ARIZONA COMMUNITY SURGEONS, PC

NEW PATIENT INTAKE FORM

Last Name	First Name	Middle Name	Nickname

Social Security	Birth Date	Age	

Birth Sex	Current Gender	Gender Identity	Sexual Orientation	Preferred Pronoun
☐ Female	☐ Female	☐ Female	☐ Straight or heterosexual	
☐ Male	☐ Male	☐ Male	☐ Choose not to disclose	
	☐ Choose not to disclose	☐ Choose not to disclose	☐ Bisexual	
	☐ Other	☐ Additional gender category or other, please specify:	☐ Lesbian, gay or homosexual	
			☐ Don't Know	
			☐ Something else, please describe:	

Contact Information

1. ☐ Primary Address ☐ Secondary Address

Street 1	Street 2	Address Type	City	State	Zip
		☐ Home ☐ Mailing			

2. ☐ Primary Address ☐ Secondary Address

Street 1	Street 2	Address Type	City	State	Zip
		☐ Home ☐ Mailing			

Home Phone	Day Phone	Cell Phone	E-Mail

In Case of Emergency Notify	Relationship	Emergency Contact Phone

ARIZONA COMMUNITY SURGEONS, PC

NEW PATIENT INTAKE FORM

Insurance Information - Please Give Your Insurance Cards To Receptionist For Scanning

Primary Insurance	ID #	Group #
Primary Insurance - Claims Billing Address		
Insured Person's Name		**Birth Date**
Secondary Insurance	**ID #**	**Group #**
Secondary Insurance - Claims Billing Address		
Insured Person's Name		**Birth Date**
Employer	**Occupation**	**Employer Phone #**
Pharmacy Name #1	**Cross Streets OR Address**	**Phone #**
Pharmacy Name #2	**Cross Streets OR Address**	**Phone #**

ARIZONA COMMUNITY SURGEONS, PC

NEW PATIENT INTAKE FORM

Demographics

Race				Ethnicity		Preferred Language	
	Asian		White		Unknown		English
	Black or African American		Other		Declined to specify		Spanish
	Declined to specify				Hispanic or Latino		Other
	Hispanic Or Latino (All Races)				Not Hispanic or Latino		
	Indian				Other		
	Multi-racial						
	Native American Indian						

Primary Care Provider

Referring Provider

ARIZONA COMMUNITY SURGEONS, PC

NEW PATIENT INTAKE FORM

Medical - Do you have any of the following? (Please check all that apply):

		Date Diagnosed
☐	Allergies	
☐	Alzheimer's Disease	
☐	Anemia	
☐	Anesthesia Reaction	
☐	Angina(Chest Pain)	
☐	Anxiety	
☐	Arthritis **Type:**	
☐	Asthma	
☐	Bleeding Disorder	
☐	Blood Clots	
☐	Cancer **Type:**	
☐	Cardiac Arrythmia (Irregular Heart Beat)	
☐	Complex Regional Pain Disorder	
☐	Congestive Heart Failure	
☐	Chronic Obstructive Pulmonary Disease (COPD)	
☐	Coronary Artery Disease	
☐	Crohn's Disease	
☐	Degenerative Joint Disease (Osteoarthritis)	
☐	Dementia	
☐	Depression	
☐	Dermatitis	

				Date Diagnosed
☐	Diabetes **Type**	1	2	
☐	Dialysis			
☐	Drug Use/Substance Dependency			
☐	Elevated Lipids **Other:**			
☐	Endocarditis			
☐	Fibromyalgia			
☐	Gallbladder Disease			
☐	GERD/Reflux			
☐	Gout			
☐	Headache, Migraine			
☐	Hepatitis/Liver Disease			
☐	HIV/Aids			
☐	Hypertension (High Blood Pressure)			
☐	Inflammatory Bowel Disease			
☐	Lyme Disease			
☐	Malignant Hyperthermia			
☐	MRSA			
☐	Myocardial Infarction (Heart Attack)			
☐	Obesity			
☐	Osteoporosis			
☐	Parkinson Disease			

		Date Diagnosed
☐	Peptic Ulcer Disease	
☐	Peripheral Vascular Disease	
☐	Psoriasis	
☐	Pulmonary Embolism	
☐	Pulmonary Fibrosis	
☐	Renal/Kidney Disease **Type:**	
☐	Scoliosis	
☐	Seizure Disorder	
☐	Sleep Apnea	
☐	Spinal Stenosis	
☐	Spondyloarthropathy (Joint Disease of the Vertebral Column)	
☐	Stroke	
☐	Systemic Lupus Erythematous	
☐	Thyroid Disease	
☐	Varicose Veins	
☐	Valvular Disease (Heart Valve Problems)	
☐	Vancomycin-Resistant Enterococci	
☐	Other	

ARIZONA COMMUNITY SURGEONS, PC

NEW PATIENT INTAKE FORM

Surgical - Do you have or have you had any of the following? (Please check all that apply):

		Date
☐	ACL Repair	
☐	Amputation	
☐	Angioplasty	
☐	Appendectomy	
☐	Arthroscopy **Site:**	
☐	Back Surgery	
☐	Bariatric/Gastric Bypass	
☐	Blood Transfusion	
☐	Breast Augmentation	
☐	Breast Biopsy **L** **R**	
☐	CABG/ Heart Bypass	
☐	Cardiac Pacemaker	
☐	Cardiac Valve Replacement	
☐	Carpal Tunnel Release	
☐	Cataract Extraction **L** **R**	
☐	Cesarean Section	

		Date
☐	Cholecystectomy	
☐	Colectomy	
☐	Colostomy	
☐	Gender Reassignment	
☐	Hemorrhoidectomy	
☐	Hernia Repair	
☐	Hip Replacement **L** **R**	
☐	Hip Replacement Revision **L** **R**	
☐	Hysterectomy	
☐	Knee Replacement **L** **R**	
☐	Knee Replacement Revision **L** **R**	
☐	Lasik	
☐	Liver Biopsy	
☐	Mastectomy **L** **R**	
☐	Meniscus Surgery **Site:**	
☐	Nephrectomy	

		Date
☐	Organ Transplant **Specify:**	
☐	ORIF **Site:** (Surgery for Fracture)	
☐	Radiation Therapy	
☐	Rotator Cuff Repair **L** **R**	
☐	Shoulder Replacement **L** **R**	
☐	Small Bowel Resection	
☐	Stents in Heart	
☐	Stents Other Body Part **Specify:**	
☐	Thyroidectomy	
☐	Tonsillectomy	
☐	Other	

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NEW PATIENT INTAKE FORM

Social

Tobacco Use

Have you ever used tobacco? ☐ No ☐ Yes ☐ Former

	Tobacco type:	Daily Use? Yes	Daily Use? No	How many/much per day:	Age started:	Age stopped:
☐	Cigarette					
☐	Cigarillo					
☐	Cigar Pipe					
☐	Chewing					
☐	Smokeless					
☐	Snuff					
☐						

Vaping Use

Vaping use? ☐ Yes ☐ No

Status: Current user ☐ Not a current user ☐ Vaping without Nicotine

Duration: Age started: ☐ Age stopped: ☐

Alcohol:

Do you drink alcohol? ☐ No ☐ Yes ☐ Formerly Frequency: ☐

ARIZONA COMMUNITY SURGEONS, PC

NEW PATIENT INTAKE FORM

Family History

☐ **No family history of:** ☐ **Unknown**

Relationship: B = Brother, F = Father, M = Mother, S = Sister

	Relationship:	B	F	M	S	Onset age:	Cause of death:
☐	ADD/ADHD						
☐	Alcoholism						
☐	Allergies						
☐	Alzheimer's Disease						
☐	Anemia						
☐	Arthritis						
☐	Asthma						
☐	Blood Disorder						
☐	Cancer						
☐	Cardiovascular Disease						
☐	Cholelithiasis						
☐	Colitis						
☐	Heart Disease						
☐	Congestive Heart Failure						
☐	COPD						
☐	Coronary Artery Disease						
☐	Coronary Artery Disease, Premature						
☐	Depression						
☐	Developmental Delay						
☐	Diabetes						
☐	Drug Abuse						
☐	Eczema						
☐	Elevated Lipids						

	Relationship:	B	F	M	S	Onset age:	Cause of death:
☐	Genetic Disease						
☐	Gout						
☐	Hearing Impairment						
☐	Hypertension						
☐	Irritable Bowel Syndrome						
☐	Learning Disability						
☐	Liver Disease						
☐	Mental Illness						
☐	Migraines						
☐	Muscle Disease						
☐	Obesity						
☐	Osteoporosis Congenital						
☐	Parkinson's Disease						
☐	Peripheral Vascular Disease						
☐	Renal Disease/Kidney Disease						
☐	Seizure Disorder						
☐	Stroke						
☐	Thyroid Disorder						
☐	Other						
	_____						
	_____						
	_____						
	_____						

Medication

	Name of Drug	Strength	Dose Per Day	Reason Prescribed
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Allergies - Please check all that apply:

- ☐ Accupril (Quinapril)
- ☐ Acetaminophen
- ☐ Acyclovir
- ☐ Advil (Ibuprofen)
- ☐ Altace (Ramipril)
- ☐ Ampicillin
- ☐ Amaryl (Glimepiride)
- ☐ Augmentin (Amoxicillin)
- ☐ Aspirin
- ☐ Bactrim (Sulfamethoxazole)
- ☐ Biaxin
- ☐ Carafate (Sucralfate)
- ☐ Ceclor (Cefaclor)
- ☐ Celebrex
- ☐ Cephalosporins
- ☐ Cipro (Ciprofloxacin)
- ☐ Clinoril (Sulindac)
- ☐ Contrast Media (loversol)
- ☐ Codeine
- ☐ Coumadin
- ☐ Darvon
- ☐ Demerol
- ☐ Depakote
- ☐ DiaBeta (Glyburide)
- ☐ Diamox
- ☐ Dicloxacillin
- ☐ Doxycycline
- ☐ Egg
- ☐ Erythromycin
- ☐ Famotidine
- ☐ Flagyl
- ☐ Floxin
- ☐ Glucotrol (Glipizide)
- ☐ Heparin
- ☐ Ibuprofen
- ☐ Inderal (Propranolol)
- ☐ Indocin (Indomethacin)
- ☐ Insulin (Animal)
- ☐ Iodine or Shellfish
- ☐ Keflex (Cephalexin)
- ☐ Klonopin
- ☐ Lasix (Furosemide)
- ☐ Latex
- ☐ Levofloxacin
- ☐ Lidocaine
- ☐ Lipitor
- ☐ Lodine
- ☐ Lopressor (Metoprolol)
- ☐ Metal/Nickel
- ☐ Micronase (Glyburide)
- ☐ Minocin (Minocycline)
- ☐ Morphine
- ☐ Motrin (Ibuprofen)
- ☐ Naprosyn (Naproxen)
- ☐ Neptazane
- ☐ Niacin
- ☐ Oxycodone
- ☐ Peanut
- ☐ Penicillin
- ☐ Percocet (Oxycodone)
- ☐ Persantine
- ☐ Plavix
- ☐ Phenytoin
- ☐ Pravachol
- ☐ Prevacid
- ☐ Prilosec
- ☐ Prinivil
- ☐ Quinolones
- ☐ Ranitidine
- ☐ Septra (Sulfamethoxazole)
- ☐ Sulfa
- ☐ Tagamet (Cimetidine)
- ☐ Tape/Adhesives
- ☐ Tegretol (Carbamazepine)
- ☐ Tenormin (Atenolol)
- ☐ Tetanus toxoid
- ☐ Tetracycline
- ☐ Ticlid
- ☐ Valium (Diazepam)
- ☐ Vancomycin
- ☐ Vasotec
- ☐ Zestrill
- ☐ Zithromax
- ☐ Zocor (Simvastatin)
- ☐ Zyloprim (Allopurinol)
- ☐ Other (i.e. Food, Environmental)

_____

_____

_____

_____

_____

ARIZONA COMMUNITY SURGEONS, PC

NEW PATIENT INTAKE FORM

Review of Systems - Do you experience any of the following:

Constitutional

No	Yes	
		Chilis
		Fatigue
		Fever
		Malaise
		Night Sweats
		Weight Gain
		Weight Loss

Other: _____

HEENT

No	Yes	
		Ear Drainage
		Ear Pain
		Eye Discharge
		Eye Pain
		Hearing Loss
		Nasal Drainage
		Sinus Pressure
		Sore Throat
		Visual Changes

Other: _____

Cardiovascular

No	Yes	
		Chest Pain
		Claudication (Leg Cramps)
		Edema/Swelling
		Palpitations
		Raynaud's Disease
		Tests or procedure on arteries or veins in legs

Other: _____

Gastrointestinal

No	Yes	
		Abdominal Pain
		Blood in Stools
		Change in Stools
		Constipation
		Diarrhea
		Heartburn
		Loss of Appetite
		Nausea
		Vomiting

Other: _____

Neurological

No	Yes	
		Dizziness
		Extremity Numbness
		Extremity Weakness
		Gait Disturbance
		Headache
		Memory Impairment
		Seizures
		Tremors

Other: _____

Integumentary

No	Yes	
		Breast discharge
		Breast lump
		Brittle hair
		Brittle nails
		Hair loss
		Hirsutism (excessive body hair)
		Hives
		Pruritus (Itching)
		Mole changes
		Rash
		Skin lesion

Other: _____

Respiratory

No	Yes	
		Cough
		Known TB Exposure
		Shortness of Breath
		Wheezing

Other: _____

Psychiatric

No	Yes	
		Anxiety
		Depression
		Insomnia

Other: _____

Metabolic/Endocrine

No	Yes	
		Cold Intolerance
		Heat Intolerance
		Polydipsia (Excessive Thirst)
		Polyphagia (Escessive Hunger)

Other: _____

Musculoskeletal

No	Yes	
		Back Pain
		Joint Pain
		Joint Swelling
		Muscle Weakness
		Neck Pain

Other: _____

Hematologic/Lymphatic

No	Yes	
		Easy Bleeding
		Easy Bruising
		Lymphadenopathy (Lymph Node Disease)

Other: _____

Immunologic

No	Yes	
		Contact Allergy
		Environmental Allergies
		Food Allergies
		Seasonal Allergies

Other: _____

Colonoscopy

Yes ☐ No ☐ Date: _____

Cologuard

Yes ☐ No ☐ Date: _____

Fecal Occult Blood Test

Yes ☐ No ☐ Date: _____

FEMALE

Genitourinary - FEMALE

No	Yes	
		Dysuria (Painful urination)
		Hematuria (Blood in urine)
		Polyuria (Genitourinary)*
		Urinary Frequency**
		Urinary Incontinence***
		Urinary Retention****

Other: _____

Reproductive - FEMALE

No	Yes	
		Abnormal Pap
		Dysmenorrhea (Painful Menstruation)
		Dyspareunia (Pain with sex)
		Hot Flashes
		Irregular Menses
		Vaginal Discharge

Other: _____

Mammogram

Yes ☐ No ☐ Date: _____

MALE

Genitourinary - MALE

No	Yes	
		Dribbling
		Dysuria (Painful urination)
		Hematuria (Blood in urine)
		Polyuria (Genitourinary)*
		Slow Stream
		Urinary Frequency**
		Urinary Incontinence***
		Urinary Retention****

Other: _____

Reproductive - MALE

No	Yes	
		Erectile Dysfunction
		Penile Discharge
		Sexual Dysfunction

Other: _____

Genitourinary - Definitions

***Polyuria (Genitourinary)**
Excessive urination of more than 3 liters per day

****Urinary Frequency**
The need to urinate many times during the day, at night (nocturia), or both but in normal or less-than-normal volumes.

*****Urinary Incontinence**
Involuntary leakage of urine.

******Urinary Retention**
The inability to completely or partially empty the bladder.

We may be prescribing medications electronically and need your permission to access your prescribed medications to avoid drug interactions and duplication. Your signature below will act as permission.

Completing this documentation prior to your appointment does not establish a Patient-Physician Relationship. Information will be reviewed by your provider when you are seen.

I attest the information provided above is true and accurate. I acknowledge I have read, signed and will abide by the Arizona Community Surgeons, PC Patient Payment and Financial Policies.

I ACKNOWLEDGE TYPING MY NAME BELOW CONSTITUTES AN ELECTRONIC SIGNATURE.

Patient's Signature: _____ Date: _____

(or Parent/Guardian if patient is a minor)

Guarantor/Persons liable for bill, if other than the patient: _____ Phone: _____

ARIZONA COMMUNITY SURGEONS, PC

NOTICE OF PRIVACY PRACTICES

PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Omnibus Rules of 2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or had the opportunity to review the Notice of Privacy Practices from Arizona Community Surgeons, PC ("ACS"), which contains a more complete description of the uses and disclosures of my health information. I understand that ACS has the right to change its Notice of Privacy Practices from time to time and that I may contact ACS at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that ACS restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand ACS is not required to agree to my requested restrictions, but if ACS does agree then ACS is bound to abide by such restrictions.

ACS does not discriminate based on race, age, sex, sexual orientation or ethnicity.

Patient Name: _____ **Patient Date of Birth**: _____

Signature: _____ **Date Signed**: _____

REQUEST FOR CONFIDENTIAL COMMUNICATION

HIPAA privacy rules give certain individuals the right to request confidential medical information. In that regard, you may select the method in which this confidential medical information is communicated. Also, ACS may need to communicate with you regarding your confidential medical information. Please select your preferred method of contact. If you would like to change your contact information in the future, please provide your request in writing to the address contained within the Privacy Practice Notice.

I give permission to disclose my confidential medical information to the following individuals:

Printed Name: _____ Relationship: _____

Printed Name: _____ Relationship: _____

Printed Name: _____ Relationship: _____

My EMERGENCY contact is:_____ **Phone**_____

I prefer to be contacted in the following manner (X all that apply):

____ Home Phone:_____ ____ Detailed Message OR ____Callback Number Only

____ Work Phone:_____ ____ Detailed Message OR ____Callback Number Only

____ Cell Phone: _____ ____ Detailed Message OR ____Callback Number Only

Written Communication: I give my consent to be contacted in the following ways:

Mail to Home Email to: _____ Fax to: _____

I ACKNOWLEDGE TYPING MY NAME BELOW CONSTITUTES AN ELECTRONIC SIGNATURE:

Signature: _____ **Date Signed**:_____

ACS OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Employee Name: _____

Reason: _____

ARIZONA COMMUNITY SURGEONS, PC

Patient Name: _____

Date of Birth: _____

Address: _____

Arizona Community Surgeon (ACS) Attestation

I acknowledge I have received the documents from Arizona Community Surgeons and consent to the following: (initials and signatures required):

_____ Notice of Privacy and HIPAA

_____ACS Finance Policy I have read and agree to this Payment Policy, Assignment and Release of Information stated in the policy. I acknowledge my financial responsibility related to the services provided by Arizona Community Surgeons, PC.

_____ Prescriptions and Narcotics Agreement

_____I give ACS permission to obtain my medication history

_____I hereby consent to the clinical exam and treatment to be provided.

_____ I give ACS permission to bill my insurance company for services and/or product(s) received on my behalf. (if applicable).

My signature is acknowledgement of receipt of these documents. I understand I am responsible for reviewing and understanding the information provided by ACS and agree to comply. My signature confirms the information provided to ACS is true and accurate. I give ACS permission to bill my insurance company for services and/or product(s) received on my behalf. (if applicable). I acknowledge typing my name below constitutes an electronic signature.

_____

Patient Signature Date