Arizona Community Physicians

Patient Information

FIRST NAME | MIDDLE | LAST NAME | ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | EMERGENCY PHONE# | EMERGENCY CONTACT NAME / RELATION

/ /

DOB | SEX | MARITAL STATUS | EMAIL | RACE (optional)

PRIMARY CARE PHYSICIAN | STUDENT? FT OR PT | PREVIOUS NAME

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE

Billing Information
(If different than patient)

FIRST NAME | MI | LAST NAME | ADDRESS | CITY | STATE/ZIP | PHONE

Primary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

SELF SPOUSE CHILD OTHER

GROUP ID# | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (If different than patient) | SUBSCRIBER PHONE (If different than patient)

/ /

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

Secondary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

SELF SPOUSE CHILD OTHER

GROUP ID# | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (If different than patient) | SUBSCRIBER PHONE (If different than patient)

/ /

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

By signing this form, I am consenting to Arizona Community Physicians' use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Arizona Community Physicians' Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Arizona Community Physicians for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.

PERSON GIVING CONSENT | RELATIONSHIP IF NOT THE PATIENT | DATE

ACP
ARIZONA COMMUNITY PHYSICIANS

Patient name:_____ **MRN:**_____

The government mandates that all healthcare is provided fairly, without regard to race or ethnicity. These registration questions are to insure we are meeting these guidelines. This information will be kept confidently.

Race

American Indian/Alaskan Native
Asian Indian
Black, African American
Caucasian (White)
Chinese
Filipino
Guamanian/Chamorro
Japanese
Korean
Native Hawaiian
Other Asian
Other Pacific Islander
Samoan
Vietnamese
Unknown
Decline

Ethnicity

Cuban
Mexican/ Mexican American
Other Hispanic/Lantino/a or Spanish Origin
Puerto Rican
Non Hispanic/Latino/a or Spanish Origin
Unknown
Decline

Preferred Language

English
Spanish
Arabic
Chinese (all types)
French
German
Greek
Italian
Japanese
Korean
Navajo
Polish
Russian
Tagalog
Ukrainian
Vietnamese
Other(Specify)_____

Interpreter Services Needed: YES NO

Employment Status of Guardian

Full Time or Part Time
Not Employed
Employer _____

Marital Status:

Married
Divorced
Legally Seperated
Single
Widowed
Signifigant Other
Other

Emergency Contact

Name_____
Phone _____
Relationship:_____
Date of Birth _____

Patient Email:_____

Do you want to sign up for MY CHART -online access to yourr Medical Records? YES NO

Patient(or Guardian) Signature:_____ Date:_____

Dyson Pediatrics

Duane Dyson, MD, FAAP Elizabeth Altomare, MD, FAAP

MRN: _____

Patient Name:	Birth Date	Age	Sex M F
Mother's Name:	Father's Name:	Forms Completed By:	Date

Household Information

Name	Relation to Child	Birth Date	Health Problems	Occupation

Social History

If mother and father are not living together or if child does not live with parents, what is the child's custody status?_____

_____

Does the child have access to a pool? Is it fenced or covered? ( )yes ( )no
Explain_____

What languages are spoken in home? ( ) English ( ) Spanish ( )Other_____

Childcare? ( )Parents ( )Relatives ( )Daycare ( )Babysitter/Nanny

Days per week at daycare (not with parents)_____

Do any household members smoke? ( )yes ( )no

Birth History

Did mother have any illness or problems with pregnancy? ( )yes ( )no Explain_____

During the pregnancy did mother use medications, drugs, smoke or drink alcohol?
( )yes ( )no Explain_____

Was the delivery ( ) Vaginal? ( ) C-section?

Was the baby ( ) Term? ( ) Early?

Gestational Age? _____weeks

What was the baby's birth weight _____ lbs _____ oz

Did your baby have any problems right after birth?

( )yes ( )no Explain_____

Did your baby pass the hearing screen?

( )yes ( )no Explain_____

Did your baby get the Hepatitis B vaccine?

( )yes ( )no Explain_____

Did your baby go home with mother from the hospital? ( )yes ( )no Explain_____

General Information

Does your child see any specialists?

( )yes ( )no Explain_____

Does your child have any serious illness or medical condition?

( )yes ( )no Explain_____

Has your child had any serious injuries or accidents?

( )yes ( )no Explain_____

Has your child had any surgeries?

( )yes ( )no Explain_____

Dyson Pediatrics

Duane Dyson, MD, FAAP Elizabeth Altomare, MD, FAAP

MRN: _____

Does your child use any medical devices?

( )yes ( )no Explain_____

Has your child been hospitalized?

( )yes ( )no Explain_____

Is your child allergic to any medications or foods?

( )yes ( )no Explain_____

Are your child's immunizations up to date?

( )yes ( )no ( ) I don't know

Medications

Name_____ Dose_____ Frequency_____

Name_____ Dose_____ Frequency_____

Developmental

Are you concerned about your child's physical development?

( )yes ( )no Explain_____

Are you concerned about your child's mental or emotional development?

( )yes ( )no Explain_____

Family History

Condition	Mother	Father	Sibling	Grandparent	Comments
Asthma					
Anemia					
Blood Disorder					
Cancer					
Heart Attack/Disease					
High Cholesterol					
High Blood Pressure					
Stroke					
Liver Disease					
Kidney Disease					
Diabetes					
Epilepsy or Convulsions					
Mental Illness (Anxiety, Depression)					
Mental Retardation					
Thyroid Disease					
Sudden Death					
Immune Problems					

Dyson Pediatrics
Cancellation and No Show Policy

4530 E. Camp Lowell Dr. Tucson, AZ 85712

PATIENT NAME_____ DOB _____

MRN _____

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hour notice. This will allow for another patient who is waiting for an appointment to be scheduled in that appointment time.

Office appointments which are canceled after 10 a.m. on the business day prior to your scheduled visit will be subject to a $35.00 cancellation fee.

All appointments without a call to cancel prior to appointment time, will be considered a no-show appointment. No-Show appointments are subject to a $35.00 no-show fee.

If you have three or more no-showed appointments in a 12 month period of time you may be dismissed from the practice and denied any future appointments with any of our physician(s).

Same day scheduled appointment cancelations may also result in a $35.00 fee depending on the time frame of your notice.

Cancelation and no-show fees are the sole responsibility of the patient (Parent) (they are not covered by your insurance) and must be paid in full prior to your next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these instances may be waived but only with managerial approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. We are happy to discuss any questions you may have about our cancelation, and no-show policy and fees.

Parent/Guardian _____

Signature_____ Date_____

ARIZONA COMMUNITY PHYSICIANS

PRINT PATIENT NAME | PT DOB | MRN

Dear Patient:

You are scheduled today for your Annual Preventative Medicine visit, commonly referred to as an Annual Physical.

Please know that your insurance may limit the reimbursement for this service to once every 365 days. If you have received this service from another provider within the past 365 days you may be charged for this visit.

The Annual Preventative Medicine visit includes the following:

- An age appropriate history and exam that is not part of disease management.
- Counseling, guidance and risk factor reduction.
- Ordering of routine tests such as screening colonoscopy, screening labs and radiology services to identify potential problems.

The Annual Preventative Medicine visit does not include the services below. If you require these additional services today, please be aware your insurance has a separate billing category for which your provider may charge your insurance. Alternatively, please let your provider know if you do not want these services.

- Evaluation and Management of <u>new or ongoing problems requiring further workup or discussion.</u> This may include a more extensive problem focused physical exam, ordering of diagnostic tests for known problems, prescription drug management, coordinating care with another specialist, or simply providing further counseling related to a chronic diagnosis.

If you have any questions regarding this information, please see the front desk staff.

I have received and read this information.

PATIENT SIGNATURE | DATE

Arizona Community Physicians, P.C.
Child Release of Information Form

Account #_____

Patient Name _____ DOB_____ Date_____

The confidentiality of our patient's medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your child's health information.

Please list the names and phone numbers of anyone who has your permission to have access to your child's medical records. This information is not limited to but includes appointments, billing information and test results.

Parent/Guardian name _____Contact Number_____

Parent/Guardian name _____ Contact Number_____

Other Adult _____Contact Number_____

Other Adult _____ Contact Number_____

I give permission for my child to be taken to their medical appointments by:

Names _____

By providing the below phone #'(s) you are giving permission, to leave appointment information or detailed information regarding, lab results, radiological results or any other imperative information on the phone # indicated below

Cell/Mobile voice mail _____ (Phone #)

Home voice mail_____ (Phone #)

DO NOT RELEASE Information to the following people: _____

Please check if your child is **16 years old or older** and you give permission for them to be seen without an adult:

_____ I give permission for my child to be seen without the presence of an adult.

_____ I give permission for my child to have minor procedures or immunizations without the presence of an adult.

I acknowledge that either I or the physician may, at any time, withdraw the option of releasing test information per the terms of this agreement, upon providing written notice. Any questions I had have been answered.

Name Parent/Guardian: _____ Signature _____

Parent/Guardian Contact Numbers: Cell_____ Work_____ Other_____

Note: these are general consent forms and are not a substitute for separate written informed consent discussing risks, benefits, and possible side effects of treatment when required (e.g., invasive procedures and immunizations). Offices treating minors will need to ensure the parent/legal guardian has separately signed and authorized the procedural or VIS vaccine forms, prior to the appointment, when permitting their child to come to the visit unaccompanied.

Arizona Community Physicians P.C.
Authorization to Disclose Medical Information

PATIENT INFORMATION

Patient Name_____ Former Name_____ Account #_____

Daytime Telephone_____ Birth Date_____

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____

Street Address _____

City/State/Zip_____

Phone # _____ Fax#_____

To release the following medical information contained in patient's medical record.

INFORMATION TO BE RELEASED TO

Name of Physician/Organization Dyson Pediatrics

Street Address 2222 N. Craycroft Rd. Ste. 150

City/State/Zip Tucson, AZ 85712

Phone # 520-202-3488 Fax# 520-202-3486

PURPOSE FOR THIS REQUEST (Please check a box)

☐ Moving ☐Treatment or consultation ☐Dissatisfaction☐ Change of Insurance Plans ☐ At patients request

☐Other (specify) _____

TYPE OF INFORMATION TO BE RELEASED (No information will be released unless a box is checked)

General Release ☐Medical Records/Excluding Protected Records (This will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated)	DATES OF TREATMENT From_____ To_____
☐ Other Records (specify) _____	From_____ To_____
Information Protected by State/Federal Law ☐ All of my records including: AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment	From_____ To_____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information understands that it is prohibited from making any disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Signature of Patient or Personal Representative Who May request Disclosure

I understand that Arizona Community Physicians may not condition my treatment on whether I sign this authorization form unless specified above under Purpose for Request. I can inspect or receive a copy of the protected health information to be used or disclosed. **I authorize Arizona Community Physicians to use and disclose the protected health information specified above**

_____ _____ _____

Signature of Patient OR Legal Representative **Date** **Please Print Name of signing party**

Patient Requesting Medical Record Copies

The standard charge for copying medical records is $6.50 for a disc and $0.07 per page for paper. However there maybe additional charges for shipping and handling.

FORM # 100
Updated: 08/04/2017