Patient information

Patient intake and medical information
Please print clearly. Bring your completed packet to your appointment.

Patient name: _____

Today's date: _____

Date of birth: _____

Gender: □ M □ F

SSN (required): _____

Marital status: □ Divorced □ Married □ Separated □ Single □ Widowed

Address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____

Cell phone: _____

Work phone: _____

Email address: _____

Emergency contact

Name: _____

Relationship: _____ Phone: _____

Language, race and ethnicity

Primary language spoken in your household:

_____

Race: □ American Indian or Alaska Native □ Asian
□ Native Hawaiian □ Black or African American □ White
□ Hispanic □ Other Race □ Other Pacific Islander
□ Refused to Report

Ethnicity: □ Hispanic or Latin □ Not Hispanic or Latin □ Refused to Report

3769 Crossings Dr., Suite B · Prescott, AZ 86305
Phone 928.888.9750 · Fax 928.888.9790

Advance directives & billing details

Patient name: _____ Date of birth: _____

Advance directives

Do you have advance directives in place? □ Yes □ No

Please bring copies of advance directives to your appointment for your chart.

Medical Power of Attorney? □ Yes □ No

Name of person(s) listed:

_____

Do not Resuscitate? □ Yes □ No

Do you have a Living Will? □ Yes □ No

Financially responsible individual

Complete this section if different from the patient.

Name of insured: _____

Relationship to patient:

_____

SSN: _____

Date of birth: _____

Gender: □ M □ F

Home phone: _____

Work phone: _____

Address: _____

Insurance information

Patient name: _____ Date of birth: _____

Primary insurance

Insurance company: _____

Group #: _____ SSN: _____

Name of the insured: _____

Policy ID: _____ Date of birth: _____

Address of the insured:

_____

Secondary insurance

Insurance company: _____

Group #: _____ SSN: _____

Name of the insured: _____

Policy ID: _____ Date of birth: _____

Address of the insured:

_____

Please note that if you have a secondary insurance and it is not identified, the patient will be financially responsible for any claims not paid.

3769 Crossings Dr., Suite B · Prescott, AZ 86305
Phone 928.888.9750 · Fax 928.888.9790

Pharmacy & medications

Patient name: _____ Date of birth: _____

Pharmacy

Name and location: _____

Phone: _____

Current medications and/or supplements

Medication / supplement and strength	Frequency

If you need more space, attach another sheet with your name and date of birth.

3769 Crossings Dr., Suite B · Prescott, AZ 86305
Phone 928.888.9750 · Fax 928.888.9790

Allergies & surgical history

Patient name: _____ Date of birth: _____

Allergies / intolerance (medication or supplements)

Agent / substance	Reaction

Surgical history

Date	Surgery

3769 Crossings Dr., Suite B · Prescott, AZ 86305
Phone 928.888.9750 · Fax 928.888.9790

Medical history

Patient name: _____ Date of birth: _____

Have you ever had, or do you currently have, any of the following medical problems? (Please Check)

- □ Abnormal Pap Smear
- □ Immune Disorders - type: _____
- □ Environmental Allergies
- □ Arthritis - type: _____
- □ Irritable Bowel Disorder
- □ Hearing loss
- □ Bulging Disc
- □ Migraines
- □ High Cholesterol
- □ Chronic Fatigue Syndrome
- □ Seizure Disorder
- □ High Blood Sugar
- □ Diabetes - type: _____
- □ Urinary Tract Disorders - specify: ____
- □ Hypothyroid
- □ Vascular Disease
- □ Other: _____
- □ Emphysema / COPD
- □ Anxiety
- □ Irregular Heart Beat
- □ Fibromyalgia
- □ Asthma
- □ Kidney Disease
- □ Heart Disease - type: _____
- □ Cancer - type: _____
- □ Prostate Disorder
- □ High Blood Pressure
- □ Depression
- □ Stroke / CVA
- □ Hyperthyroid
- □ Eczema
- □ Uterine or GYN Problems - specify: ___
- □ Abnormal Mammogram

Additional details

3769 Crossings Dr., Suite B · Prescott, AZ 86305
Phone 928.888.9750 · Fax 928.888.9790

Hospitalizations & family history

Patient name: _____ Date of birth: _____

Hospitalizations

Date	Reason

Family history

For each condition, check Yes or No and list the affected relative(s).

Relatives: mother, father, sibling, children, paternal grandmother, paternal grandfather, maternal grandmother, maternal grandfather, or other family member.

Type of disease	Yes or No	Relationship
Diabetes	□ Yes □ No	
High Blood Pressure	□ Yes □ No	
High Cholesterol	□ Yes □ No	
Heart Disease Type: _____	□ Yes □ No	
Cancer Type: _____	□ Yes □ No	
Chronic Mental Illness Type: _____	□ Yes □ No	
Other Type: _____	□ Yes □ No	

3769 Crossings Dr., Suite B · Prescott, AZ 86305
Phone 928.888.9750 · Fax 928.888.9790

Social history

Patient name: _____ Date of birth: _____

Tobacco

Do you currently use tobacco? □ Yes □ No

If yes, complete the amounts below. If no, skip to past tobacco use.

Cigarettes per day: _____ Packs per day: _____

Chewing tobacco per day:

_____

Did you use tobacco in the past? □ Yes □ No

If yes, when did you quit?

_____

Drugs

Do you use any illicit drugs? □ Yes □ No

If yes, complete the details below. If no, skip to Alcohol.

Which drug(s)? □ Marijuana □ Cocaine □ Meth. □ Heroin

Other: _____

How much per week: _____

Alcohol

Do you drink alcohol? □ Yes □ No

If yes, how often (day / month / week):

_____

How many drinks do you have at one sitting?

_____

In the last year, have you had more than 6 alcoholic drinks in one sitting? □ Yes □ No

If so, how many times in a month does this occur?

_____

3769 Crossings Dr., Suite B · Prescott, AZ 86305
Phone 928.888.9750 · Fax 928.888.9790

Lifestyle & household

Patient name: _____ Date of birth: _____

Caffeine

Do you drink caffeine? □ Yes □ No

If yes, how many cups / ounces per day:

_____

Cups per day: □ None □ 1-2 □ 2-3 □ 3-4 □ More than 4

Diet

How would you describe your diet?

_____

Does your diet contain prepackaged or processed foods? □ Yes □ No

If yes, how often? _____

Is it 2000 or less calories per day? □ Yes □ No

Average grams of sugar per day in your diet:

_____

Carbohydrates per day:

_____

Exercise & hobbies

Do you currently exercise? □ Yes □ No

If yes, how many days per week?

_____

Hobbies: _____

Household

Marital status is recorded on the Patient information page.

Number of children: _____

GYN & pregnancy history

Complete these sections if they apply to you.

Patient name: _____ Date of birth: _____

GYN history

Symptoms / question	Notes / dates
Periods	□ Regular □ Irregular
Sexual activity	□ Yes □ No
Last mammogram	Date:
Last Pap smear	Date:
Abnormal Pap smear	□ Yes □ No
Date of last period	Date:
Menopause began at age	Age:

O/B history

Symptoms / question	Notes / counts
Gravida (number of pregnancies)	
Para (number of viable births)	
Stillbirth(s)	
Miscarriage(s)	
Abortion(s)	
C-section(s)	

3769 Crossings Dr., Suite B · Prescott, AZ 86305
Phone 928.888.9750 · Fax 928.888.9790

Immunizations & preventive care

Patient name: _____ Date of birth: _____

Immunizations

Vaccines	Yes or No	Date / who administered
Tetanus / Tdap	□ Yes □ No	
Pneumococcal	□ Yes □ No	
Influenza	□ Yes □ No	
Shingles (Zostavax)	□ Yes □ No	
Other: _____	□ Yes □ No	

Preventive medicine

Screening test	Yes or No	Date
Vision screen	□ Yes □ No	
Osteoporosis screen	□ Yes □ No	
Colorectal cancer screen	□ Yes □ No	
Last cholesterol lab test	□ Yes □ No	
Last glucose (blood sugar) lab test	□ Yes □ No	
Last hemoglobin A1c lab test	□ Yes □ No	

Release of test information & patient communication

Patient name: _____ Date of birth: _____

I request and give consent to First Choice Medical Center and/or its staff to relay any and all communications regarding my lab results, radiological testing, referral information or any other pertinent information to be handled in the following manner.

Written communication

Address: _____

City: _____ State: _____ ZIP: _____

Communication

Phone number: _____

May we leave a detailed message? □ Yes □ No

Please provide my medical information to individual(s) other than myself or state NONE.

Name: _____ Phone: _____

Name: _____ Phone: _____

Appointment reminders

Please indicate what your preferred contact is for your Appointment Reminders:

□ CALL - Phone: _____ (Home / Cell / Work)

□ TEXT - Phone: _____

□ EMAIL - Email address: _____

Patient portal

Would you like NFM to establish Patient Portal access? □ Yes □ No

Email address: _____

Signature: _____ Date: _____

Patient name: _____

Office & financial policy

Patient name: _____ Date of birth: _____

Thank you for choosing First Choice Medical Center (FCMC) for your healthcare needs. Our Office and Financial Policy is an important part of your healthcare. Please review the following Office and Financial Policy.

1. Office & Phone Hours

Our normal office hours are Monday - Friday from 8:00 a.m. - 5:00. Phones will be answered during this time with the exception to 12:00 p.m. - 1:00 p.m., while the practice is closed for lunch.

2. Appointments

Patient appointments are scheduled Monday - Friday from 8:00 a.m. - 4:00 p.m.

3. On-Time

All attempts are made by our office to keep your scheduled appointments on time, however, unforeseen issues may come up that may cause delays and we apologize, in advance, when this occurs, however, each of our patients are important to us and are given the attention that is needed to address each patient's medical needs.

4. Cancellations/No Shows

FCMC offers Appointment Reminder Calls as a courtesy to our patients. If you arrive more than 15 minutes late for your scheduled appointment, we may ask that you reschedule your appointment. If you No Show an appointment or Cancel and do not notify us at least 24 hours prior to your scheduled appointment, you will be charged $70.00. Any early or extended appointments missed will be charged $130.00.

5. Medications

We do not prescribe any medications over the phone. You must be seen by a provider in order to receive a prescription of any nature. For any medication refills, please contact your pharmacy first, however, if you request a refill and leave a message with one of our MA staff then please allow a minimum 72 hours' notice. For requests after 4:00 p.m. on Fridays, these requests will be addressed the following business day. Please note, our providers do not refill medications after-hours for ANY reason, this includes pain medications. It is your responsibility to keep track of the level of your medications and call our office during normal business hours to request medication refills.

6. After Hours On-Call Services

First Choice Medical does not have after hour's on-call services between the hours of 5:00 p.m. and 8:00 a.m. During this time period, if you require urgent medical services, we recommend that you proceed directly to your nearest Emergency Department or Urgent Care Center. We have conveniently placed the names and phone numbers of some of these facilities on our website.

7. Treatment Of Minors

Patients under the age of 18 must be accompanied by a responsible adult or have written permission, for treatment, from a parent or guardian.

8. Patient Portal

FCMC offers a Patient Portal service for patients to receive non-urgent lab, radiology, and other diagnostic test results, request appointments, medication refill, and referrals, and contact FCMC staff for billing and non-urgent medical questions. This service is not intended to treat or obtain care for urgent or emergency conditions. Patient Portal is offered through FCMC's electronic medical record vendor, e-CW ®. Both, FCMC and e-CW maintains this portal utilizing appropriate technical safeguards and encryption as required by HIPAA. FCMC will not have any access to your portal user ID and password due to HIPAA regulations. It is your responsibility to keep your portal user ID and password secure.

9. Laboratories

FCMC houses a Laboratory in our office for our patient's convenience and we will automatically send lab testing to this lab unless otherwise directed by you before the draw. If your insurance company requires the use of a specific laboratory, you must notify the phlebotomist in order to ensure your blood is sent to the correct lab. If you are unsure, we suggest that you contact your insurance carrier prior to having any labs drawn to ensure your labs are sent to the correct laboratory. Please note that there may be some labs ordered by our providers that are not a covered benefit on your insurance plan as our providers order what they deem as medically necessary and not based on insurance coverage. The lab will bill your insurance company directly for any lab testing done in our office. It is your responsibility to provide your current insurance and billing information to the Phlebotomist. If you receive any bill(s) from the lab for any lab testing done in our office, please contact the lab directly, which is listed on the invoice, and they will contact our office for assistance, if needed, as FCMC does not have access to lab Patient Billing. If you experience any issues related to the service you received from the phlebotomist, please make sure you tell our check-out desk immediately.

10. Insurance Participation

Although FCMC is contracted with most insurance companies, it is your responsibility to make sure that our physician is an in-network provider in your specific plan and knowing your insurance coverage and benefits. The qualifying TIN's that you should verify is 47-3062253. We ask that your contact your insurance company directly if you have any questions regarding your coverage. FCMC is not contracted with any State-funded plans, including Medicaid or AHCCCS.

11. Billing

I request and authorize FCMC to bill my insurance company on my behalf. FCMC agrees to invoice my insurance company in a timely manner and will assist in any way reasonably to help get claim(s) paid by my insurance. I authorize FCMC to release the necessary information in order to complete and process my claim(s). At times, your insurance may request that you supply certain information to them directly. It is your responsibility to comply in a timely manner as well. Please be aware that the balance of your claim(s) is your responsibility, whether or not your insurance company pays your claim(s).

12. Co-Pays, Deductibles, & Payments

I agree to pay my co-pay, coinsurance, and deductible AT TIME OF SERVICE. We collect for the office visit portion ONLY, and will bill your insurance for all services rendered during the appointment. Any additional services (EKG, Urinalysis, etc) provided on the date of service that your insurance determines patient responsibility, will be billed to you after FCMC has received payment by your insurance company for your claim(s). If you are CASH PAY and do not have insurance, payment for ALL services rendered will should be collected AT TIME OF SERVICE.

13. "Non-Covered" Services

I understand that some, and perhaps all, of the services I receive may not be covered by my insurance or deemed "not medically necessary or considered experimental" by my insurance company. I agree to pay for any services that my insurance determines as "non-covered."

14. Updates & Coverage Changes

Our staff may ask you to verify your insurance and billing information at each and every visit and may request a copy of your insurance card each time. Current information is crucial in order for FCMC to obtain timely payment from your insurance information. We ask that you notify us as soon as possible if your medical coverage changes so we can make the appropriate changes. If your insurance company does not pay a claim within 90 days, the full balance will be billed to you.

15. Returned Checks

Any returned checks for Non-Sufficient Funds will be charged a processing fee of $45.00.

Acknowledgments

Patient name: _____ Date of birth: _____

Office & financial policy

I hereby acknowledge that I have reviewed and understand First Choice Medical Center's Office & Financial Policy.

Signature: _____ Date: _____

Patient name: _____

Privacy acknowledgment

I understand how medical information about me may be used and disclosed, and how I can get access to my information as described under the HIPAA Notice. At any time, I can request a copy of the updated HIPAA Notice from FCM and it is also available on our website.

Signature: _____ Date: _____

Patient name: _____