DC RANCH FAMILY MEDICINE & AESTHETICS

PATIENT INFORMATION

Name: _____ Preferred Name: _____
Last First MI

Address: _____ Date of Birth: _____
Street Unit#

_____ Age: _____ Gender: M F TG
City State Zip

Marital Status: S P M D W

Responsible Guardian(s) _____ Relationship _____

Billing Address if different: _____
Street Unit#

_____
City State Zip

Home ( ) _____ Cell ( ) _____ Full Time AZ Resident: ☐Yes ☐No

Emergency Contact: _____ Phone: _____ Relationship: _____

E-mail Address for Patient Portal:

Referring Provider: _____ OR you heard about us by? Web Search/ Insurance/ Friend/ Media

Employer/Occupation: _____ Status: ☐Full Time ☐ Part Time

Students: School Name_____ Status: ☐Full Time ☐Part Time

Primary Insurance: _____ Subscriber ID #: _____Group #_____

Claims Address:_____ Payor ID#_____
Street City State Zip

Policy Owner: _____ Date of Birth _____ Phone _____

Relationship of Patient to Policy Owner: ☐Self ☐Spouse ☐Child

Secondary Insurance: _____ Subscriber ID #: _____Group #_____

Claims Address:_____ Payor ID#_____
Street City State Zip

Policy Owner: _____ Date of Birth _____ Phone _____

Relationship of Patient to Policy Owner: ☐Self ☐Spouse ☐ Child

Primary Pharmacy:_____ Cross Streets:_____Phone: _____

Secondary if applicable:_____ Cross Streets:_____Phone: _____

DC RANCH FAMILY MEDICINE & AESTHETICS

FINANCIAL POLICY

Please initial next to each paragraph to acknowledge that you have read and agree to the terms discussed

_____ I understand it is my responsibility to know my insurance coverage and network. I understand I am responsible to pay for any charges that could be denied or not covered by my policy. Any dispute for unpaid charges will be billed to the member. I understand in the event I'm entitled to health insurance benefits relating to my medical treatment, I hereby assign those benefits to this office and apply to my bill.

_____ I understand filing a claim is time sensitive (90 days) and it's my responsibility to provide the office with updated policy information, including keeping my Coordination of Benefits up do date or claims will be denied and I will be responsible. *The practice doesn't become involved in any disputes between the patient and the insurance company.*

_____ I understand I'm required to pay at the time of visit my portion according to my insurance, including co-pays, deductibles or co-insurance. Account balances, Aesthetic Services, B-12 injections, and Self-Pay visits are to be paid in full at time of service. *Returned checks will result in a fee of $25.*

_____ I understand invoices are due immediately upon receipt. *Three statements will be mailed before being considered delinquent. After 60 Days the delinquent account will be turned over to an outside collection agency of our choice with or without notice. The patient/guarantor agrees to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35% of the delinquent balance, such contingency fee to be added and collected by the collection agency immediately upon our referral of your account to them.*

_____ I understand it is my responsibility to arrive on time for my appointment and I may be asked to reschedule if more than 15 minutes late. If more than 3 appointments are missed without proper notice, you can be dismissed from our practice and/or charged $25 for the missed appointment. *Please notify us 24 business hours in advance to cancel and/or reschedule your appointment.*

_____ I understand the Annual Wellness Physical is a preventative well visit, allowed once a year. This visit code does not cover being seen for a sickness, injury, etc. A separate visit charge will apply if time is spent outside the insurance guidelines of prevention.

_____ I understand my provider may order blood work or diagnostic images from an outside facility. I understand they are separate entities and billing is not associated with DC Ranch Family Medicine, PLLC. Nor does the practice have access to those billing statements.

I have read the Financial Policies and I understand these terms and agree to pay this account in accordance with the rates and payment terms of DC Ranch Family Medicine, PLLC.

_____ _____

Printed Guarantor Name *Patient Name if different*

****Guarantor Signature:** _____ **Date:** _____

DC RANCH FAMILY MEDICINE & AESTHETICS

Acknowledgement Re: Notice of Privacy Practices AND Financial Policy:

I have been offered a copy of the Notice of Privacy Practices. I understand that DC Ranch Family Medicine, PLLC has the right to change its Notice of Privacy Practices and that I may contact DC Ranch Family Medicine, PLLC at any time to obtain a current copy. I have also read, understand, and agree to the provisions of the Financial Policy.

****Patient Signature:** _____ **Date:** _____

Authorization for Release of Health Information:

I hereby authorize the release any medical or incidental information to my referring physician or any other provider(s) who have been or may become involved with my care.

I hereby authorize the release of health information and record(s) of my visit(s) to my insurance company If needed in the processing of any insurance claim and/or other third parties responsible for payment of my medical charges.

I hereby authorize DC Ranch Family Medicine, PLLC and its Employees permission to discuss, send and/or receive my personal health information to/with the following individual(s):

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

I understand it is my responsibility to update any changes with the office about the above individuals

****Patient Signature:** _____ **Date:** _____

Please initial next to each paragraph to acknowledge that you have read and understand the following Office Policies:

_____ I understand medication refills are handled during normal business hours and not prescribed or refilled after hours**.**

_____ I understand the practice does not treat pain management or ADD and will refer me to another provider.

_____ I understand verbal abuse towards the office staff or providers will not be tolerated and I will be dismissed from the practice.

_____ I understand if I have a medical need after hours and can't wait until the next business day to immediately contact the E.R. or Urgent Care of my choice for immediate medical attention.

****Patient Signature:** _____ **Date:** _____

****Printed Signature Name:** _____

DC RANCH FAMILY MEDICINE & AESTHETICS

Arneyo Perez, M.D.

20945 N. Pima Road, Suite 110, Scottsdale, AZ 85255
Phone 480.800.3550 Fax 480.800.3551

Authorization for Request of Medical Information

_____

TO: Provider/Facility

_____

Street City State Zip

Phone #: _____ Fax #:_____

I, _____, hereby request that you release the indicated medical records to DC Ranch Family Medicine, PLLC. The office of Dr. Arneyo Perez.

INFORMATION TO BE RELEASED: ***Do not send CD's larger than 3 MB**

☐Complete Records ☐Other: _____

_____ _____

Patient Name *(please print)* Date of Birth

_____

Street City State Zip

Patient/Guardian Signature_____ **Date**_____

DC RANCH FAMILY MEDICINE & AESTHETICS

MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

DOB: _____ Height: _____ Weight: _____ Hispanic or Latino Ethnicity? ☐Yes ☐No

Date of **Last Annual Physical**: _____

Do you have an **advance directive**? (Legal document specifying actions to be taken if you are no longer able to make those decisions due to illness or incapacity) ☐Yes ☐No

Drug Allergies: ☐Yes ☐No Drug: _____ Reaction: _____
Drug: _____ Reaction: _____

Daily Medications: (include pain, herbal, vitamins, supplements & any over the counter medication)

Name Dosage/Strength Times/day Month and Year Start Date

_____

_____

_____

_____

_____

Have you had a **colonoscopy** or alternative test? ☐Yes ☐No Year _____ Results _____ Provider_____

Do you have **Diabetes**? ☐Yes ☐No Last A1C #_____ Monitoring Provider _____

Date of last **eye exam** _____ from the office of _____

Do you **use tobacco**? ☐Yes ☐No ☐Quit Date _____ Use **e –cigarettes**? ☐Yes ☐No ☐Quit Date _____

If Yes, how many per day? _____ How many years? _____ Interested in **Quitting**: ☐Yes ☐No

Do you **exercise**? ☐Yes ☐No How Often? _____ What type? _____

Do you drink **alcohol**? ☐Yes ☐No If yes, average consumption is _____ drinks per ☐day ☐week ☐month

Do you experience **sadness** or have been **depressed** the past year? ☐Yes ☐No

Are you currently on any **hormonal** therapy? ☐Yes ☐No What type? _____

Are you **currently** sexually active? ☐Yes ☐No Birth Control Method _____

Do you have **children**? ☐Yes ☐No If yes, gender & age(s)_____

Do you have urinary **urgency**? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Have you received the following **immunizations**?

Influenza	**☐Yes**	**☐No**	**Date: _____**	Pneumonia	☐Yes	☐No	Date: _____
Tetanus	☐Yes	☐No	Date: _____	Shingles	☐Yes	☐No	Date: _____
HPV	☐Yes	☐No	Date: _____	Meningitis	☐Yes	☐No	Date: _____
MMR	☐Yes	☐No	Date: _____	Chicken Pox	☐Yes	☐No	Date: _____
Hepatitis A/B	☐Yes	☐No	Date: _____	DTaP/Tdap	☐Yes	☐No	Date: _____

Surgical History including Cosmetic: (Type and date)

_____ _____

_____ _____

_____ _____

Please specify your current and past medical conditions:

☐ ADHD/ADD ☐ AIDS/HIV ☐ Anemia ☐ Arthritis ☐ Autoimmune Disorder

☐ Asthma ☐ Bladder Issues ☐ Blood Clots ☐ Cancer of _____year_____

☐ Depression ☐ Diabetes ☐ Eating Disorder ☐ Fibromyalgia ☐ Gastro conditions

☐ Gout ☐ Heart Disease ☐ Hepatitis _____ ☐ High Cholesterol ☐ High Blood Pressure

☐ Hypertension ☐ Kidney Trouble ☐ Neurological ☐ Seizures ☐ Stroke

☐ Substance Abuse of _____ ☐ STD(s) _____ ☐ Thyroid Disorder ☐ Ulcers

☐ Stomach issues _____ ☐ Other _____

Family medical conditions; *example* - Diabetes, Hypertension, Heart Disease, Stroke, Mental Illness, Cancer

OF Father: _____ ☐ Alive ☐ Deceased

OF Mother: _____ ☐ Alive ☐ Deceased

OF Sibling: ☐ M ☐ F _____ ☐ Alive ☐ Deceased

OF Sibling: ☐ M ☐ F _____ ☐ Alive ☐ Deceased

OF Children: ☐ M ☐ F _____ ☐ Alive ☐ Deceased

OF Children: ☐ M ☐ F _____ ☐ Alive ☐ Deceased

Genetic Cancer Preliminary Screening:

Have you or a relative **aged 50 and under** been diagnosed with breast or ovarian cancer? ☐Yes ☐No

Has a family member been known to have the BRCA mutation? ☐Yes ☐No ☐Unknown

Have you or a relative **aged 50 and under** been diagnosed with colon or uterine cancer? ☐Yes ☐No

Has a family member been known to have Lynch Syndrome Mutation? ☐Yes ☐No ☐Unknown

FEMALES

When was your last Mammogram? Date _____ Imaging Facility _____ Results_____

What was the first day of your last period? Date _____ or _____ > 1 year

Are you pregnant and/or nursing? ☐Yes ☐No

Do you leak urine when you cough, sneeze, and/or laugh? ☐ Always ☐Sometimes ☐Never

Have you had vaginal rejuvenation treatments? ☐Yes ☐No What type? _____ How many? _____

Do you have a history of recurrent vaginal bacterial or yeast infections? ☐Yes ☐No How often? _____

Do you have a history of recurrent urinary tract infections? ☐Yes ☐No How often? _____

The last time you had sexual intercourse did you experience vaginal dryness, internal/external pain? ☐Yes ☐No