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

PEDIATRICS NEW PATIENT QUESTIONNAIRE

Patient Name _____ Age_____ Sex_____ Patient Date of Birth_____

Mother's Name_____ Age_____ Father's Name_____ Age_____

Siblings' Names_____

Family History

Are the child's parents both in good health? Yes ☐ No ☐

Check any diseases that the child's parents, grandparents, brothers, sisters, aunts, or uncles have had:

☐ Asthma	☐ Allergies	☐ Diabetes
☐ High Blood Pressure	☐ Heart disease before age 50	☐ High Cholesterol
☐ Seizures	☐ Cancer	☐ Tuberculosis
☐ Kidney Stones	☐ Sudden unexplained death	☐ Mental Illness

List any other significant chronic illnesses in the family: _____

Is there a smoker in the household? Yes ☐ No ☐

Do both parents live at home? Yes ☐ No ☐ If "No", with whom does the patient live? _____

Pregnancy and Birth

Mother's age at child's birth _____

Did mother have an illness during pregnancy? Yes ☐ No ☐ List illness: _____

Did mother take medications other than vitamins? Yes ☐ No ☐ List: _____

Was the baby premature? Yes ☐ No ☐ If "Yes", the baby was born at _____ weeks.

Child's birth weight _____ What type of delivery? Vaginal ☐ C-section ☐

Did the baby have trouble while in the hospital? Yes ☐ No ☐

If " Yes", what kind of trouble?_____

Past Medical History (these questions refer to the child)

Any allergic reactions to medications, foods, insect bites or stings? Yes ☐ No ☐
If "Yes", which ones?_____

Reactions to immunizations? Yes ☐ No ☐ Which ones?_____

Hospitalizations? Yes ☐ No ☐ Why, what age?_____

Surgeries? Yes ☐ No ☐ What kind, at what age?_____

Serious Injuries Yes ☐ No ☐ What kind, what age?_____

Medications taken regularly? Yes ☐ No ☐ Which ones?_____

Check any medical problems your child has had:

☐ Asthma	☐ Frequent Ear Infections	☐ Frequent Strep Throat	☐ Constipation
☐ Pneumonia	☐ Vision/Hearing problems	☐ Urinary Tract Infections	☐ Heart Problems
☐ Seizures	☐ Allergies	☐ Anemia	

List any other medical problem your child has that is not listed: _____