MEDICAL HISTORY FORM

Patient's Name____ How do you want us to address you? ________________________

DOB ____/____/_____ Age______ Height __________ Weight ___________ Referring Dr.________________________________

Why are you here to see the doctor? ____

MEDICATIONS

MEDICATIONS TAKEN REGULARLY	REASON	DOSE	How Often?	Start Date

MEDICINE ALLERGIES	REACTION
FOOD ALLERGIES	**REACTION**

PROCEDURE/SURGERY Side	YEAR

Have you had a colonoscopy? _______ If so approximately when? _____________

Have you had a mammogram? _______ If so approximately when? _____________

PAST MEDICAL HISTORY

DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO
Anemia			Heart Murmur			Mitral Valve Prolapse		
Arthritis			Diabetes			Rheumatic Fever		
Asthma			Glaucoma			Skin Cancer		
Bleeding Problem			Hepatitis			Stroke		
Blood Transfusion			High Blood pressure			Thyroid Disease		
Cancer (Other)			HIV/AIDS			Tuberculosis		
Heart Disease			Kidney Disease					

If yes to any of the above, please describe the condition: ____

____

YOUR FAMILY HISTORY

DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO
Breast Cancer			Diabetes			Heart Disease		
Melanoma			Stroke			Kidney Disease		
Other Cancer			High Blood Pressure			Depression		

If yes to any of the above, please identify your relation to the family member and age of diagnosis: _______________

____

TOBACCO USE: □ YES □ NO □ FORMER

Type ____________ # of Years ____________

Units per day ________ Year quit _______

DRINKS ALCOHOL: □ YES □ NO □ FORMER

Type ______________ Amount ___________

Frequency _____________ Last drink __________

EXERCISE: □ YES □ NO

Can you walk up 2 flights of stairs? □ YES □ NO

Occupation ___________________________

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REVIEW OF SYSTEMS

Patient Name ______________________________ **Date** ______________

Are you currently experiencing any of the following?

CONSTITUTIONAL

YES NO

- ☐ ☐ Chills
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Malaise
- ☐ ☐ Night Sweats
- ☐ ☐ Weight gain
- ☐ ☐ Weight Loss

Other: ______________________________

HEENT

YES NO

- ☐ ☐ Ear drainage
- ☐ ☐ Ear pain
- ☐ ☐ Eye discharge
- ☐ ☐ Eye pain
- ☐ ☐ Hearing loss
- ☐ ☐ Nasal drainage
- ☐ ☐ Sinus pressure
- ☐ ☐ Sore throat
- ☐ ☐ Visual changes

Other: ______________________________

RESPIRATORY

YES NO

- ☐ ☐ Chronic cough
- ☐ ☐ Cough
- ☐ ☐ Known TB exposure
- ☐ ☐ Shortness of breath
- ☐ ☐ Wheezing

Other: ______________________________

CARDIOVASCULAR

YES NO

- ☐ ☐ Chest pain
- ☐ ☐ Claudication
- ☐ ☐ Edema (swelling)
- ☐ ☐ Palpitations

Other: ______________________________

GASTROINTESTINAL

YES NO

- ☐ ☐ Abdominal pain
- ☐ ☐ Blood in stools
- ☐ ☐ Change in stools
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Heartburn
- ☐ ☐ Loss of appetite
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

Other: ______________________________

BREAST

YES NO

- ☐ ☐ Nipple discharge
- ☐ ☐ Breast lump
- ☐ ☐ Inverted nipples
- ☐ ☐ Breast pain
- ☐ ☐ Breast swelling
- ☐ ☐
- ☐ ☐

Other: ______________________________

METABOLIC/ENDOCRINE

YES NO

- ☐ ☐ Brittle hair
- ☐ ☐ Brittle nails
- ☐ ☐ Cold intolerance
- ☐ ☐ Hair changes
- ☐ ☐ Heat intolerance
- ☐ ☐ Hirsutism (excessive bodily hair)
- ☐ ☐ Polydipsia (excessive thirst)
- ☐ ☐ Polyphagia (over eating)

Other: ______________________________

NEUROLOGICAL

YES NO

- ☐ ☐ Dizziness
- ☐ ☐ Extremity numbness
- ☐ ☐ Extremity weakness
- ☐ ☐ Gait disturbance
- ☐ ☐ Headache
- ☐ ☐ Memory loss
- ☐ ☐ Seizures
- ☐ ☐ Tremors

Other: ______________________________

PSYCHIATRIC

YES NO

- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Insomnia

Other: ______________________________

INTEGUMENTARY

YES NO

- ☐ ☐ Contact allergy
- ☐ ☐ Hives
- ☐ ☐ Itching
- ☐ ☐ Mole changes
- ☐ ☐ Rash
- ☐ ☐ Skin lesion

Other: ______________________________

MUSCULOSKELETAL

YES NO

- ☐ ☐ Back pain
- ☐ ☐ Joint pain
- ☐ ☐ Joint swelling
- ☐ ☐ Muscle weakness
- ☐ ☐ Neck pain

Other: ______________________________

HEMATOLOGIC/LYMPHATIC

YES NO

- ☐ ☐ Easy bleeding
- ☐ ☐ Easy bruising
- ☐ ☐ Lymphadenopathy (swelling of lymph nodes)

Other: ______________________________

GENITOURINARY

YES NO

- ☐ ☐ Painful/difficult urination
- ☐ ☐ Excessive urination
- ☐ ☐ Blood in urine
- ☐ ☐ Incontinence

Other: ______________________________

IMMUNOLOGIC

YES NO

- ☐ ☐ Environmental allergies
- ☐ ☐ Food allergies
- ☐ ☐ Seasonal allergies
- ☐ ☐ Limited range of motion
- ☐ ☐ Redness or tenderness

Other: ______________________________

PASTS TESTS/DIAGNOSTICS/LABS:

DATE	TYPE

I have reviewed the above recorded information Physician Signature ______________________________ Date ______________

Arizona Community Surgeons
dba
The Institute for Plastic Surgery

Patient Registration Form

Patient Information-Please Print

Name ____
Last First Nickname MI

Address ____
Street City St Zip Code

Phone w/area code ___________________ Cell ________________ Work ___________________

DOB ___________ SS #_________________________ Email Address ____________________________________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Hispanic or Latino

☐ Native Hawaiian or Other Pacific Islander ☐ Multi-racial ☐ Other **Preferred Language:______________________**

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

If married, spouses name _______________________________ DOB: _______________ Phone #_________________

Emergency Contact ____ DOB: _________________

Relationship ____________________ Phone #__________________

Primary Care Physician ___________________________ Address________________________ Phone_______________

Referring Physician ___________________________ Address__________________________ Phone_______________

Employer _____________________________________ Occupation _________________________

Employer address ____________________________________ Employer Phone _____________________

Person responsible for bill, if other than patient ________________________________ DOB __________

Address ____ Phone ___________________

SS# ___________________ Relationship _____________________

Insurance Information

Primary Insurance _________________________ Policy # _______________________ Group # _________________

Policy Holder ____________________________ SS # ___________________________ DOB ____________

Secondary Insurance _________________________ Policy # _______________________ Group # ______________

Policy Holder ____________________________ SS # ___________________________ DOB ____________

Workers Comp Information: (Must be completed for us to file your claim otherwise you will be billed)

Date of Injury: _____________ Claim #: ______________________ Case Worker: _______________________

Carrier __________________ Address: ____

Employer at time of injury _____________________________________

All Patients Please Complete and Sign This Release of Medical Records and Assignment of Benefits

I hereby authorize Arizona Community Surgeons, PC dba The Institute for Plastic Surgery to release to or request from my insurance company, other physicians or hospitals, any information including the diagnosis and records of any treatment or examination rendered to me during surgical care, that may be necessary to process my health insurance claim and that the information may be faxed. I also authorize and request my insurance companies to pay directly to the above named corporation the amount due me in my pending claim for medical and/or surgical treatment or service. I also understand that if it becomes necessary to refer my account for collection, I will be liable for the reasonable collection fees and court costs expended therein.

Patient's Signature: ____ Date: ______________
(Parent or guardian if minor)

Payment Policy

Patients with Insurance: Insurance cards must be presented at the time of check in prior to your visit. As our participation with insurances can change, it is your responsibility to call your insurance company before each appointment to verify we still are participating providers for your insurance plan. Your health insurance is a contract between you and your insurance company.

Private Pay and Patients without Insurance: Typically at the time that we scheduled your appointment we would have let you know that you need to pay a certain amount at the time of the visit in order to be seen. This amount will be used as a deposit for care rendered on that day. If there is a balance over the amount we collected from you, you will be billed for that balance.

Co-Payments: We are required to collect your co-payment at the time of service. We accept cash, check and most credit cards. If you are unable to pay your co-payment at the time of service your appointment may need to be rescheduled.

Returned Checks: If your check gets returned to us for non-sufficient funds, you will be assessed a $25 charge.

Forms Completion/Medical Records: There may be a charge for forms, letters or copies of medical records. The type of service requested by the patient will determine the charge. For example, disability forms will be assessed a $20 processing fee for each form. There will not be a charge for medical records sent to any physician for continuing care but we do require a signed medical records release form signed by the patient. Please be aware that we do retain the right to charge patients who are requesting copies of their medical records for personal use. All patients will be required to sign a medical records release before any information can be given to them.

PATIENT IS RESPONSIBLE FOR ADVISING OUR OFFICE OF ANY CHANGES TO THEIR ADDRESS, PHONE NUMBER, INSURANCE PLAN, PAYOR OR COVERAGE.

I have read and agree to this Payment Policy.

_____________________________ ___________ ________________________________ ____________

Printed Patients Name DOB Patient or Guardian's signature Date

Arizona Community Surgeons PC

Electronic Prescribing
Pharmacy Selection & Consent

Preferred Pharmacy Selection

Please indicate your preferred pharmacy (ies) for any medications we may prescribe:

Pharmacy Name	
Address and/or Cross Streets	
Phone Number	

Pharmacy Name	
Address and/or Cross Streets	
Phone Number	

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record. This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for ARIZONA COMMUNITY SURGEONS, PC to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Patient Name (Print)

Date of birth

Patient or Parent/Guardian Signature

Date

Arizona Community Surgeons PC

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used 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.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or had the opportunity to review the Notice of Privacy Practices from Arizona Community Surgeons, PC ("ACS"), which contains a more complete description of the uses and disclosures of my health information. I understand that ACS has the right to change its Notice of Privacy Practices from time to time and that I may contact ACS at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that ACS restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand ACS is not required to agree to my requested restrictions, but if ACS does agree then ACS is bound to abide by such restrictions.

Signature: ____

Patient Name: ____________________________________ DOB: __________

Relationship to Patient: ____

Date: ____

Please inform us if there is any person(s) to whom we may inform about your medical condition, diagnosis and/or your financial account:

Name: ____________________ Relationship: ________________ Phone: __________

Name: ____________________ Relationship: ________________ Phone: __________

Name: ____________________ Relationship: ________________ Phone: __________

ACS OFFICE USE ONLY:

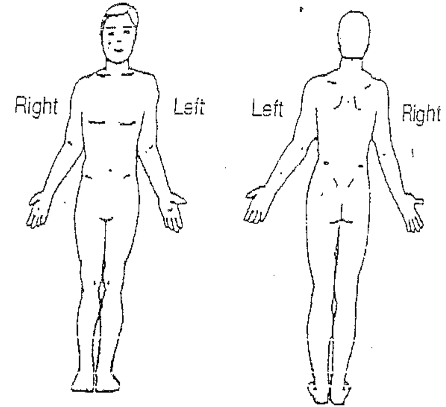
I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: ________________ Employee Name/Initials: ________________

Reason: ____

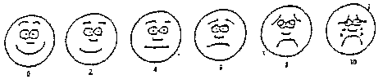
Patient Name: _______________________________ DOB: __________ Date:________

If The Reason For Your Visit Today is **Pain Related**, Please Take the Time to Fill Out The Following:



1. Please circle the face that shows your pain at its best:

2. Please circle the face that shows your pain at its worst:



3. Where is your pain?
   Mark the areas on your body where you are feeling pain.

4. Circle the word(s) that best describe your pain

   Aching Throbbing Shooting Stabbing Gnawing Sharp Tender

   Burning Exhausting Tiring Nagging Penetrating Numb Miserable

5. Is your pain **Continuous** **Occasional**
6. Circle the time of day your pain is worse **Morning** **Afternoon** **Evening** **Night**
7. What makes your better?____
8. What makes your pain worse? ____

If The Reason For Your Visit Today is **Neuropathy,** Please Take The Time To Fill Out The Following:

9. How long have you had Neuropathy? ____
10. Who was the first doctor to Diagnose you with Neuropathy?___________________________________
11. Are you taking or have you taken Neurontin?__________ Does/did it help with your pain?___________
12. Are you taking any other medication for your pain? ___ if so, which medication(s)________________
13. Did the doctor that diagnosed you with Neuropathy perform an EMG? ____ If so, When?___________
14. Do you have Diabetes? _____ If so, when were you diagnosed? _____________________________
15. Have you had Chemotherapy? ____ If so, when? ____________________ for how long?___________
    How many cycles?_______________ Which Chemotherapy medication(s)?______________________
16. Have you been exposed to heavy metals (Arsenic, Lead, Mercury)? ______ If so, how?____________
17. Do you have any back or spine problems?_______ Have you had back or spine problems?__________
    Have you had back or spine surgery? _____ If you answered yes to any of the above, Please describe:

____

Christopher T. Maloney, Jr., M.D.

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