INNOVATIVE PRIMARY CARE OF LAKE HAVASU LLC

New Patient Information Packet

PATIENT'S NAME: _____

ADDRESS:_____

PHONE: _____

CITY:_____STATE: _____ZIPCODE:_____

DOB:_____AGE:_____SOCIAL SECURITY:_____

MARITAL STATUS:_____MARRIED SINGLE WIDOWED DIVORCED

REFERRED BY: _____

PATIENT EMPLOYER:_____

RESPONSIBLE PARTY

RESP PARTY NAME:_____

PATIENT RELATIONSHIP TO RESPONSIBLE PARTY: SELF SPOUSE CHILD OTHER

ADDRESS: _____

DOB:_____SOCIAL SECURITY #:_____

PHONE NUMBER: _____CELL NUMBER: _____

EMPLOYER INFORMATION:_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

ADDRESS: _____

PHONE: _____FAX:_____

SUBSCRIBER'S NAME: _____DOB:_____

RELATIONSHIP TO THE SUBSCRIBER: SELF SPOUSE CHILD OTHER

INSURANCE ID#: _____GROUP#: _____

CO-PAYMENT: _____

SECONDARY INSURANCE

SECONDARY INSURANCE: _____

ADDRESS: _____

PHONE: _____FAX:_____

SUBSCRIBER'S NAME: _____DOB:_____

RELATIONSHIP TO THE SUBSCRIBER: SELF SPOUSE CHILD OTHER

INSURANCE ID#: _____GROUP#: _____

CO-PAYMENT: _____

WE APPRECIATE THE OPPORTUNITY TO SERVE YOU

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

PLEASE RELEASE MY MEDICAL RECORDS TO:

NAME: _____RELATIONSHIP: _____

NAME: _____RELATIONSHIP: _____

IN CASE OF AN EMERGENCY PLEASE CONTACT:

NAME: _____RELATIONSHIP: _____

PHONE: _____

NAME: _____RELATIONSHIP: _____

PHONE: _____

CANCELLATION POLICY:

1. WE REQUEST THAT YOU PLEASE GIVE OUR OFFICE A 24 HOUR NOTICE IN THE EVENT THAT YOU NEED TO RESCHEDULE YOUR APPOINTMENT.THIS WILL MAKE THE APPOINTMENT TIME AVAILABLE TO SOMEONE ELSE.
2. IF YOU MISS AN APPOINTMENT AND DO NOT CONTACT US WITH AT LEAST 24 HOURS NOTICE, WE WILL CONSIDER THIS TO BE A MISSED APPOINTMENT AND A **$25.00** FEE WILL BE ASSESSED TO YOU.
3. AS A COURTESY, WE WILL MAKE REMINDER CALLS FOR APPOINTMENTS.

SIGNED: _____DATE: _____

NO SHOW CHARGE

THERE WILL BE A $25.00 CHARGE FOR NO SHOW APPOINTMENTS

SIGNED:_____DATE:_____

PRESCRIPTION REFILLS:

PLEASE ALLOW 24 HOURS FOR PRESCRIPTION REFILLS. CALL YOUR PHARMACY AT LEAST 72 HOURS PRIOR TO RUNNING OUT OF YOUR MEDICATION.
BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ THE PRESCRIPTION POLICY.

SIGNED: _____DATE: _____

OFFICE POLICY ON PAYMENT:

IT IS OUR POLICY TO REQUIRE PAYMENT OF ALL OFFICE CHARGES AT THE TIME THEY ARE GIVEN, UNLESS PRIOR ARRANGEMENTS HAVE BEEN SPECIFICALLY MADE. ALL ACCOUNTS OVER 60 DAYS WILL BE CHARGED INTEREST RATE OF 1 ½ PERCENT PER MONTH (18% ANNUAL) OR A $2.00 MINIMUM. IN THE EVENT ANY BALANCE DUE HEREUNDER NOT PAID AS AGREED, THE UNDERSIGNED JOINTLY AND SEVERELY AGREE TO PAY ALL COSTS CHARGED BY THE COLLECTION COMPANY, WHICH COSTS WILL NOT EXCEDD $20% OF SAID UNPAID BALANCE INCLUDING A REASONABLE ATTORNEY FEE.

INSURANCE POLICY:

SOME INSURANCE PROVIDERS MAY ALLOW REIMBURSEMENT ON ALLOWED MEDICAL CHARGES. AS A COURTESY TO YOU, WE WILL PROVIDE AN ITEMIZED STATEMENT. YOU MAY SEND TO YOUR INSURANCE COMPANY FOR PAYMENT.WE WILL BE HAPPY TO SUBMIT TO MOST INSURANCE EMPLOYMENT AND ANY OTHER PERTINENT INFORMATION.

YOU ARE RESPONSIBLE FOR ALL DEDUCTIBLES AND CHARGES NOT COVERED BY INSURANCE:

PLEASE UNDERSTAND THAT WE CANNOT, AS A THIRD PARTY BECOME INVOLVED IN PROLONGED INSURANCE NEGOTIATIONS. THIS IS YOUR RESPONSIBILITY.

CONSENT FOR TREATMENT:

I VOLUNTARILY CONSENT TO RECEIVE MEDICAL AND HEALTHCARE SERVICES PROVIDED BY LOIDA ARQUIZA, FNP-BC. I UNDERSTAND THAT SUCH SERVICES MAY INCLUDE DIAGNOSTIC PROCEDURES, EXAMINATIONS, AND TREATMENT. I UNDERSTAND THIS CONSENT WILL BE VALID AND REMAIN IN EFFECT AS LONG AS I REMAIN A PATIENT.

AUTHORIZATION FOR RELEASE FOR MEDICAL RECORDS:

I AUTHORIZE LOIDA ARQUIZA, FNP-BC TO RELEASE ANY MEDICAL INFORMATION INCLUDING DIAGNOSIS, XRAYS, TEST RESULTS, REPORTS AND RECORDS PERTAINING TO ANY OF THE FOLLOWING PURPOSES: DIAGNOSTIC, INSURANCE, LEGAL AND AT TIMES WHEN THE DOCTOR DEEMS IT NECESSARY IN ORDER TO ENSURE THE BEST MEDICAL CARE ON MY BEHALF. I FURTHER UNDERSTAND THAT ANY PERSON(S) THAT RECEIVE THESE MEDICAL RECORDS WILL NOT RELEASE ANY OF THE MEDICAL INFORMATION OBTAINED BY THIS AUTHORIZATION TO ANY OTHER PERSON OR ORGANIZATION WITHOUT A FURTHER AUTHORIZATION SIGNED BY ME FOR RELEASE OF THE INFORMATION.

I HAVE READ THE ABOVE AND ACCEPT FINANCIAL RESPONSIBILITY IN FULL FOR THIS ACCOUNT.

SIGNED: _____DATE: _____

REASON FOR TODAY'S VISIT: TELL US WHY YOU ARE HERE:

_____

WHEN DID YOU FIRST NOTICE THE SYMPTOMS?

_____

WHAT TREATMENT HAVE YOU RECEIVED FOR YOUR CONDITION?

_____

NAME AND ADDRESS OF OTHERS THAT HAVE TREATED YOU:

_____

_____

DAILY HABITS:

WHAT TYPE OF EXERCISE DO YOU PERFORM ON A DAILY BASIS?
_____NONE _____MODERATE _____HEAVY

SOCIAL HISTORY:

DO YOU SMOKE? _____YES _____NO _____PAST HOW LONG AGO?_____

DO YOU DRINK ALCOHOL? _____YES _____NO NUMBER IN WEEK_____

HAS ANYONE EVER TOLD YOU TO CUT DOWN ON YOUR DRINKING?___YES ___NO

DO YOU USE DRUGS FOR REASON THAT ARE NOT MEDICAL? ____YES ____NO
IF YES PLEASE LIST_____

SURGICAL HISTORY

HAVE YOU HAD A HYSTERECTOMY? _____YES _____NO

OTHER SURGERIES	YEAR	REASON

FAMILY HISTORY

	AGE	HEALTH	AGE AT DEATH	CAUSE
FATHER				
MOTHER				

NUMBER OF SIBLINGS_____NUMBER OF LIVING_____NUMBER DECEASED_____

NUMBER OF CHILDREN_____NUMBER OF LIVING_____NUMBER DECEASED_____

LIST AGES_____

HEALTH OF CHILDREN_____

MEDICATIONS

DRUG ALLERGIES _____YES _____NO

TO WHAT? _____

TYPE OF REACTION? _____

CURRENT MEDICATIONS:

(LIST ALL MEDICATION YOU ARE TAKING INCLUDING VITAMINS, SUPPLEMENTS AND ASPIRIN).

MEDICATION	DOSAGE AND HOW OFTEN	HOW LONG HAVE YOU BEEN TAKING	NEED REFILL

HEALTH HISTORY

DATE OF LAST MAMMOGRAM_____ DATE OF LAST CHEST X-RAY_____

DATE OF LAST BONE DENSITY_____ DATE OF LAST COLONOSCOPY_____

CONSTITUTIONAL

___RECENT WEIGHT GAIN

BRUISING

AMOUNT_____

___RECENT WEIGHT LOSS

AMOUNT_____.

___NODULES/BUMPS

___FATIGUE

___WEAKNESS

GASTROINTESTINAL

___NAUSEA

___VOMITING

___INCREASING CONSTIPATION

___PERSISTENT DIARRHEA

__BLACK STOOLS

INTEGUMENTARY

___EASY

___REDNESS

___RASH/HIVES

___HAIR LOSS

ENT

__RINGING IN EARS

___LOSS OF SMELL.

___LOSS OF TASTE

___LOSS OF HEARING

___FREQUENT SORE THROAT.

___DIFFICULTY SWALLOWING.

___DRYNESS IN NOSE

GENITOURINARY

___DIFFICULT URINATION

___PAIN OR BURNING

___DISCHARGE FROM PENIS/VAGINA.

___GETTING UP AT. NIGHT TO URINATE.

___VAGINAL DRYNESS.

___SEXUAL DIFFICULTIES

___PROSTATE TROUBLE

NEUROLOGICAL

___DIZZINESS

___FAINTING

___MEMORY LOSS

___NIGHT SWEATS

___LOSS OF CONSCIOUSSNESS

CARDIOVASCULAR

___CHEST PAIN

___IRREGULAR HEARTBEAT

___DEPRESSION

FOR WOMEN ONLY

AGE WHEN PERIODS BEGAN_____

PERIODS REGUALR ___YES____NO

PSYCHIATRIC

___ANXIETY

___HIGH BLOOD PRESSURE

___SWELLING OF LEGS

___HALLUCINATIONS

HOW MANY DAYS APART_____

DATE OF LAST PERIOD_____

DATE OF LAST PAP_____

BLEEDING AFTER MENOPAUSE____YES___NO

NUMBER OF PREGNANCIES _____

NUMBER OF MISCARRIAGES_____

___AGITATION

RESPIRATORY

___SHORTNESS OF BREATH

SNEEZING

___COUGH

___WHEEZING

FULLNESS

ENDOCRINE

___EXCESSIVE THIRST

ALLERGIC

___FREQUENT

___RUNNY NOSE

___ITCHY EYES

___EAR

MUSCULOSKELETAL

___JOINT PAINS

___MUSCLE WEAKNESS.

___MUSCLE STIFFNESS

HEMATOLOGIC

___SWOLLEN TENDER LYMPH NODES

___ANEMIA

___ANTICOAGULANTS (BLOOD THINNERS)

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been notified that there is a copy of Innovative Primary Care of Lake Havasu LLC Notice of Privacy
Practices available for my review in the waiting room detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my personal and medical information:

_____

_____

Please list names of family or persons whom you are consenting Innovative Primary Care of Lake Havasu LLC to speak with regarding your personal medical information or to whom you consent for us to release
copies of your medical records:

Name: _____ Relationship_____ Phone_____

Name: _____ Relationship_____ Phone_____

Name: _____ Relationship_____ Phone_____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____

Date: _____

If not signed by the Patient, please indicate the relationship to the patient (i.e. spouse)

Relationship:

_____

Witness:

_____

If Patient refused to sign, indicate your attempt to obtain a signature below.

( ) Patient refused to sign this Acknowledgement of Privacy Practices

Date: _____

INNOVATIVE PRIMARY CARE OF LAKE HAVASU LLC

Loida Arquiza, FNP-BC

TO: _____

ADDRESS: _____

FAX: _____

HEREBY I REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

1945 MESQUITE AVE SUITE B
LAKE HAVASU CITY, AZ 86403

PHONE: 928-733-6287
FAX: 928-733-6305

PATIENT'S NAME (please print): _____

PATIENT'S SIGNATURE: _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE NUMBER: _____