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 ☐ Yellow Pages ☐ Mailer ☐ Internet ☐ Physician ☐ Friend ☐ Other:_____

OBSTETRICAL MEDICAL HISTORY

Patient Name _____ Date Form Completed _____

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? ..... ☐ Yes ☐ No
   If yes, please list: _____
2. Please mark any condition that you have or have had in the past:

☐ Arthritis or Lupus	☐ Cancer	☐ Fibromyalgia	☐ HIV
☐ Asthma	☐ Chicken Pox	☐ Group B Strep	☐ Hyperactivity|ADD
☐ Bladder or Kidney Infections	☐ Depression	☐ Headaches	☐ Kidney Disease
☐ Bleeding Disorder	☐ Diabetes	☐ Heart Problems	☐ Migraine Headaches
☐ Blood Disease	☐ Emotional Disorders	☐ Hepatitis	☐ Skin Disorders
☐ Bowel Disease	☐ Epilepsy	☐ Herpes	☐ Thyroid Disorder
		☐ High Blood Pressure	☐ Other

   Describe, if needed: _____
3. Please indicate any operations or surgery you have had: _____
4. Please describe any health problems or symptoms you are having at this time:

EXPOSURES AFFECTING HEALTH

1. Do you use tobacco? ☐ Yes ☐ No If yes, how much per day? _____
2. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often? _____
   What type of drink(s)? _____
3. Please list any medications taken since your last period, including over-the-counter medications: _____
4. Have you had an influenza (flu) vaccine? ☐ Yes ☐ No If yes, when? _____
5. Please list any drugs used in the past (i.e. cocaine, marijuana, pain medication, meth, etc.):
   Dates last used: _____
6. Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any other reason to believe you may have been exposed to AIDS?
7. Do you work with, or have you been exposed to chemicals or radiation (i.e. x-rays)? ..... ☐ Yes ☐ No
   If yes, please describe: _____
8. Are you on a special diet? ..... ☐ Yes ☐ No
   If yes, please describe: _____
9. Do you have cats? ..... ☐ Yes ☐ No

GYNECOLOGIC HEALTH HISTORY

1. When was your last menstrual cycle (period)? _____
2. When was your last Pap Smear? _____ Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No If yes, when? _____
   What was the diagnosis? _____
   What was done? _____
3. Have you ever had gonorrhea, chlamydia or pelvic inflammatory disease? ☐ Yes ☐ No
   If yes, when and where were you treated? _____
4. Have you ever had herpes? ..... ☐ Yes ☐ No
5. Did you receive the HPV vaccine (Gardasil)? ..... ☐ Yes ☐ No
6. Do you use contraceptives? ☐ Yes ☐ No If yes, what type: _____
7. Have you had bladder or kidney infections? ..... ☐ Yes ☐ No
   If yes, what was done? _____
8. Do you have a history of infertility? ☐ Yes ☐ No If yes, please describe when and treatment received: _____
9. Please list any other concerns you have related to your past health history:

Patient Signature _____ Print Name _____ Date _____

PHYSICIAN NOTES

Patient Name _____ **ALLERGIES** _____

OBSTETRICAL MEDICAL HISTORY, PAGE 2

10. Do you have any religious or other objections to any form of medical treatment you would like to make us aware of (i.e. refusal of blood transfusion)? _____

11. Do you have any special needs for: Hearing: ☐ Yes ☐ No Vision: ☐ Yes ☐ No Language: ☐ Yes ☐ No

FAMILY HISTORY & GENETIC HISTORY

1. Have either you or the baby's father had a child born with a birth defect? ☐ Yes ☐ No
   If yes, please describe: _____

2. Did either you or the baby's father have a birth defect yourselves? ☐ Yes ☐ No
   If yes, please describe: _____

3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis). _____
   _____
   How is the affected child/person related to you? _____

4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? ☐ Yes ☐ No
   If yes, have either of you had genetic counselling? ☐ Yes ☐ No
   If yes, have either of you had chromosomal studies? ☐ Yes ☐ No
   Where and results: _____

5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if either you or the baby's father is of one of these backgrounds:

   Jewish ancestry? ☐ Yes ☐ No If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No
   Date: _____ Result: _____

   African-American? ☐ Yes ☐ No If yes, have you had Sickle Cell screening? ☐ Yes ☐ No
   Date: _____ Result: _____

6. Please mark if anyone in your family or the baby's father's family has:

Diabetes	☐ Yes	☐ No	If yes, how is that person related to you? _____
Bleeding Disorder	☐ Yes	☐ No	If yes, how is that person related to you? _____
High Blood Pressure	☐ Yes	☐ No	If yes, how is that person related to you? _____
Cancer	☐ Yes	☐ No	If yes, how is that person related to you? _____
Hepatitis	☐ Yes	☐ No	If yes, how is that person related to you? _____
HIV	☐ Yes	☐ No	If yes, how is that person related to you? _____
Twins/multiple gestation pregnancy	☐ Yes	☐ No	If yes, how is that person related to you? _____

7. Please list any other concerns you have about birth defects or inherited disorders:
   _____
   _____

8. Will you be 35 or older at the time the baby is born? ☐ Yes ☐ No

9. Will the father be 50 or older? ☐ Yes ☐ No

_____ _____ _____
Patient Signature Print Name Date

Physician Notes: _____
_____
_____
_____

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: _____