1st *Care* Family Medical

1635 W Glendale Ave, Phoenix AZ 85021 (P) 602-544-2273 (F) 602-544-3017

637 E Main Street, Mesa AZ 85203 (P) 480-272-8877 (F) 480-272-8998

Patient Information:

Name:____ Age:____ ☐ Male ☐ Female

Date of Birth:_______________ Pharmacy: ____________________ Location: ________________________

Address: ____

City: ________________ State: ________ Zip Code: ______________

SS#_____-____-_____ Phone Number: Home (_____) ____-_____ Cell (_____) ____-_____

Insurance Company: ____________________________ or Self Pay ( )

How did you hear about 1st Care Clinic?

Street Sign( ) Friend/Family( ) Yellow Pages( ) Internet( ) Flyer( ) Ads( ) Ins Co( )

Responsible Party:

Name:____________________________ Age:_____ Relationship to Patient: ______________________

Date of Birth:__________________ SS#_______-______-_______

Phone Number: Home (_____) _______-_______ Cell (_____) _______-_______

Emergency Contact:

Name:_________________________________ Relationship: ___________________

Phone Number: Home (_____) ______-_______ Cell (_____) ______-_______

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE ACT

I ______________________ have had the opportunity to read/ review the NOTICE OF PRIVACY PRACTICE ACT provided to me at 1st Care Medical Clinic. The NOTICE OF PRIVACY PRACTICE ACT will be kept in the lobby and in each exam room for my review beginning April 14, 2006 and will be available ongoing. I understand that if I wish to have a copy of THE NOTICE OF PRIVACY PRACTICE ACT that I may ask for and receive one at the check-in or out desk.

Cancellation Policy: I understand that when I make an appointment, the physician, provider and staff are scheduled in for my care. I agree to pay a $50 fee if I miss my scheduled appointment or not cancel 24 hours in advance. **Please Initial ____**

Patient or Guardian Signature: ____________________________ Date: ________________

Financial Agreement and Authorization:

I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize 1st Care Medical Clinic to obtain on my behalf any insurance information covered by "The Privacy Act" from insurance company(s) file(s). I hereby authorize payment directly to the physician(s) for medical and/or surgical all reimbursement benefits. I am responsible and agree to pay all charges for visits and lab tests as deemed necessary by my provider. I FURTHER AGREE TO PAY ALL COLLECTION COSTS, ATTORNEY FEES, AND OTHER COLLECTIONS THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNTS THAT ARE OUTSTANDING BALANCES.

- If you have insurance, as a courtesy we will gladly bill your insurance company provided you give us all the information we need for billing. All co-pays, deductibles and co-insurance which are your portion of the bill are due at the time of service.
- If you are a self-pay patient, the payments for the visit or tests are due at the check-in time. We accept cash and most major credit cards. We do not accept checks.

Power of Attorney/Living Will:

Do you have a Power of Attorney or a Living Will : **Yes___ No____**

If not, do you need a Power of Attorney or a Living Will : **Yes____ No___**

Patient or Guardian Signature: ____________________________ Date: ____________________

Allergies (Please Explain Reaction and Severity)

- ☐ Codeine ________________________
- ☐ Penicillin _______________________
- ☐ Aspirin __________________________
- ☐ Iodine __________________________
- ☐ Novocain ________________________
- ☐ Adhesive _______________________
- ☐ Sulfa ______________________________
- ☐ Morphine ___________________________
- ☐ Ace Inhibitors ________________________
- ☐ NO KNOWN ALLERGIES
- ☐ Other: ______________________________

List all medical conditions

- ☐ Cardiovascular Disease
- ☐ Cancer __________________________
- ☐ Kidney Disease
- ☐ Bleeding disorders
- ☐ Lung Disease____________________
- ☐ Circulatory problems
- ☐ Varicose Veins
- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Problems
- ☐ Gout
- ☐ Anxiety
- ☐ Hemophilia
- ☐ Depression
- ☐ Diabetes
- ☐ Weight loss
- ☐ Neuropathy
- ☐ Hepatitis A, B or C
- ☐ Phlebitis
- ☐ Fainting
- ☐ Hypertension Disorder
- ☐ Chemical Dependency
- ☐ Low Blood Pressure
- ☐ Swelling
- ☐ Lupus
- ☐ Heart Burn
- ☐ Rheumatic fever
- ☐ Diarrhea
- ☐ Stroke
- ☐ Headaches
- ☐ Ulcers
- ☐ Constipation

Other: ____________________________________

List other doctors you have seen for your problems.
____
____

List any treatment received from a doctor for any health issues in the past year.
____
____

List previous surgeries including dates.
____
____

List Hospitalizations including dates.
____
____

Immediate Family History?
____
____

Medications List :
____
____
____

Females

Are you Pregnant? Yes: _____ No:_____
Last Menstrual Period? _____________
Number of Pregnancies? _____________
Number of Births? __________________

Social History

Do you smoke tobacco? Yes: _____ No: ______
#Packs per day ____ #of Years Smoking _____
Previously smoked? Yes: ____ No: _____
#Packs per day _____ #of years since stoped ___
Alcohol Intake? Yes: _____ No: _____
Occasional: ____ Moderate: ____ Severe: _____

Consent to Routine and surgical procedures:

I hereby authorize 1st Care Family Medical and their assistants to perform routine and general procedures. I acknowledge I have the right to refuse treatment at any given time during the course of treatment.

Patient or Guardian Signature:

____

Date: _________________________