# MSP: *INTERNAL MEDICINE*
## PATIENT REGISTRATION

Name: _____ Date of Birth: _____

Address: _____

City/ZIP: _____ Home phone: _____ Cell: _____

Social Security Number: _____ E-mail Address: _____

**PHARMACY Name & Location:** _____ Consent to Request Rx History (Y/N) _____

**Gender**: Female [ ] Male [ ] **Marital Status**: Married [ ] Single [ ] Widowed [ ] Divorced [ ]

**Race**: Caucasian [ ] Hispanic [ ] African American [ ] Asian [ ] American Indian/Alaskan [ ]
Native Hawaiian/Other [ ] Other [ ] _____ Refused by Patient [ ]

**Ethnicity**: Hispanic Origin [ ] Not of Hispanic Origin [ ] Refused by Patient [ ]

Preferred Language: _____

Retired [ ] Employed [ ] Employer: _____ Work phone: _____

### Emergency Contact

Name: _____ Relationship: _____ Telephone: _____

**PERMISSION TO DISCUSS MEDICAL INFORMATION/TEST RESULTS WITH:**

1. _____ 2. _____ 3. _____

**Primary:** Insurance Company _____

ID# _____ Group# _____ Policy Holder Name: _____

DOB: _____ Relationship to Insured: _____

**Secondary:** Insurance Company: _____

ID# _____ Group# _____ Policy Holder Name: _____

DOB: _____ Relationship to Insured: _____

### INSURANCE PAYMENT/FINANCIAL RESPONSIBILITY RELEASE

**NOTE: ALL INSURANCE COPAYS ARE DUE AT TIME OF SERVICE.**

I request that payment of authorized Medicare benefits, or any other insurance benefits be made to either me or on my behalf to Multi-Specialty Physicians – Internal Medicine of Surprise/Sun City/Goodyear for any services furnished to me by the Physician/Provider. I authorize any holder of medical information concerning me to be released to my insurance carrier or Health Care Financing, its agents; any information needed to determine these benefits or the benefits payable for related services. A photocopy of this authorization shall be considered effective and valid as the original. **I understand that I am financially responsible for all charges not covered by my insurance company.**

| Signature: | Date: |
|---|---|
| | |

# Notice of Privacy

***To Our Patients*:** This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to your privacy**

- Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
- We realize that these laws are complicated, but we must provide you with the following important information.

***Use and disclosure of your health information in certain special circumstances***

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.

***Your rights regarding your health information***

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests
2. You can request a restriction of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing.
5. Right to copy this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
8. I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

## I hereby acknowledge that I have been presented with a copy of Notice of Privacy

Signature _____ Print Name: _____ Date: _____

**Notice to Patients:**

- **ALL insurance copays are due at the time of service.**
- **If you missed three consecutive appointments, we reserve the right to discharge you from our practice as a patient. If an appointment needs to be rescheduled or cancelled, please contact us within 24-hours from your appointment time. Thank you for your cooperation.**

# INTERNAL MEDICINE

Patient Name: _____ DOB: _____ Date: _____
**PLEASE PRINT**

Reason for today's visit: _____

Do you have an advanced directive (living will)? YES NO

Are you allergic to any medications: YES NO If yes please list: _____
_____
_____

Are you allergic to Bee Stings: YES NO

Are you allergic to any foods: YES NO If yes please list: _____
_____

## IMMUNIZATION HISTORY

**Please list any immunizations you have had within the last ten years**

Flu shot YES NO Date : _____ Pneumonia YES NO Date: _____

Hepatitis A YES NO Date: _____ Hepatitis B series of three shots: YES NO

Tetanus YES NO Date: _____ Hep B Dates: _____

## MEDICATIONS

Please list all medications you are currently taking **INCLUDING** over the counter medications and supplements:

| NAME OF MEDICATION | DOSAGE | WHEN DO YOU TAKE | HOW OFTEN |
|---|---|---|---|
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What pharmacy do you currently use? _____ Phone #: _____

Location (cross streets): _____

# PATIENT HISTORY FORM

**Patient Name:** _____ **DOB:** _____

**PLEASE PRINT**

**Have you ever had or do you now have any of the following**:

| Illness | Yes | No | Illness | Yes | No | Illness | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Diabetes Type 1 | | | Hyperthyroidism | | | Liver Disease | | |
| Diabetes Type 2 | | | Graves Disease | | | Hepatitis A | | |
| Asthma | | | Peptic Ulcer Disease | | | Hepatitis B | | |
| COPD | | | GERD | | | Hepatitis C | | |
| Emphysema | | | Hypothyroidism | | | Cirrhosis | | |
| Hypertension | | | Dementia | | | Skin Problems | | |
| Heart Attack | | | Alzheimer | | | Renal Failure | | |
| Congestive Heart Failure | | | Parkinson's | | | Kidney Problems | | |
| Carotid Artery Disease | | | TIA's | | | Bladder Problems | | |
| High Cholesterol | | | Stroke | | | Abnormal Heart Beat | | |
| GI Bleed | | | Motor Vehicle Accident | | | Lupus | | |
| Bowel Obstruction | | | Blood Transfusion | | | Fibromyalgia | | |
| Pulmonary Embolism | | | Migraines | | | Diarrhea/Constipation | | |
| Deep Vein Thrombosis | | | Fainting | | | Seizure | | |
| Peripheral Vascular Disease | | | Dizziness | | | HIV | | |
| Bronchitis, Chronic | | | | | | | | |

**Please indicate any other past or present history not listed above:**

**Past Surgical History: Please list any past surgeries, auto accidents, fractures or falls you may have had.**

| Type of Surgery | Surgery Date | Additional Information |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Family Medical History**:

| Illness | Mother | Age | Father | Age | Grandmother | Age | Grandfather | Age | Siblings | Age |
|---|---|---|---|---|---|---|---|---|---|---|
| Heart Attack | | | | | | | | | | |
| Heart Disease | | | | | | | | | | |
| Blood Clots | | | | | | | | | | |
| Diabetes Mellitus | | | | | | | | | | |
| Hypertension | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | |
| Depression | | | | | | | | | | |
| Breast Cancer | | | | | | | | | | |
| Colon Cancer | | | | | | | | | | |
| Prostate Cancer | | | | | | | | | | |
| Ovarian Cancer | | | | | | | | | | |
| Migraines | | | | | | | | | | |
| Alcoholism | | | | | | | | | | |

# INTERNAL MEDICINE

**Patient Name: _____ DOB:_____ Date: _____**

## SOCIAL HISTORY

| | YES | NO | |
|---|---|---|---|
| Do you smoke or chew tobacco? | | | **How Often How Much** |
| Do you drink alcoholic beverages? | | | **How Often How Much** |
| Are you using illicit drugs or have you used illicit drugs in the past? | | | |
| What is your occupation? | | | |
| Do you have pets? If so how many and what kind. | | | **Cat Dog Bird Other** |
| Have you had a complete physical in the last year? | | | **Month Year** |
| Have you had blood work done in the last year? | | | **Month Year** |
| Do you exercise? | | | **How Often** |
| Do you regularly get 6 to 8 hours of sleep? | | | |
| Do you regularly eat 3 meals per day? | | | |
| Are you satisfied with your weight? | | | |
| Do you drive? | | | |
| Do you wear a seat belt when driving/riding in an automobile? | | | |
| Do you having driving restrictions (ie; eye glasses etc)? | | | **Please specify:** |
| Do you have any hearing problem? | | | |
| If yes to above do you wear hearing aids? | | | |
| Do you have any visual problems? | | | **Please specify:** |
| Do you have physical limitations? | | | **Please specify?** |
| Do you live alone? | | | |
| Do you have a family support system? | | | |
| Do you have a support system other than immediate family? | | | |
| Have you had a colonoscopy? | | | **Date:** |
| **WOMAN**-Do you regularly perform self-breast exam? | | | |
| When was your last pap smear? | | | **Date:** |
| Have you had a mammogram? | | | **Date:** |
| Have you had a dexa-scan: | | | **Date:** |
| **MEN**-Do you regularly perform self-testicular exams? | | | |
| Have you had a PSA test? | | | **Date:** |
| Have you had a digital rectal exam? | | | **Date:** |

## Multi-Specialty Physicians - MSP

**Surprise Office**
15021 W. Bell Rd. Ste.125
Surprise, AZ 85374
623-476-7880

**Sun City Office**
10249 W. Thunderbird Blvd Ste.100
Sun City, AZ 85351
623-972-1151

**Goodyear Office**
3090 N. Litchfield Rd. Ste.120
Goodyear, AZ 85395
623-536-0707