West Valley Internal Medicine L.L.C.

Patient Information

Name: _____ Sex ☐ M ☐ F Date of Birth: _____
Last First Middle

Social Security Number: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address: _____
Street (Include Apt #) City State Zip

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Employer: _____ Work Phone: _____

Primary Care Physician: _____
Name City State Phone

Emergency Contact: _____
Name Relationship to Patient Phone

Responsible Party: _____
Name Relationship to Patient Date of Birth

_____
Address Phone

Primary Insurance: _____

Insurance Subscriber: _____ Subscriber Sex: ☐ Male ☐ Female
Name

Subscriber Date of Birth: _____ Subscribers Social Security #: _____

Policy #/Subscriber ID # _____ Subscriber's Employer: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Secondary Insurance: _____

Insurance Subscriber: _____ Subscriber Sex: ☐ Male ☐ Female
Name

Subscriber Date of Birth: _____ Subscribers Social Security #: _____

Policy #/Subscriber ID # _____ Subscriber's Employer: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Consent for Medical Treatment and Release of Benefits and Information

I agree to examination and treatment by West Valley Urgent Care medical personnel, including but not limited to injections, local anesthetics, minor surgical procedures or other procedures discussed with me and recommended by West Valley Urgent Care Providers. I have verified the information on the Patient Information and authorize my insurance benefits to be paid directly to the doctor. I authorize the doctor or the insurance company to release any information required for this claim.

_____ _____ _____
Signature Relationship to Patient Date

Revised 05/25/10

West Valley UrgentCare

Language, Ethnicity & Race Data Collection

Patient Name: _____ Date of Birth: _____

Language Information Request

Language the patient currently speaks? _____

Primary (Native) language spoken by the patient? _____

Secondary language spoken by the patient? _____

Ethnicity and Race

___ No, not of Hispanic, Latino/a, or Spanish origin

___ Yes, Mexican, Mexican American, Chicano/a

___ Yes, Puerto Rican

___ Yes, Cuban

___ Yes, Another Hispanic, Latino/a, or Spanish origin

___ Prefer not to disclose

What race(s) that best fits you. (Check all that apply)

___ American Indian or Alaska Native

___ Caucasian

___ Black or African American

___ Chinese

___ Filipino

___ Japanese

___ Asian

___ Other Pacific Islander

___ Indian

___ Native Hawaiian

___ Multiracial

___ Other

Please specify: _____

___ Prefer not to disclose

West Valley Internal Medicine L.L.C.

FINANCIAL AGREEMENT

Welcome to West Valley Internal Medicine (WVIM). We are committed to providing you with the best possible medical care. The following is a statement of our Financial Policy, which we require you read and sign prior to receiving treatment.

I understand that WVIM participates in a variety of insurance plans and that in order to ensure appropriate insurance billing it is my responsibility to:

* Provide my insurance card at each visit.
* Be prepared to pay my co-payment responsibility at each visit, which is collected prior to being treated, unless prior arrangements have been made with the WVIM Billing Department.
* To pay for medical services **not covered** under your insurance plan. Payment for these services is due at check out after services have been rendered, or we will bill the patient for the total.

- I understand that if the patient is a minor (under 18 years of age) that I am financially responsible for services provided and that I must provide the insurance card, any referrals and/or payment.
- I understand that WVIM will provide assistance with some insurance questions; however, I must contact my insurance company with questions regarding specific coverage issues.
- I understand that if I do not have insurance, that the initial office visit payment is due prior to services being rendered. I understand that any additional services provided/prescribed by WVIM, such as x-rays, injections and etc. are extra. I further understand I will be provided with the amount due prior to any additional services being rendered and that payment for the additional services is due at check out.
- I understand that if WVIM is unable to verify my eligibility with my insurance company, I may be required to make a monetary deposit and that upon receipt of payment from my insurance company; I will be reimbursed minus any co-payments, co-insurances and/or deductibles, if any.
- I understand that if at 30 days, of WVIM's bill submission date to my insurance carrier has not responded, my account balance will be transferred to patient responsibility and a billing statement will be sent to me and I will contact my insurance carrier to request prompt release of payment for the services received.
- In the event that I fail to pay the outstanding balance of my account to WVIM for services provided to me, I understand that my account will be turned over to a collection agency and I will be responsible for an additional 35% collection fee, as well as attorney fees and interest charges.

* As a courtesy to other patients, we ask that you provide us with at least 24 hours' notice if you need to cancel or reschedule your appointment. WVIM reserves the right to charge a $25 fee, or $50 fee for Saturdays, to all patients who are in violation of this policy.

Acknowledgement of Understanding

I acknowledge that I have read and fully understand the Patient Financial Agreement as outlined above. I have also been given a copy of the Patient Financial Agreement for reference.

Patient/Responsible Party Signature	Printed Name	Date

17218 N. 72nd Drive, Suite 100 ▪ Glendale, Arizona 85308
14811 W. Bell Road, Suite 101 ▪ Surprise, Arizona 85374
4110 N. 108th Ave. Suite 101 ▪ Phoenix, Arizona 85037

Phone (623) 334-8670 ▪ Fax (623) 334-8675
Phone (623) 815-9073 ▪ Fax (623) 815-9201
Phone (623) 218-0780 ▪ Fax (623) 218-0786

Revised 08/27/2013

West Valley Internal Medicine L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement ***

I, _____, have received a copy of this office's
(Patient's Name)

Notice of Privacy Practices.

_____

Please Print Name (Responsible Party)

_____

Signature (Responsible Party)

_____

Date

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

Arrowhead - 17218 N. 72nd Dr. Ste 100 – Glendale, AZ 85308 Phone: 623-334-8670 Fax: 623-334-8675
Surprise - 14811 W. Bell Rd. Ste 101 – Surprise, AZ 85374 Phone: 623-815-9073 Fax: 623-815-9201
Avondale - 4110 N. 108th Ave Ste 101 – Phoenix, AZ 85037 Phone: 623-218-0780 Fax: 623-218-0786

West Valley Internal Medicine L.L.C.

I, _____ D.O.B. _____
(Patient's Name)

Hereby authorize West Valley Internal Medicine, L.L.C. to discuss my personal medical records with:

_____
(Name of Person(s) [EXCLUDING MEDICAL PROFESSIONALS])

_____
_____
(Relationship to Patient)

☐ I wish to release ALL aspects of my records to the above mentioned person(s).
☐ I wish to release Limited aspects of my records to the above mentioned person(s).

Please limit the information to:

Lab Reports _____ Referral Information _____
Imaging Results _____ Office Visit Notes _____
Prescriptions _____ Misc. Documents _____

☐ At this time I DO NOT wish to authorize West Valley Internal Medicine, L.L.C. to discuss my records with anyone other than myself.

I understand that I may revoke or change this release at any time at my discretion.

Formal advance directives are documents written in advance of serious illness that state your choices for health care, or name someone to make those choices, if you become unable to make decisions. Through advance directives, such as living wills and durable powers of attorney for health care, you can make legally valid decisions about your future medical treatment.

☐ I already have an advanced directives on file with the state of AZ and will bring in a copy for your files.
☐ I do not currently have an advanced directives on file and would like more information on how to put on into place.
☐ I do not currently have an advanced directives on file but would not like to complete one at this time.

X _____ _____ / _____ / _____
Patient's Signature / Legal Guardian Date

X _____ _____ / _____ / _____
Office Staff Signature Date

17218 N. 72nd Drive, Suite 100 • Glendale, AZ 85308 Phone: 623-334-8670 • Fax: 623-334-8675
14811 W. Bell Road, Suite 101 • Surprise, AZ 85374 Phone: 623-815-9073 • Fax: 623-815-9201
4110 N. 108th Ave., Suite 101 • Phoenix, AZ 85037 Phone: 623-218-0780 • Fax: 623-218-0786

Health History

Patient Name_____ **Birthday**____/____/_____

In order to meet all your healthcare needs, please fill out all forms completely.
This is a confidential record of your medical history and will be kept in this Office.

Todays Date____/____/_____

Birth Place_____
Highest level of School_____
Occupation_____
Previous Occupation_____
Marital Status:
Married Divorced Single Widow
Seperated

Hobbies_____
Exercise yes/no
times per week_____
Habits:
Smoking yes/no
packs per week_____ n/a
Date quit_____/_____
Alcohol yes/no
type/amount per week_____
Caffeine yes no
type/amount per day_____
Street drugs yes no
type/amount per day_____
Last Dental exam____/____/_____

Have you ever taken Fen-Phen/Redux?
yes no

Last physical exam_____/____/_____
Name of Doctor_____
Dr. Phone #_____

List all serious Illnesses, surgeries and hospitalizations you have had and year they occurred. n/a

_____
_____
_____
_____
_____
_____

Medications

name:	Dose:

Describe all serious accidents or injuries.

Type of accident or injury:	Date it occurred
	___/___
	___/___
	___/___
	___/___
	___/___
	___/___

Family Medical History

Relationship	Mother	Father	Grandmother	Grandfather
Age				
Diabetes	yes/no	yes/no	yes/no	yes/no
High blood pressure	yes/no	yes/no	yes/no	yes/no
Heart Disease	yes/no	yes/no	yes/no	yes/no
Cancer	yes/no	yes/no	yes/no	yes/no
Tuberculosis	yes/no	yes/no	yes/no	yes/no
Stroke	yes/no	yes/no	yes/no	yes/no
Epilepsy	yes/no	yes/no	yes/no	yes/no
Allergies	yes/no	yes/no	yes/no	yes/no
Anemia	yes/no	yes/no	yes/no	yes/no
Bleeding tendency	yes/no	yes/no	yes/no	yes/no
High Cholestrol	yes/no	yes/no	yes/no	yes/no

Past Medical History

Measles	yes/no	Migraines	yes/no	Hernia	yes/no
Mumps	yes/no	Tuberculosis	yes/no	Back Pain	yes/no
chickenpox	yes/no	Blood transfusion	yes/no	Hives	yes/no
Whooping Cough	yes/no	Hypertension	yes/no	Asthma	yes/no
Scarlet Fever	yes/no	Hypotension	yes/no	Eczema	yes/no
Diphtheria	yes/no	Hemorrhoids	yes/no	Bronchitis	yes/no
Smallpox	yes/no	Mitral Valve Prolapse	yes/no	Stroke	yes/no
Pneumonia	yes/no	Kidney Disease	yes/no	Hepatitis	yes/no
Rheumatic Fever	yes/no	Thyroid Disease	yes/no	Ulcer	yes/no
Heart Disease	yes/no	Bleeding tendency	yes/no	Diabetes	yes/no
Arthritis	yes/no	AIDS or HIV	yes/no		
Veneral Disease	yes/no	High Cholestrol	yes/no		
Anemia	yes/no	Cancer	yes/no		
Bladder Infections	yes/no	Polio	yes/no		
Epilepsy	yes/no	Glacoma	yes/no		

Chief Complaint:

Please list (by order of importance) the present health concerns, symtoms or problems you are experiencing.

Complaint	Duration
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have now or in the past year:

Weakness or Paralysis	yes/no	Leg pain or cramps	yes/no	Chest pain or discomfort	yes/no
Weight Change	yes/no	Difficulty swallowing	yes/no	Purple fingers or lips	yes/no
Change in appetie	yes/no	Heartburn	yes/no	Swelling of extremities	yes/no
Sensitive to cold or heat	yes/no	Frequent belching	yes/no	Heart Palpatatioins	yes/no
Persistent Fever	yes/no	Abdominal cramps	yes/no	Depression	yes/no
Night sweats or flashes	yes/no	Nease/vomiting	yes/no	Memory Loss	yes/no
Skin rash	yes/no	Vomiting or coughing blood	yes/no	poor coordination	yes/no
Change in nails or hair	yes/no	Chonic diarrhea	yes/no	Dizziness	yes/no
Headaches	yes/no	Chronic constipation	yes/no		
bleeding or bruising	yes/no	Rectal bleeding	yes/no	**Men only:**	
Blurred vision	yes/no	Dark urine	yes/no	Discharge from penis	
Eye Pain	yes/no	Jaundice	yes/no	pain in testicles	
infected eye	yes/no	Frequent urination	yes/no	Impotence	
Wear glasses or contacts	yes/no	Increase in thirst	yes/no	**Women only:**	
Ringing in the Ears	yes/no	Painful urination	yes/no	Age of period____	
Discharge from Ears	yes/no	Difficulty urination	yes/no	days period last____	
Ear Pain	yes/no	Blood in urine	yes/no	Flow Heavy yes/no	
Frequent nose bleeds	yes/no	Lack of Sex drive	yes/no	Date of last period_____	
Frequent colds	yes/no	Hemorrhoids	yes/no	Last pelvic exam_____	
Sinus troubles	yes/no	Backaches	yes/no	Last mammogram_____	
Loss of smell	yes/no	joint pain or stiffness	yes/no	Vaginal itching yes/no	
Mass/discharge from breast	yes/no	Swollen Joints	yes/no	Pain during Sex Yes/no	
Shortness of Breath	yes/no	Muscle cramps	yes/no	Birth Control yes/no	
Bloody sputum	yes/no	Sleeplessness	yes/no	# of pregnancies_____	
Wheezing	yes/no	Seizures	yes/no	# full term births_____	
			yes/no	#preterm births_____	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can de dangerous to my/or my childs health. It is my responsibility to inform the doctor's office of any changes in my/or my childs medical status. I also authorize the health care staff to perform the necessary health care services I or my child may need.

Signature of patient or parent of minor_____Date_____

Physician Signature_____Date_____