New Patient Information

Pacific Family Medicine
2360 W Ray Rd, Suite 2, Chandler AZ 85224
Phone: (480) 855-3770 Fax: (480) 855-7906

Name: _____ Date of Birth: _____

□ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ Email: _____

SS#: _____ Home Phone: _____ Cell Phone: _____

Language Preference: □ English □ Spanish □ Other: _____

Race: □ American Indian or Alaska Native □ Hispanic or Latino □ Other: _____
□ Asian □ Native Hawaiian/Other Pacific Islander □ Decline to specify
□ Black or African American □ White

How did you hear about us? □ Internet □ Friend/Family □ Advertisement □ Insurance

Pharmacy Information

Name: _____ Address: _____ Phone: _____

Responsible Party (For Minors Only)

Name: _____ Date of Birth: _____ Relationship: _____

SS#: _____ Home Phone: _____ Cell Phone: _____

Driver's License #: _____ State: _____ Email: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Cancellation Policy

I understand that when I make an appointment, the physician and staff are scheduled for my care. **I agree to pay a $25 fee if I miss my scheduled appointment or do not cancel 24 hours in advance.**

Initials _____

Patient/Guardian Signature: _____ Date: _____

Name: _____ **Date of Birth:** _____

Medical History

List all other doctors you have seen for your problems _____

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

List hospitalizations including dates _____

Power of Attorney/Living Will:
Do you have a Power of Attorney or a Living Will? □ Yes □ No If not, would you like to have one? □ Yes □ No

FINANCIAL AGREEMENT AND AUTHORIZATION

- I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize Pacific Family Medicine, Inc. to obtain on my behalf any insurance information covered by "The Privacy Act" from insurance companies.
- I hereby authorize payment directly to the provider(s) for medical and/or surgical benefits. I am responsible and agree to pay all charges for visits, tests, and procedures 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. Any balance of $5.00 or less will not be sent to the collection but will remain in your account until the next visit.
- 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 time of check-in. We accept cash and most major credit cards. We do not accept checks.

Initials _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use or disclose your protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information.

By signing this form, you understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law. The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- We may call, email, or send a text to you to confirm appointments.
- We may leave a message on your answering machine regarding appointment dates and times.
- We will not give any results over the phone or over an answering machine.
- We will not discuss your medical condition with any member of your family unless they are present during your visit.

Patient Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____

Witness: PACIFIC FAMILY MEDICINE REPRESENTATIVE

CPE/Well Woman

Name: _____ DOB: _____ Date: _____

List all of your medical conditions: _____

_____

List previous surgeries including dates: _____

List all medications/supplements you take: _____

_____

Do you have any allergies? (Please list allergies) _____

When was your last colonoscopy? _____

Do you feel depressed? ☐ Yes ☐ No

Do you feel anxious? ☐ Yes ☐ No

SOCIAL HISTORY

Do you use nicotine products? ☐ Yes ☐ No ☐ In the past

How long have you been using nicotine products? _____

How many cigarettes a day (if any)? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ In the past

If so, how many drinks a week?

Liquor _____ Wine _____ Beer _____

Do you drink coffee or caffeinated tea? ☐ Yes ☐ No

Do you use marijuana products? ☐ Yes ☐ No

Do you, or have you, used any street drugs?

(cocaine, heroin, meth etc.)

☐ Yes ☐ No Explain _____

FAMILY HISTORY

Mother Age _____ Is she alive? ☐ Yes ☐ No Any medical conditions? _____

Father Age _____ Is he alive? ☐ Yes ☐ No Any medical conditions? _____

Siblings How many? _____

How many brothers? _____

How many sisters? _____

Any medical conditions? _____

ADVANCED DIRECTIVE

What person will represent you in case of a medical emergency?

Full name: _____ Relationship: _____

Do you have a written document of this? ☐ Yes ☐ No

WOMEN

Preventive History

Date of last Pap smear _____

Have all of your Pap smears been normal? ☐ Yes ☐ No

Date of last mammogram _____

Were the results normal? ☐ Yes ☐ No

Menstrual History

Date of your last menstrual period _____

Age you were when your periods started _____

Have you gone through menopause? ☐ Yes ☐ No

Is your period regular? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Any other form of birth control? (condoms etc.) _____

Have you had your tubes tied? ☐ Yes ☐ No

Pregnancy History

Have you ever been pregnant? ☐ Yes ☐ No

If so, how many times have you been pregnant? _____

How many children have you had? _____

Have you ever had a miscarriage, stillborn child, or abortion?

☐ Yes ☐ No

Have you ever had a C-section? ☐ Yes ☐ No

Have you had a hysterectomy? ☐ Yes ☐ No

Name: _____ Date: _____

PHQ-9

Over the last 2 weeks, how many days have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

PHQ-9 Total Score: _____

GAD-7

Over the last 2 weeks, how many days have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3

GAD-7 Total Score: _____

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

PACIFIC FAMILY MEDICINE

NATIVIDAD VERDEJO-PEREZ, MD & SEILLY CABRALES, PA

Authorization for Release of Protected Health Information (PHI)

PATIENT NAME _____ DATE OF BIRTH _____

HOME PHONE _____ CELL PHONE _____

RELEASE TO	**RELEASE FROM**
☐ **Mail** ☐ **Family Member** ☐ **Fax** ☐ **Patient** 2360 W RAY RD SUITE 2 CHANDLER, AZ 85224 PHONE: (480) 855-3770 FAX: (480) 855-7906	Name: _____ Telephone: _____ Fax: _____

RECORDS TO BE RELEASED

_____Clinic Visit Notes _____X-ray Reports _____Specialist _____Entire Record

_____Ob-Gyn _____X-ray Films _____Physical Therapy _____Workers' Compensation

_____Lab Reports _____Hospital _____Physicals/Pre-op _____Prior Clinic

_____Most Recent Visit _____Other:_____

**All records pertaining to a sensitive nature will be released unless marked by an X below:

☐ Mental Health ☐ Psychotherapy ☐ HIV/Aids/STDs ☐ Chemical/Alcohol dependency

PURPOSE OF RELEASE

_____Change of Clinic _____Specialty Consultation _____Legal _____Insurance

_____Continuation of Care _____Other: _____

ACKNOWLEDGEMENT OF UNDERSTANDING

• This authorization will expire one year from date of signature or for a lesser period if specified here: _____ Initials_____

• I may revoke this authorization at any time by providing notification in writing to PFM, and it will be effective on the date received except to the extent action has already been taken.

• When PFM discloses PHI pursuant to this authorization, we can no longer guarantee confidentiality or prevent re-disclosure, and the information may no longer be protected by federal privacy rules.

• By signing this authorization, I agree to allow PFM and all their staff members to disclose the following PHI to the above stated person(s) or entity.

• By signing this authorization I agree to all its contents and release PFM from any and all liability resulting from re-disclosure.

• I further understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form

SIGNATURE (Patient or Legal Representative)_____ DATE_____