Physician Group
OF ARIZONA, INC.

Clinic Name:_____

Physician/Provider being seen today:_____

PATIENT INFORMATION

Date	Patient last name	Patient first name	Patient middle name

Primary Address	City	State	Zip

Alternate Address	City	State	Zip

Gender	DOB	Status: ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Divorced	Race	Ethnicity	Home phone ☐ Primary ☐ Alternate

Social Sec. #	Occupation	Employer

Employer address	City	State	Zip

Driver's license #	E-mail address	Business phone	Cell phone

RESPONSIBLE PARTY INFORMATION

Relationship to patient	Last name	First name	Home phone

Home address	City	State	Zip

Social Sec. #	Occupation	Employer	Business phone

Company address	City	State	Zip

Spouse first name (and last, if different)	Employer	Phone

INSURANCE INFORMATION (Must be filled out completely for verification purposes)

Check here if you have NO insurance ☐

Primary insurance company	Co-pay amount	Policyholder name	Policyholder DOB	Patient relationship to insured: Self / Spouse / Child / Other

Insurance company address	Effective date	Phone

Group or policy #	Medicare #	Medicaid #

2nd insurance company	Co-pay amount	Policyholder name	Policyholder DOB	Patient relationship to insured: Self / Spouse / Child / Other

Insurance company address	Effective date	Phone

INJURY INFORMATION (Must be filled out completely)

Reason for visit?	What type of injury are we seeing you for? (indicate right or left, if appropriate)

Was this an: ☐ Accident ☐ Injury	Date of accident or injury	Place of accident or injury: ☐ Work ☐ Auto ☐ Home ☐ School Other:_____

Name of school	Sport/Activity	How was injury sustained?

Is this employment related? ☐ Yes ☐ No	If so, who is your company's industrial carrier?

Name and address of place of injury

Name and address of referring physician	Phone (required)

Emergency contact information (full name, relationship to patient)	Phone (required)

I declare that the above answers and statements are true and correct to the best of my knowledge. I hereby acknowledge that I have read this entire section front and reverse, and agree to of all the terms herein.

_____ Date

x_____ Signature of Responsible Party/Patient

NEW PATIENTS: Please indicate how you heard about us.

☐ Newspaper ☐ Radio ☐ TV ☐ InQuicker – Online Scheduling ☐ Mailer ☐ Internet ☐ Physician ☐ Friend ☐ Other:_____

ARIZONA ASSOCIATES FOR WOMEN'S HEALTH

HISTORY SHEET

Date_____

Name_____ Age_____ DOB_____

What brings you to the office today?

_____

_____

_____

MENSTRUAL HISTORY

Date last period started_____ Do you have bleeding between periods? _____

How many days between periods? _____ How many days do you bleed? _____

Do you have painful periods? _____

If your problem is lack of periods or irregular periods please describe under "COMMENTS".

COMMENTS:

_____

_____

PAP SMEAR HISTORY

Date of last Pap: _____ Normal _____ Abnormal _____

Have you had an abnormal pap smear? _____

OBSTETRICAL HISTORY

Have you ever been pregnant Yes or **No-if "no", skip this section and continue with the next section.**

Please list the number of times pregnant _____

How many births_____how many miscarriage/abortions_____how many premature births_____

How many children are living_____children who died before 1 month old_____born with defect_____

Please list all pregnancies in order of dates. List number and letter that applies that applies to each date.

Date of delivery/miscarriage/abortion	**Type of delivery**: Live birth/stillbirth/ Premature/miscarriage/abortion/ Vaginal delivery/c-section	**Complications:** None/diabetes/ Bleeding disorders/convulsions/high blood pressure/infant intensive care/ other

GYNECOLOGICAL HISTORY

Have you ever had pelvic surgery? Yes No If so, please list under "COMMENTS" include place and date of surgery.

Have you ever had a vaginal discharge or infections? Yes No

Have you ever had a tubal infection? Yes No

COMMENTS:

_____

_____

SEXUAL HISTORY

Are you currently having sex? Yes No

Do you have sex with: Men Women Both

Do you have more than one partner? Yes No

How long have you been with the same partner? _____

Do you have bleeding or pain with intercourse? Yes No

Have you ever had gonorrhea, syphilis, Chlamydia or herpes or other STDs_____? Yes No

Have you been exposed to Multiple partners, gay or bisexual partners, IV drug user? Yes No

Have you any reason to believe that you may have exposed to AIDS or a positive HIV partner? Yes No

MAMMOGRAM HISTORY

Have you had a mammogram? Yes No

Date of mammogram: _____ Normal_____ Abnormal _____

Do you have any breast problems? Yes No

Do you have any nipple discharge or leaking? Yes No

Anyone in your family with breast cancer? Yes No

Do you perform monthly self-exams? Yes No

COMMENTS: _____

_____

CONTRACEPTION HISTORY

Type	Present	Past
None		
Pill/Oral Contraceptive		
Depo Provera		
IUD		
Diaphragm		
Condoms		
Tubal Ligation		
Vasectomy		
Rhythm		
Foam/Vaginal Insert		
Etonogestrel Implant		

GENERAL MEDICAL

Childhood diseases? Yes ____ No ____ If yes, please list: _____

Adult Diseases? Yes _____ No _____ If yes, please list: _____

Drug Allergies? Yes _____ No _____ If yes, please list: _____

Medications or Drugs you are currently taking: _____

_____

Have you ever taken hormones? Yes _____ No _____ If yes, please list: _____

Vitamin pills (what and how much)? _____

_____

Do you smoke cigarettes? Yes___ No ___ If yes, amount? _____ For how long? _____
Do you drink alcohol? Yes ___ No ___ If yes, how much? _____
Do you use any street drugs? Yes__ No___ If yes, which ones?_____
Do you drink coffee or tea? Yes ____ No ____ If yes, how much? _____
Has your weight changed in the last year? Yes ____ No _____ If yes, how much? _____

DO YOU HAVE ANY ABNORMALITIES OF:

Head, eyes, ears, nose, throat (headaches, difficulties with vision, "fits", convulsions, etc)? Yes _____ No _____
Breathing (coughing, wheezing, TB, etc.)? Yes _____ No _____
High or Low Blood Pressure? Yes _____ No _____
Heart palpitations, chest pains, shortness of breath, history of heart disease or murmur? Yes _____ No _____
Breast discharge (bloody, watery, or milky), breast pain or lumps? Yes _____ No _____
Nausea, vomiting, jaundice, bloody bowel movements, diarrhea? Yes _____ No _____
Kidney or bladder infection, stones, blood in urine? Yes _____ No _____
Diabetes? Yes _____ No _____
Arthritis, bone or joint pain? Yes _____ No _____
Skin problems, including excessive hair, loss of hair, change in color or acne? Yes _____ No _____
"Nervous problems" (depression, suicide attempts, anxiety or psychiatric consultation) Yes _____ No _____
If you have answered yes to any of the above, please explain:

_____

_____

FAMILY HISTORY

Have any of your natural family had any of the following: (parents, sisters, brothers, grandparents)

	YES	NO
Unavailable		
High Blood Pressure		
High Cholesterol		
Heart Disease / Stroke		
Cancer (any)		
Diabetes		
Genetic Disorder		

PAST HOSPITALIZATIONS AND SURGERY

Month/Year	Major Illness/Surgery	Complications (if any)

_____ _____

Signature Date

Physician Group
OF ARIZONA, INC.

Patient Name (last, first, MI):	Date of Birth (mm/dd/yyyy):	Medical Record #:

As either the Patient or the legally authorized representative of the Patient, on behalf of the Patient receiving care in this Physician Group of Arizona, Inc., (PGA) Facility, I make the following consents, understandings, and agreements on my own behalf and on behalf of the Patient in partial consideration of health care services to be provided to the Patient in the PGA Facility, including IASIS Healthcare and its affiliates.

Consent for Services: I hereby give consent to the Facility, its contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty involved in the health care services for which this consent is given. I understand that physicians are separately responsible to explain what they do and, in some cases, to obtain separate consent for services they perform.

Assignment of Benefits: Any and all benefits from insurance companies and other third party payors that are payable to the Patient or on behalf of the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to the Facility for the exclusive purpose of paying for charges associated with the health care services provided to the Patient in the Facility. I understand and intend that all insurance companies and other third party payors will pay benefits directly to the Facility in payment of the Facility's charges and the charges of any other health care providers for whom the Facility is authorized to bill in connection with health care services provided to the Patient.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all the health care services rendered to the Patient in the Facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding contract discounts). Patient and the undersigned, if other than the Patient, remain responsible for all copayments, deductibles, co-insurance, and/ or non-covered services regardless of amount paid by insurance or third party payor. I understand and agree than any amounts not paid within 30 days of the date of the Facility's bill or statement for payment shall accrue interest at the rate of 1.5 % per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay a 20% collection fee, all costs and reasonable attorney's fees in connection with the collection process. A service charge may be collected in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to the Facility. Patients that present as self-pay will receive a discount on specified services when services are paid in full on the day of visit.

Medicare/Medicaid/Tricare Patient's Certification: I certify that the information given by me in applying for payment under the titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its service.

Release of Information: The Facility is required by law to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time.

The following applies if initialed at the end of this paragraph: Because of the Patient's strongly held religious beliefs, this consent does not include consent to administer blood or other blood products unless the Patient subsequently agrees otherwise. The Patient understands that this limitation may cause some health care providers to decline to provide care, and may, in the opinion of some providers, adversely affect the outcome of the care.

DATE:_____ INITIALS:_____

The undersigned signs this document either as the Patient or the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document, as well as a copy of my billing rights according to the Fair Credit and Billing act. This document will remain in effect unless revoked in writing.

DATE:_____ SIGNATURE:_____

WITNESS TO SIGNATURE:_____ RELATIONSHIP IF OTHER THAN PATIENT:_____

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED OR BEEN OFFERED A COPY OF PGA'S NOTICE OF PRIVACY PRACTICE.

DATE:_____ INITIALS:_____

STAFF USE ONLY: IF UNABLE TO OBTAIN ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES, A DOCUMENTED REASON BY THE PGA STAFF MEMBER MUST BE ENTERED BELOW IN ACCORDANCE TO PGA POLICY:

Physicians Group of Arizona

AZ Associates for Women's Health

Stephen Frausto, MD

Manisha Purohit, MD

Brigett Warner WHNP-BC

Cynthia Cabello WHNP-BC

PHARMACY INFORMATION

PATIENT NAME: _____ **D.O.B.**_____

PHARMACY: _____

PHONE: _____

OR

CROSS STREETS: _____

OR Zip Code_____ _____

Physician Group
OF ARIZONA, INC.

The Arizona Department of Health Services licenses this office.

As required by Arizona Department of Health rules and other statutes, rules and requirements, this office has provided you with a copy of your Patient Rights. By your signature below, you acknowledge receipt of your Patient Rights.

Per my request, I read the laminated copy of the patient rights in the office and do not want to take a copy home with me._____

Per my request, I was given a paper copy of the patient rights to take home with me_____

Printed Name: _____

Relationship to Patient: _____

Signature: _____

Date and Time Received: _____