APEX PHYSICIANS
INFECTIOUS DISEASES SPECIALISTS
7312 E. Deer Valley Road, Suite 100 • Scottsdale, Arizona 85255
Phone: (480) 454-4185 • Fax: (480) 745 2420

New Patient Registration Form

Last Name: _____First Name: _____M.I._____

Date of Birth: _____/_____/_____ Sex: M/F Social Security Number: _____/____/_____

Address:

_____
(Street) (City/State/Zip)

Preferred Phone: _____ Secondary Phone:_____

Email Address: _____

Who may receive information regarding your protected health information?

_____
(Name) (Relationship to You)

Who do we call for an emergency? _____ Phone: _____

May we leave messages regarding test results and appointments on your phone's voicemail? ___ Yes ___ No

How did you hear about our Practice?_____

Primary Care Physician: _____ Phone Number: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____
(Street) (City/State/Zip)

Pharmacy Name: _____

_____
(Address of Cross Streets) (Phone Number)

Where would you like your LABS to be drawn? _____

_____
(Address or Cross Streets) (Fax or Phone Number)

Guarantor Information: (Person Responsible for Payment)

Guarantor Name: _____ Social Security Number: ____-__-_____

Relationship to Patient: (Circle one) Self/Spouse/Parent Date of Birth:___/____/____

Address: (if different from above)_____

Employer Name: _____ Employer Phone: _____

Employer Address:

_____

(Street) (City/State/Zip)

Primary Insurance Information:

Insurance Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date:_____

Policy Holder's Social Security Number: _____-____-_____ Policy Holder's DOB:

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Secondary Insurance Information:

Insurance Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____-____-_____ Policy Holder's DOB:
____/___/___

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Apex Physicians. I acknowledge that I am financial responsible for payment whether or not covered by insurance.

Signature: _____ Date: ____/____/_____

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New Patient Health History

Please take a moment to provide your most up-to-date health information. We will upload your responses below, along with the information contained in the medical records sent to us, to your medical chart to ensure we have your most complete medical history. If you have other medical conditions that are not listed in the options below, please tell them to your medical assistant.

Patient Name: _____ Date of Birth:_____

Reason for Visit: _____

Additional Complaint(s): _____

Age: _____ Height: _____ feet _____ inches Weight: _____ pounds

MEDICAL HISTORY - Please tell us if a doctor or hospital has given you any of the following medical diagnosis:

Breast
- ☐ Breast abscess
- ☐ Breast cancer
- ☐ Breast implant complication
- ☐ Inflammatory breast disorder

Cardiovascular (Heart/Vessels)
- ☐ Aortic aneurysm
- ☐ Atrial fibrillation
- ☐ Cardiomyopathy
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Endocarditis
- ☐ Hypertension
- ☐ Lymphedema
- ☐ Peripheral vascular disease
- ☐ Rheumatic fever
- ☐ Valvular heart disease
- ☐ Venous insufficiency

Dermatologic (Skin)
- ☐ Eczema
- ☐ Hidradenitis suppurative
- ☐ Psoriasis
- ☐ Shingles (Zoster)
- ☐ Skin abscess
- ☐ Skin cancer

Endocrine (Hormonal)
- ☐ Diabetes mellitus
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Polycystic ovarian syndrome
- ☐ Thyroid cancer

Gastrointestinal
- ☐ Cirrhosis of liver
- ☐ Colon cancer
- ☐ Crohn's disease
- ☐ Esophageal reflux (GERD)
- ☐ Pancreatic cancer
- ☐ Peptic ulcer
- ☐ Ulcerative colitis

Gynecologic
- ☐ Cervical cancer
- ☐ Endometriosis
- ☐ Leiomyosarcoma
- ☐ Ovarian cancer
- ☐ Ovarian cyst

Hematologic (Blood)
- ☐ Anemia
- ☐ Anticoagulants, long term
- ☐ Asplenia (no spleen)
- ☐ Leukemia

Hematologic (Blood) Cont.
- ☐ Multiple myeloma
- ☐ Myelodysplastic syndrome (MDS)
- ☐ Sickle cell anemia
- ☐ Lymphomia

Infectious/Immunologic
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Hepatitis B virus
- ☐ Hepatitis C virus
- ☐ Herpes simplex, genital
- ☐ Herpes simplex, oral
- ☐ HIV
- ☐ HPV Human papiloma virus
- ☐ Immunodeficiency state
- ☐ MRSA
- ☐ Syphilis
- ☐ Tuberculosis

Kidney/Renal
- ☐ Chronic kidney disease
- ☐ ESRD on dialysis
- ☐ Kidney cancer
- ☐ Kidney stone (nephrolithiasis)
- ☐ Kidney transplant status
- ☐ Lupus nephritis
- ☐ Polycystic kidney
- ☐ Solitary kidney

NEW PATIENT HEALTH HISTORY

MEDICAL HISTORY(continued)

Musculoskeletal (bone/Joint)

- ☐ Carpal tunnel syndrome
- ☐ Diabetic foot infection
- ☐ Gout
- ☐ Hip fracture
- ☐ Low back pain
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Spinal stenosis
- ☐ Tendon rupture

Neurologic (Brain/Nervous system)

- ☐ Dementia
- ☐ Epilepsy (seizures)
- ☐ Meningitis
- ☐ Migraine headache
- ☐ Parkinson's disease
- ☐ Stroke

Psychiatric

- ☐ Alcoholism
- ☐ Anxiety disorder
- ☐ Bipolar disorder
- ☐ Chronic fatigue syndrome
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Schizophrenia

Respiratory (Lung/Airway)

- ☐ Allergic rhinitis
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Interstitial lung disease
- ☐ Lung cancer
- ☐ Pulmonary embolism

Respiratory (Lung/Airway Cont.

- ☐ Pulmonary fibrosis
- ☐ Sinusitis chronic

Rheumatologic (Autoimmune)

- ☐ Rheumatoid arthritis
- ☐ Sarcoldosis
- ☐ SLE (Lupus)
- ☐ Vasculitis

Urologic (Bladder/Prostate)

- ☐ SPH (enlarged prostate)
- ☐ Bladder cancer
- ☐ Prostate cancer Urinary
- ☐ incontinence Urinary
- ☐ retention
- ☐ UTIs, recurrent

SURGICAL HISTORY - Please tell us if you have had any of the following surgical procedures:

- ☐ AICD (defibrillator)
- ☐ Appendectomy
- ☐ Arteriovenous fistula
- ☐ Arteriovenous graft
- ☐ Breast surgery
- ☐ Cholecystectomy (Gallbladder)
- ☐ Coronary bybass (CABG)
- ☐ Dialysis catheter
- ☐ Gastric bypass/sleeve
- ☐ Heart valve replacement
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee replacement
- ☐ Organ transplant
- ☐ Pacemaker
- ☐ Port catheter
- ☐ Shoulder replacement
- ☐ Spine surgery
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Ventriculoperitoneal shunt

FAMILY HISTORY - Please tell us if any of the following medical problems occur in your immediate family:

- ☐ No major medical problems
- ☐ I was adopted
- ☐ Aortic aneurysm
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast cancer
- ☐ Chronic kidney disease
- ☐ Colon cancer
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Diabetes melitus
- ☐ Hypertension
- ☐ Immunodeficiency disorder
- ☐ Lung cancer
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Psoriasis
- ☐ Rheumatoid arthritis
- ☐ Sarcoldosis
- ☐ SLE (Lupus)
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcerative colitis

SOCIAL HISTORY - Please tell us briefly about your habits, work, and partnership status:

Alcohol: ☐ 3 or more drinks/day ☐ 2 or more drinks/day ☐ Past Alcohol ☐ Never/Rare Alcohol

Tobacco: ☐ Every day ☐ Some days ☐ Former smoker ☐ Never Smoker ☐ Smokeless Tobacco

Recreational drugs: ☐ Never ☐ Past Use ☐ Recent/Ongoing use ☐ Recovering addict

Exercise (weekly): ☐ Light ☐ Moderate ☐ Vigorous ☐ Rare or none

Occupation: _____ ☐ Full time ☐ Part time ☐ Unemployed ☐ Disability ☐ Retired

Parnership status: ☐ Single ☐ Living w/partner ☐ Disability ☐ Retired

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Consent To Communicate Health Information

As a patient, you may designate a partner, family member, friend, or other persons with who Apex Physicians can communicate about your health care status. This form is not required in all circumstances for your doctor or others at Apex Physicians to be able to communicate with your family about your health care. However, by designating on this form certain individuals who you want to be informed about your care, you can ensure that your provider can communicate without delay with the person(s) you designate below.

I,_____ hereby consent to have my health information and care discussed with the following:

Name	Relationship	Phone number
Name	Relationship	Phone number
Name	Relationship	Phone number

I understand that this consent can be revoked by submitting a written request to Apex Physicians. I understand that I have the right to revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. This consent shall remain in effect until such time as I revoke it in writing.

By signing below I indicate that I have read and understood the policy described above.

Signature of Patient or Legal Surrogate	Date	Time
Printed Name of Patient or Legal Surrogate	Relationship (if Legal Surrogate)	

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Patient Name: _____ Date of Birth:___/__/__

Current Medication:
We encourage you to bring your medications to the office with you so that we can review your medications and enter them into the medical record. Or, if you prefer, bring in a list of your medications, or complete this form ahead of time, and hand it to your medical assistant when you arrive for your office visit.

☐ I take no medications

Medications	Dose	Frequency	Reason

Medication Allergies

☐ I have no known medication allergies.

Medication Name	What was the reaction?	When did this happen?

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APPOINTMENT POLICIES AND FINANCIAL RESPONSIBILITY AGREEMENT OFFICE VISIT/ TELEHEALTH APPOINTMENTS

APPOINTMENT POLICIES

Our office hours are Monday through Friday 8:00am until 4:30pm. Clinic hours vary by provider. We make every effort to schedule your appointment at the most convenient time for you. If you cannot keep your appointment, please let us know of your cancellation as soon as possible so that we may offer the slot to another patient.

A $50 fee will be applied to all missed appointments or late cancellation (appointments cancelled within 24 hours of the scheduled time.) To help remind you of your upcoming appointment, we will send out reminders via text or email. If need be, you will have the opportunity to cancel your appointment by replying to any of these reminder messages. Please bring your insurance card and a photo ID to every visit. Please also include proof of a physical address (i.e. no P.O. box addresses allowed.)

INSURANCE – ALL PATIENTS

We must collect all fees and co-payments that your insurance may require at the time of your visit, including a pre-payment toward any unmet deductible - this is a contractual obligation we have with the insurance companies and these fees cannot be waived. Please make every effort to make sure we are in-network with your specific insurance plan. If your insurer required a pre-authorization for you to see one of our provides, then you are responsible for obtaining that referral or authorization from your primary care physician. We will assist as able, but if an authorization is required and not obtained, then you will be responsible for the full payment of the visit and any associated service fees. We are a third party with your insurance company. Please understand that the Explanation of Benefits that we receive from your insurer is how we apply any payment or deductible to your account. We are not responsible for any discrepancies with your insurance company. We will help provide any necessary medical records (from our physicians) if you need to file an appeal with your insurer.
_____ (Initial)

NON-INSURED PATIENTS & NON-CONTRACTED PATIENTS

This applies to patients who do not have insurance or that have insurance coverage with a plan with which we do not participate (out-of-network). Apex Physicians have made the patient aware that their services will NOT be covered by insurance and the patient agrees to be a self-pay patient. You must make full payment for all services rendered at the time of your visit.
_____ (Initial)

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE MY INSURANCE COMPANY, INCLUDING MEDICARE IF I AM A MEDICARE BENEFICIARY, TO MAKE PAYMENTS TO APEX PHYSICIANS FOR MEDICAL OR SURGICAL SERVICES OR ITEMS RENDERED TO ME OR MY DEPENDENT(S) BY APEX PHYSICIANS. SHOULD MY INSURANCE CARRIER DENY APEX PHYSICIANS PAYMENT, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I AUTHORIZE APEX PHYSICIANS TO RELEASE ANY AND ALL OF MY RECORDS TO MY INSURER, OR ANY OTHER THIRD-PARTY PAYER, LEGALLY RESPONSIBLE FOR THE PAYMENT OF MEDICAL EXPENSES. I CERTIFY THAT THE INFORMATION PROVIDED OR TO BE PROVIDED BY ME IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IT IS MY RESPONSIBILITY TO UPDATE ANY AND ALL PERSONAL, INSURANCE AND HEALTH INFORMATION.

_____ (Initial)

Delinquencies and other fees after 120 days: any delinquent debts will be referred to an outside collections' agency, at which time they will assume full responsibility for your account. If it looks like you will be unable to fulfill your debt within 120 days, please contact our office immediately so that we can help set up a payment plan or make other arrangements. Returned check are subject to a $35.00 insufficient funds charge. This fee is assessed to us by our bank which we then forward on to you.

I UNDERSTAND THAT APEX PHYSICIANS IS NOT RESPONSIBLE AND WILL NOT COMPLETE ANY SHORT-TERM DISABILITY OR FMLA FORMS/PAPERWORK. THIS IS THE RESPONSIBILITY OF THE PATIENT AND/OR THEIR PCP

_____ (Initial)

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, PAID OR UNPAID BY INSURANCE.

By signing below, I indicate that I have read and understood the Appointment Policies and Financial Agreement described above.

_____ _____

Signature of Patient or Legal Surrogate Date Time

_____ _____

Printed Name of Patient or Legal Surrogate Relationship (if Legal Surrogate)

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Authorization for Release of Protected Health Information

<u>*From our specialists to your providers***</u>**

Patient Name: _____ DOB: _____

Address: _____ SS# _____

_____

Phone # _____

To (for staff ONLY): Dr. _____

_____

_____

Phone: _____

Fax:_____

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

I _____ do I _____ do NOT authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be redisclosed by the recipient and may no longer be protected information.

This authorization will expire on _____ (date) or one year from date signed.

_____ Date: _____

Patient or Personal Representative's Signature