Gilbert Medical Center PLLC

We are pleased to welcome you to our practice, please fill out paperwork completely. If you have any questions we will be glad to assist you.

PATIENT INFORMATION (Please Print)

Patient's Legal Name: _____ ____ _____ ss#:_____
First MI Last

DOB:_____ Age:_____ **Marital Status:** M S W O **Sex:** M F

Address:_____ _____City:_____ State:_____

Zip Code:_____ Home Phone:_____ Cell Phone:_____

Email address:_____ Preferred Pharmacy:_____

Race: _____ American Indian or Alaska Native _____ White
_____ Asian _____ Hispanic
_____ Black or African American _____ Other
_____ Hawaiian or Other Pacific Islander

Ethnicity: _____ Hispanic or Latino
_____ Not Hispanic or Latino

Language: _____

Employer:_____ Phone:_____

Employer Address:_____ _____ _____ _____
Address City State Zip Code

EMERGENCY CONTACT

Name: _____ Phone:_____

Relationship to patient: _____

INSURANCE INFORMATION (Please give receptionist your insurance card to copy)

Primary: _____ ID#: _____ Group#:_____

Subscriber Name:_____ s#: _____

DOB:_____ Employer:_____

Secondary: _____ ID#: _____ Group#:_____

Subscriber Name: _____ ss#:_____

DOB: _____ Employer: _____

WORK COMP/MVA INFORMATION- Please note that if you answer yes to any of the following questions, we must have all the information before you can be seen.

Is your injury work related? ☐ Yes ☐ No
Has a claim already been filed? ☐ Yes ☐ No
Is your injury due to a motor vehicle accident? ☐ Yes ☐ No

PERSON RESPONSIBLE FOR BILL (If patient is a minor)

Name: _____ DOB:_____ ss#:_____

Address: _____ Phone: _____
(If different than patient)

AUTHORIZATION:

I herby authorize my insurance benefits to be paid directly to the facility and the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge I have access to a copy of the Gilbert Medical Center/TPG/HPI Privacy Notice.

Print Name: _____ Signature:_____

Date: _____

PATIENT FINANCIAL RESPONSIBILITIES AND OBLIGATIONS

Thank you for choosing Gilbert Medical Center as your health care provider. Your clear understanding of our patient's financial responsibility is important to our professional relationship. **It is your responsibility to notify our office of any patient information changes (address, name, insurance information, etc).**

Co-pays/Balances: **All co-pays and balances are due at time of check-in. If your deductible has not been met you will be required to pay for your visit upfront until your deductible has been satisfied. Failure to pay all amounts due will subject you to collections efforts. Overdue accounts may be assigned to a third party debt collector.** We accept cash, check, money orders, Visa, MasterCard, and Discover.

Insurance Claims: In order to properly bill your insurance company, we require that you disclose all insurance information including: primary, secondary, as well as any change of insurance. Failure to provide complete insurance information may result in nonpayment by your insurance, thus you will be responsible for the entire bill.

Returned checks: The charge for a returned check is $35. This amount plus the amount of the check will be due. You will receive a notice from Checks Inc. regarding your account.

Personal Disclosures: The patient consents to the use and the release of their personal financial records to third party agencies for payment of medical claims.

I have read and understand the above Patient Financial Responsibilities policy and by signing this page I agree to the terms and conditions stated above.

_____ _____ _____

Print Name Signature Date

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

By state law you must be advised that: **The information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease, which may include, but are not limited to diseases such as Hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).**

I hereby authorize the physicians and staff of Gilbert Medical Center to release any and all medical records and also consent to having test results mailed for:

_____ _____

Patient's full name (PRINT) Date of Birth

_____

Social Security No.

_____ _____ _____ _____

Address City State Zip Code

All information is to be released to: _____

_____

_____

I understand this consent can be revoked at any time, except that disclosure is made in good faith has already occurred in reliance on this consent. Gilbert Medical Center, all employees and officers, and attending physicians are released from legal responsibility or liability for the release of the above requested information.

_____ _____

Patient or Legal Representative (Print Name) Signature

_____ _____

If other than patient, provide relationship to patient Date

PATIENT HISTORY FORM

Patient Name _____ Age_____ Sex_____ Patient Date of Birth_____

Social Security Number_____ Today's Date_____

Past Medical History

Previous Physician's name_____ Date of last exam _____

Have you ever been hospitalized? □ Yes □ No If yes, what for?_____

Have you ever been tested for hepatitis A,B or C? □ Yes □ No Which hepatitis virus?_____

Have you been vaccinated for hepatitis B? □ Yes □ No If yes, date vaccine series completed_____

Have you been vaccinated for hepatitis A? □ Yes □ No If yes, date vaccine series completed_____

Last Tuberculosis (TB) screening?_____ Result of TB screening □ Positive □ Negative

If positive TB screen, date of last chest x-ray_____ Result of chest x-ray □ Positive □ Negative

Have you had a sexually transmitted disease? □ Yes □ No Diagnosis_____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

□Heart disease/Murmur/Angina	□ Shortness of breath	□ Eye disorder/Glaucoma	□ Diabetes
□ High Cholesterol	□ Asthma	□ Seizures	□ Kidney/Bladder problems
□ High blood pressure	□ Lung problems/cough	□ Stroke	□ Liver problems/Hepatitis
□ Low blood pressure	□ Sinus problems	□ Headaches/Migraines	□ Arthritis
□ Heartburn (reflux)	□ Seasonal allergies	□ Neurological problems	□ Cancer
□ Anemia or blood problems	□ Tonsillitis	□ Depression/Anxiety	□ Ulcers/colitis
□ Swollen ankles	□ Ear problems	□ Psychiatric care	□ Thyroid problems

Please describe any current or past medical treatment not listed above

_____

_____

Please list your past surgeries

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? □ Yes □ No

Please list_____

Medications

Please list_____

_____

PLEASE COMPLETE REVERSE SIDE ⇨

Social and Preventative History

Do you currently smoke or chew tobacco? □ Yes □ No If no, have you in the past? □ Yes □ No
How many packs per day?_____

Do you drink alcohol, beer, or wine? □ Yes □ No If no, have you tried in the past? □ Yes □ No
How many drinks per week?_____

Do you currently drink coffee and /or tea? □ Yes □ No If yes, how many cups per day?_____

Do you exercise daily/weekly? □ Yes □ No

Do you use seatbelts while driving? □Yes □ No Do you wear a helmet while riding a bike? □ Yes □ No

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	□ Yes □ No	_____	_____
Father	□ Yes □ No	_____	_____
Sisters	□ Yes □ No	_____	_____
	□ Yes □ No	_____	_____
	□ Yes □ No	_____	_____
Brothers	□ Yes □ No	_____	_____
	□ Yes □ No	_____	_____
	□ Yes □ No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	**Which family member?**
Anemia or blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heat disease	_____
High blood pressure	_____
HIV disease/AIDS	_____
Mental Illness/Depression	_____
Stroke	_____
Other serious Illness	_____

Females: Gynecological History

How many times have you been pregnant?_____ Date of last Pap Smear_____

Have you had an abnormal Pap Smear? □ Yes □ No Diagnosis_____ Follow up_____

Have you had a sexually transmitted disease? □ Yes □ No Diagnosis_____

Date of last mammogram_____ Mammogram results_____

Have you ever had a biopsy? □Yes □ No Biopsy results_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature_____ Date_____