Southwestern Pediatrics & Family Care

Last Name: ____________________First Name: ___________________Date of Birth: __________

Gender: Male / Female / Other: _________ Marital Status: Single/Married/Divorced/Widowed

Social Security #: _______________

Race: _______________ Ethnicity: _______________ Pharmacy: _________________________

Address: ____________________________ City: ______________ State: _____ Zip: __________

Mailing Address: ______________________ City: _______________ State: ______ Zip: ________

Home Phone#: ________________ Work Phone#: ______________ Cell #: _________________

***Please provide us with your email address*:** ____

Name of Employer: ___________________ Occupation: _______________ Phone#: __________

Spouse's Name: ____________________ Date of Birth: _________ Social Sec. # ______________

Spouse's Employer: _____________________ Phone#: __________________ Ext.: ___________

Emergency Contact_________________________ Phone#: _______________________________

INSURANCE INFORMATION

Insurance Company: ________________________________ Effective Date: _________________

Member ID: ______________________________ Group: _________________________________

Policy Holder: ____________________________ Policy Holder's Date of Birth: _______________

Do you have secondary Insurance? Yes No

Insurance Company: ________________________________ Effective Date: _________________

Member ID: ______________________________ Group: _________________________________

Policy Holder: ____________________________ Policy Holder's Date of Birth: _______________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also give my permission for Southwestern Pediatrics & Family Care to download and maintain my electronic prescription history for my medical treatment.

Signature: _____________________________________ Date: ______________________________

Southwestern Pediatrics & Family Care

PERSONAL HISTORY

Current meds OTC & Supplements	*DOSE/STRENGHT*	*TIMES PER DAY*
1.		
2.		
3.		
4.		

ALLERGIES (MEDICINE/FOOD)

Allergic to	*Reaction*

PREVIOUS CONDIONTIONS/ DIAGNOSES

	YES	*NO*		*YES*	*NO*	*OTHER CONDITIONS*	*DATE*
ANEMIA			*HAY FEVER*			*APPENDICITIS*	
ASTHMA			*LIVER TROUBLE*			*GALLBLADDER*	
CANCER OR TUMOR			*HEADACHES*			*HERNIA*	
EPILEPSY, SEIZURES			*LOW BLOOD PRESSURE*			*HYSTERECTOMY*	
DEPRESSION			*HIGH BLOOD PRESSURE*			*TONSILS*	
DIABETES			*HERNIA*			*HEART PROBLEM LIST*	
FEMALE DISORDERS			*HEMORRHOIDS*				
HEPATITIS, JAUNDICE			*KIDNEY PROBLEMS*				
MALARIA			*NERVOUS BREAKDOWN*				
PROSTATE PROBLEM			*ARTHRITIS*				
SKIN RASH			*STOMACH TROUBLE, ULCER*				
THYROID			*TUBERCULOSIS*				
VARICOSE VEINS			*SEXUALLY TRANSMTD. DISEASE*				

PREVIOUS SURGERIES / HOSPITALIZATIONS:

PAST SURGERY OR HOSPITALIZATION	*DATE*

TODAYS DATE: ________ NAME: ___________________________ M/ F DATE OF BIRTH: _________________

Southwestern Pediatrics & Family Care

FAMILY HISTORY (Check All That Apply)

	Alcohol Abuse	Breast Cancer	Ovarian Cancer	Prostate Cancer	Diabetes	Heart Disease	High Cholesterol	Hyper-tension	Mental Illness
Mother									
Father									
Sister									
Brother									
Daughter									
Son									
Other Relative									

HABITS:

Do you use tobacco? ☐ No ☐ Yes, what form? __________ How much? ______ For how long? _______

☐ In the past How many years ago did you quit? ______________________

Have you tried to quit? ☐ No ☐ Yes Would you like to quit? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ In the past ☐ Yes, how many drinks per week? ____________________

Do you, or have you used recreational drugs? ☐ No ☐ Yes, describe: ____________________________

Do you get regular exercise? ☐ No ☐ Yes, what kind of exercise? _______________________________

How often? _____________

Do you have smoke detectors? ☐ No ☐ Yes

Pets in Home? ☐ No ☐ Yes Kind of Pets? ___________________________

Past Health Last Dates of:

No. Of Pregnancies: ______ LMP: _________ PAP: _________ No. Of Births: ________

Birth Control? ☐ No ☐ Yes Breast Exam: ______________ No. Of Abortions / Miscarriages: _______

STD hx? ☐ No ☐ Yes Last Mammo: ________________ Last Bone Density Test: _________________

Last EKG: ___________________ Last Prostate Exam: ____________________

Last Colonoscopy: ___________________ Last Stool test: __________________

PCV Vaccine: ______________________ Shingles Vaccine: ________________ Flu Vaccine: __________

COVID Vaccine: Date 1st __________ 2nd __________ Booster ______________

Have you ever been diagnosed with COVID? ________ Date_________

TODAYS DATE: _______ NAME: _________________________ M/ F DATE OF BIRTH: ________________

Southwestern Pediatrics & Family Care

Medical Records Release

Patient Name ______________________________________ Date of Birth _________________

Phone Number _____________________________ Work Number _______________________

Address ____

I authorize the release of photocopies of the following medical records and/or x-ray films/reports to the possession or control of Southwestern Pediatrics & Family Care, its employees and/or agents of the purpose here of "Medical record" and "X-ray films" shall include ALL confidential "HIV related" information as defined in A.R.S. section 36-661, confidential "Alcohol or Drug Abuse" related information as defined in 42-CFR section 21 ET SEQ, confidential communicable disease information as defined in A.R.S section 36-3661 and confidential mental diagnosis and treatment information.

MEDICAL RECORDS TO INCLUDE:

ACCUTE ILLNESS SUMMARY
IMMUNIZATION RECORDS
GRAPHIC GROWTH CHART
WELL VISIT EVALUATION SHEET/FORMS
HOSPITAL DISCHARGE SUMMARIES (if applicable)

This consent will expire 120 days after the signed date below. I have given my consent freely, voluntarily, and without coercion. I may revoke this authorization at any time, providing that I notify Southwestern Pediatrics & Family Care in writing to that effect. I understand that any release which was made prior to my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

I hereby authorize:

Dr. / Facility: _____________________________________ *Phone:* ________________________

Fax: ______________________ *Address:* ____

City: __________________________ *State:* ____________ *Zip Code:* ________________________

Please send/release photocopies of medical records to:

SOUTHWESTERN PEDIATRICS & FAMILY CARE
21300 N. John Wayne Pkwy #112
Maricopa, AZ 85139
Ph: 520-568-9500 Fax: 520-568-9533

Signature: ____ Date: _________________________

Southwestern Pediatrics & Family Care

INSURANCE / FINANCIAL POLICY PATIENT AGREEMENT

As a courtesy to our patients, we will file insurance claims for those insurances with which we participate. The agreement of the insurance carrier to pay for medical care is a contract between you and your insurance company. Any amount not covered by your insurance company is your financial responsibility. This includes co-payment, coinsurance, and deductibles. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. It is your responsibility to notify our office when either your insurance plan or benefits change. All insurance contracts require us to collect deductibles, coinsurance and co-pay amounts at the time of service.

*** IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS***

PAYMENT

Payment will be requested at the time of service for all services which are non-covered or determined to be patient's responsibility, including co-payments, co-insurance, and deductibles. (This is the policy of your insurance company)

We will kindly reschedule your appointment if you are unable to provide payment of co-pays, co-insurance, and deductibles.

Payment for past due balances for previous services rendered is also expected when you are seen in this office. We will be happy to set up a payment plan for you.
Delinquent accounts over 60 days will be sent to collections for processing. At which point all collection fees, contingent or not, shall be added to the patient's responsibility. In the event legal action is required, the patient shall be responsible attorney's fees and cost. Please remember we will be happy to set up a payment plan for you.

APPOINTMENT POLICY

Southwestern Pediatrics & Family Care strives to provide the best possible care and provide availability to each of our patients. Our policy is to charge $30.00 for each missed appointment unless it is cancelled at least ***24 hours in advance,*** *and/or for established patients that have* ***three "no-show"*** *appointments, that patient and any person who is either a guarantor for, or guarantee of, the account in question may be* ***discharged*** *from the practice and asked to seek healthcare with another physician. Patients seeking to establish care with us who fail to cancel or reschedule their initial appointment at least 24 hours prior to the scheduled appointment are also considered to be "no-shows". The second instance of failing to keep their initial appointment as scheduled will result in denial of entry to the practice.*

I hereby authorize Southwestern Pediatrics & Family Care to release information required by my insurance company for payment of my medical bills or to review activities related to my healthcare provider's participation in my health plan. I assign Southwestern Pediatrics & Family Care all benefits to which is entitled for medical services rendered.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND I AGREE TO ABIDE BY ITS TERMS.

PRINTED NAME: ___________________________________ DATE: _________________________________

SIGNATURE: _______________________________________ WITNESS: ______________________________

Southwestern Pediatrics & Family Care

21300 N. John Wayne Pkwy #112
Maricopa, AZ 85139
Phone: (520) 568-9500 Fax: (520) 568-9533

Authorization for Release of Medical Information

Patient's Name: ____ Date of Birth: ___________________

Address: ____

City/State/Zip Code: ____

Patient's Phone #: ____

Parent/Guardian Name: ____

I hereby authorize Southwestern Pediatrics & Family Care to release photocopies of my Medical Records concerning the above-named patient to:

____

____

____

I authorize the release of photocopies of the following medical records and/or x-ray films in the possession of control of Southwestern Pediatrics & Family Care its employees, and/or agents. If further information is required, we will be happy to provide to you the records at a nominal charge of $10 base fee and .25 cents for each page. When we are required to produce the chart for a second time, a $10 retrieval fee is required in addition to the above requirements. If you have personal records that you wish us to put in your chart, please make sure to retain a copy for your records. This consent will expire 120 days after the signed date below. I have given my consent freely, voluntarily, and without coercion. I may revoke this authorization at any time, providing that I notify Southwestern Pediatrics & Family Care in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that photocopy of this authorization is considered acceptable in lieu of the original.

<u>I understand that Southwestern Pediatrics & Family Care DOES NOT release copies of records received from other than Health Care Providers.</u>

Signature: ____ Date: ________________________

Southwestern Pediatrics & Family Care
Privacy Practices Acknowledgement

I have received the NOTICE OF PRIVACY PRACTICES and I have been provided the opportunity to review it.

Patient Name: ____ Date: _________________

Signature: ____ Date: _________________

Active AHCCCS Members Only

If you are a member of any AHCCCS plan, you must notify us of all insurance coverage you may carry. We realize that insurance coverage can change frequently. This policy is intended to ensure that we provide the most accurate billing information to your insurance plan(s).

I certify that as of the date of my signature below I do NOT have insurance coverage of any kind other than AHCCCS.

Patient Name: ____ Date of Birth: _______________

____ ______________________

Signature of AHCCCS Plan Member (Guardian) Date