you for choosing us as your health care provider. The following is a statement of our financial policy which we require you to read and sign prior to treatment. All patients must complete our patient information forms before seeing the doctor.

Regarding Insurance

We accept assignment of insurance benefits at the time of service. Please understand that we file insurance claims as a courtesy to our patients. We cannot bill your insurance unless you bring all your insurance information (i.e. your card and the correct address to bill claims.) Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. It is your responsibility know your coverage, this includes referrals that are required by your HMO, co-pays, deductibles, and if we are listed as a provider with your insurance plan. If your insurance company has not paid your account in full within 120 days, you will be notified by our billing department that the balance been transferred to your name, you would need to contact your insurance company and make arrangements with them regarding payment. Please be aware some services may be non covered services and not covered under Medicare and/or your medical insurance.

Payments

All patients are responsible for payment (this includes co-pays and deductibles) at the time of service. The adult accompanying a MINOR is responsible for payment in full. Patients that are minors that are not accompanied by an adult will be denied services unless prior written approval has been given for those services.

Policy on Disability Forms, FMLA Forms, Leave of Absence Forms, Employer or Company Specific Forms.

As of 09/01/15 there will be a $50.00 charge for all forms that fall into the above categories. This fee is due at the time the form is presented to the office. The form will not be completed until this is paid please allow 5-7 days (not including weekends) for the form to be completed. A $50.00 fee will be assessed for every new form presented. This fee is due to the extensive time and work involved in filling, examining, and copying records.

Please note: There may be additional charges if we are presented with forms that don't fall into the above categories.

I HAVE READ THE POLICY IN FULL. I UNDERSTAND THAT REGARDLESS OF INSURANCE I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES. I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT OR ANY OTHER MEDICAL PROVIDER THAT I LISTED ON A REFERRAL BASIS. I AGREE TO PAY FOR SERVICES RENDERED SET FORTH IN THE FINANCIAL POLICY.

SIGNATURE:____

East Mesa Orthopedics & Sports Medicine
4850 E Baseline Ste 118
Mesa, AZ 85206

Attention Patients

1. All medications will be dispensed electronically **only,** effective 01/01/2019.

2. It is very important that we have your correct pharmacy on file in order to prescribe you medication. Please fill out your pharmacy information below. If we don't have your correct pharmacy your prescription will be delayed. Once a prescription is sent electronically to the pharmacy listed below, we cannot change the pharmacy and or prescription. It is the patient's responsibility to inform us of any changes to their pharmacy.

3. Patient's that are calling for refills, please call at least 3-4 days prior to you running out of medication. This will allow time for the physician to approve it and electronically prescribe it. There will be no last minute refills so please be prepared to know when you are running out of medication with a 3-4 day notice. Once an opioid is prescribed there will be no changes to that medication. Please inform your doctor of any issues with certain medications you may have.

Pharmacy Name: ____

Pharmacy address or Cross Streets: ______________________________

Pharmacy Phone #: ____

I have read and understand the above rules regarding my prescriptions.

____
Print Patient Name

____
Patient Signature   Date: