Gilbert Center For Family Medicine

Registration

Patient Information

_____ _____ _____
Last Name **First Name** **Middle Name**

_____-_____-_____ _____/_____/_____ ☐ Female ☐ Male
Social Security **Birth Date** **Gender**

Marital Status ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Race ☐ Caucasian/White ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian *Government Regulation*
☐ Hispanic/Latino ☐ Middle Eastern ☐ Pacific Islander ☐ Other ☐ Declined TO Specify

Ethnicity ☐ No Hispanic/ Latino Origin ☐ Hispanic/ Latino Origin ☐ Unknown ☐ Declined TO Specify *Government Regulation*

_____ _____ _____ _____
Address **Apt#** **City** **State** **Zip**

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home Phone ☐ **Primary** **Day Phone** ☐ **Primary** **Alternative Phone** ☐ **Primary**

_____
Email Address

_____ _____ _____
Emergency Contact Last Name **Emergency Contact First Name** **Relationship**

(_____)_____-_____ Home ☐ Work ☐ Cell ☐ _____
Emergency Contact Phone **Phone Type** **How did you hear about our office?**

Guarantor Information

_____ _____ _____
Guarantor Last Name **Guarantor First Name** **Guarantor Middle Name**

_____-_____-_____ _____/_____/_____ ☐ Female ☐ Male
Social Security **Birth Date** **Gender**

_____ _____ _____ _____-_____
Address **Apt#** **City** **State** **Zip**

_____ (_____)_____-_____ (_____)_____-_____
Guarantor Relationship **Home Phone** **Primary** **Day Phone** **Primary**

Insurance Information

_____ _____ _____
Policy Holder Last Name **Policy Holder First Name** **Policy Holder Middle Name**

_____-_____-_____ _____/_____/_____ ☐ Female ☐ Male
Social Security **Birth Date** **Gender**

_____ _____ _____ _____-_____
Address **Apt#** **City** **State** **Zip**

_____ (_____)_____-_____ (_____)_____-_____
Policy Holder Relationship **Home Phone** **Primary** **Day Phone** **Primary**

_____ _____ _____
Primary Insurance Company **Policy Number** **Group Number**

_____ _____ _____
Secondary Insurance Company **Policy Number** **Group Number**

Acknowledgement

I certify that the above information is true and correct. I hereby authorize release of any and all medical information that may be requested by the above named insurance carrier(s) in order to process claim for benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all charges accumulated from any missed appointments that were not cancelled by the patient at-least 24 hours prior to my scheduled appointment. In the event of default and account is placed with a collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of the outstanding balance at the time the account is placed the agency and interest accrual of 10% per year on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs that occur.

_____ _____/_____/_____
Patient Signature **(If Minor: Parent/ Legal Guardian)** **Date**

Gilbert Center For Family Medicine

Patient Information

Name _____ Birth Date _____/_____/_____

Medical History 1

Pharmacy

Primary _____ **Cross Streets** _____

Secondary or Mail Order _____ **Cross Streets** _____

Advanced Directives

Type □ None □ Refuse □ Do Not Resuscitate
□ Living Will □ Do Not Place On Life Support □ Power of Attorney

Effective Date ____/____/_____

Allergies

□ **No Allergies**

Please Specify Allergy & Reaction

_____ _____ _____

_____ _____ _____

Medications

□ **No Medications**

Medication Name	Strength	Directions

Past Medical/Surgical History

□ **No Relevant History**

Past Medical History

	Year		Year		Year
□ Allergies	_____	□ COPD	_____	□ Liver Disease	_____
□ Anemia	_____	□ Coronary Artery Disease	_____	□ Migraine Headaches	_____
□ Angina	_____	□ Crohn's Disease	_____	□ Myocardial Infarction	_____
□ Anxiety	_____	□ Depression	_____	□ Osteoarthritis	_____
□ Arthritis	_____	□ Diabetes	_____	□ Osteoporosis	_____
□ Asthma	_____	□ Gallbladder Disease	_____	□ Peptic Ulcer Disease	_____
□ Atrial Fibrillation	_____	□ GERD	_____	□ Renal Disease	_____
□ Benign Prostatic Hypertrophy	_____	□ Hepatitis C	_____	□ Seizure Disorder	_____
□ Blood Clots	_____	□ Hyperlipidemia	_____	□ Thyroid Disease	_____
□ Cancer *Type* _____	_____	□ Hypertension	_____		
□ Cerebrovascular Accident	_____	□ Irritable Bowel Disease	_____		

Past Surgical History

	Year		Year	Females Only	Year
□ Angioplasty	_____	□ Gastric Bypass	_____	□ Augmentation Mammoplasty	_____
□ Angio w/stent	_____	□ Hernia Repair *Site* _____	_____	□ Bilat. Tubal Ligation	_____
□ Appendectomy	_____	□ Hip Replacement *Side* ___	_____	□ Breast Biopsy *Side* _____	_____
□ Arthroscopy Knee *Side* ___	_____	□ Knee Replacement	_____	□ Cesarean Section	_____
□ Back Surgery	_____	□ Lasik	_____	□ D and C	_____
□ CABG	_____	□ Liver Biopsy	_____	□ Hysterectomy	_____
□ Carpel Tunnel Release	_____	□ ORIF	_____	□ Mastectomy	_____
□ Cataract Extraction *Side* __	_____	□ Pacemaker	_____	□ Myomectomy	_____

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Medical History 2

☐ Cholecystectomy	_____	☐ Small Bowel Resection	_____	☐ Reduction Mammoplasty	_____
☐ Colectomy	_____	☐ Thyroidectomy	_____	☐ TAH/BSO	_____
☐ Colostomy	_____	☐ Tonsillectomy	_____	☐ Vaginal Hysterectomy	_____

Additional History

System	Disease	Year
Management	**Outcome**	**Year**

Males Only **Year**

☐ Prostate Biopsy _____
☐ TURP _____
☐ Vasectomy _____

☐ Patient Adopted — Family History — ☐ No Relevant History

Diagnosis	Family Member(s) Immediate Family/Blood Relatives *Please Specify Side Of Family (Mother or Father)*	Age Onset	Death Cause
ADD/ADHD			☐ Yes
Alcoholism			☐ Yes
Allergies			☐ Yes
Alzheimer's Disease			☐ Yes
Asthma			☐ Yes
Blood Disease			☐ Yes
CAD (Coronary Artery Disease)			☐ Yes
CAD - Premature			☐ Yes
Cancer *Type* _____			☐ Yes
CVA (Stroke)			☐ Yes
Depression			☐ Yes
Developmental Delay			☐ Yes
Diabetes			☐ Yes
Eczema			☐ Yes
Hearing Deficiency			☐ Yes
Hyperlipidemia			☐ Yes
Hypertension			☐ Yes
Irritable Bowel Disease			☐ Yes
Learning Disability			☐ Yes
Mental Illness			☐ Yes
Migraines			☐ Yes
Obesity			☐ Yes
Osteoarthritis			☐ Yes
Osteoporosis			☐ Yes
PVD			☐ Yes
Renal Disease			☐ Yes
Seizure Disorder			☐ Yes
Other_____			☐ Yes

Social History

Statuses

Race
☐ African American/Black ☐ Caucasian/White ☐ Pacific Islander/Native Hawaiian
☐ American Indian/Alaska Native ☐ Hispanic/Latino ☐ Other
☐ Asian ☐ Middle Eastern ☐ Do Not Wish To Disclose

Ethnicity ☐ Hispanic/Latino Origin ☐ No Hispanic/Latino Origin ☐ Unknown

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____

Language Spoken At Home ☐ English ☐ Spanish ☐ Other _____

Country Of Birth ☐ USA ☐ Other _____ **Hand Dominance** ☐ Right ☐ Left ☐ Ambidextrous

Employer (Name) _____ **Occupation (Type Of Work)** _____

Employment Status
☐ Full Time ☐ Self-Employed ☐ Retired *Date* ___/___/___
☐ Part Time ☐ Unemployed ☐ Other _____

Work Restrictions
☐ avoid dust/fumes ☐ no heavy lifting
☐ no climbing ☐ Other _____

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Medical History 3

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Legally Separated ☐ Annulled ☐ Other _____

Previously Widowed ☐ No ☐ Yes

Previous Divorce ☐ No ☐ Yes

Has Children ☐ No ☐ Yes **Number of Sons** _____ **Number of Daughters** _____

Tobacco / Alcohol / Caffeine

Uses Tobacco ☐ Current ☐ Former ☐ Never ☐ Unknown

Tobacco Type ☐ Chewing ☐ Cigar ☐ Cigarettes ☐ Pipe ☐ Smokeless ☐ Snuff

Units / Day _____
Years Used _____
Pack Years _____

Ever Tried To Quit? ☐ No ☐ Yes **Year Quit** _____ **Longest Tobacco Free** _____

Relapse Reason _____ **Passive Smoke Exposure** ☐ No ☐ Yes

Smoker Status ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Smoker, Status Unknown ☐ Never Smoker ☐ Former Smoker ☐ Unknown If Ever Smoked

Drinks Alcohol ☐ No ☐ Yes ☐ Formerly **Caffeine** ☐ No ☐ Yes

Lifestyle – Other

Activity Level ☐ Moderate ☐ Sedentary ☐ Vigorous

Health Club Member ☐ Now ☐ Previously ☐ Never

Type Of Exercise _____

Exercise Frequency _____

Hours / Week _____

Hobbies / Activities _____

Diet History ☐ Diabetic ☐ Vegan ☐ Vegetarian ☐ High Fiber ☐ Low Sodium ☐ High Protein ☐ Other

Animals In The Home ☐ No ☐ Yes *Type* _____

Lifestyle – Home Environment / Safety *(For Insurance Company Purposes)*

Smoke Detectors In Home ☐ No ☐ Yes

Carbon Monoxide Detectors In Home ☐ No ☐ Yes

Falls In The Last Year ☐ No ☐ Yes Number/Falls _____

Radon In The Home ☐ No ☐ Yes ☐ Treated ☐ Untested

Pool / Spa At Home ☐ No ☐ Yes

Seat Belt Use ☐ No ☐ Yes

Home Heating Method ☐ Gas ☐ Electric

Firearms At Home ☐ No ☐ Yes ☐ No Answer

Disease Management

Health Maintenance

	Date		Date	Females Only	Date
☐ H&P (Physical Exam)	___/___/___	☐ Influenza Vaccine	___/___/___	☐ GYN Exam	___/___/___
☐ Lipid Panel	___/___/___	☐ Tdap Vaccine	___/___/___	☐ Breast Exam	___/___/___
☐ EKG	___/___/___			☐ Pap	___/___/___
☐ Colonoscopy	___/___/___	**Males Only**	**Date**	☐ Mammogram	___/___/___
☐ FOBT	___/___/___	☐ PSA	___/___/___	☐ Dexa Scan	___/___/___

******DIRECTIONS******

Our preferred method to receive forms is via email. Please send forms at least 24 hours prior to your appointment. Not having these in advance may delay your appointment time.

Email: **Save this PDF file to your computer after completion.**
Go to emailyourdoc.com for secure emailing.
Upload the file and email it to office@mdofficemail.com.

Fax: **(480) 539-1763.**

Hand Carry: **Bring a copy with you to your appointment (if possible) at least 24 hours prior.**

Privacy Practices Acknowledgement

_____ _____/_____/_____

Patient Name **Birth Date**

Acknowledgement I hereby acknowledge that I have been presented with a copy of Gilbert Center For Family Medicine's Privacy Practice Notice.

_____ _____/_____/_____

Patient Signature **(If Minor: Parent/ Legal Guardian)** **Date**

Release Information to Relative/ Friend

Release I give my consent and authorization to the staff of Gilbert Center for Family Medicine to relay medical information to the following persons. This information may include but is not limited to scheduled appointments and/ or surgeries, lab results, radiological results and medications.

Authorization By ☐ Patient ☐ Legal Guardian_____

Information To Be Disclosed

☐ Entire Record ☐ Billing ☐ Medications
(Includes Sexually Related Information)

☐ Other _____

Information NOT To Be Disclosed

☐ Nothing To Be withheld ☐ Entire Record ☐ Billing ☐ Medications ☐ Sexually Related Information

☐ Other _____

Reason for Disclosure

☐ Continued Medical Care ☐ Family/ Spouse Use ☐ School Use ☐ Employer Use ☐ Insurance Use

☐ Other _____

Disclosure End Date

☐ One Year ☐ Until Revoked In Writing ☐ Until_____/_____/_____

Disclosure To

☐ Any Healthcare Provider/ Facility ☐ Spouse ☐ Children

☐ Other_____ ☐ Okay To Leave Voicemail
(_____)_____-_____

Names _____ _____ _____

_____/_____/_____

Patient Signature **(If Minor/ Legal Guardian)** **Date**

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Records Release

_____ _____/_____/_____
Patient Name **Birth Date**

_____ _____-_____-_____
Address **Social Security Number**

Authorization

- o I authorize the release of my medical records **from another provider/facility to Gilbert Center for Family Medicine.** (Provider/Facility→ GCFM)
- o I authorize the release of my medical records from **Gilbert Center for Family Medicine to another provider/facility.** (GCFM→ Provider/Facility)

Records To Be Released **Medical records shall include all confidential aids, communicable disease, HIV related information, confidential alcohol or drug abuse related information, and confidential mental health diagnosis/treatment information. Release the following described medical records only (specify types and dates).**

- o All medical records authorized to be released.
- o Other medical records authorized to be released:_____

Provider /Facility Information	
_____ Provider/ Facility Name	(_____)_____-_____ Phone
_____ Address	(_____)_____-_____ Fax

Consent: **This consent will expire sixty (60) days after the signed date below.** I may revoke this authorization at any time providing I notify Gilbert Center For Family Medicine in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I **herby release Gilbert Center For Family Medicine from all legal responsibility or liability that may arise from the act** I **have authorized above.**

_____ _____/_____/_____
Patient Name **(If Minor: Parent / Legal Guardian)** **Date**

_____ _____/_____/_____
Patient Signature **(If Minor: Parent / Legal Guardian)** **Date**