Digestive Institute of Arizona
3011 S. Lindsay Rd. Suite·115
Gilbert , AZ 85295
602·541·1575 ~ Fax: 602·926·1418

Patient Registration Information

Patient's Personal Information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Asian ☐ Native American ☐ Mexican-American ☐ Alaskan Native ☐ Pacific Islander

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Decline to answer

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Patient's / Responsible Party Information

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Patient's Insurance Information

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

Patient's Referral Information

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Pharmacy Information

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Emergency Contact

Is this person legally allowed to make medical decisions on your behalf? ☐ Yes ☐ No

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Assignment of Benefits • Financial Agreement

I hearby give authorization for payment of insurance benefits to be made directly to Digestive Institute of Arizona, forservices rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of defaultI agree to pay all costs of collections and reasonable attorney's fees. I hearby authorize this healthcare provider to reaease all informationnecessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

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Y N

Constitutional:
- ☐ ☐ Chills
- ☐ ☐ Excessive sweating
- ☐ ☐ Fever
- ☐ ☐ Insomnia
- ☐ ☐ Night sweats
- ☐ ☐ Weight gain
- ☐ ☐ Weight loss

Eyes:
- ☐ ☐ Blindness
- ☐ ☐ Cataract
- ☐ ☐ Eye discharge
- ☐ ☐ Eye pain
- ☐ ☐ Glaucoma
- ☐ ☐ Sensitivity to light
- ☐ ☐ Vision change

Cardiovascular:
- ☐ ☐ Irregular heartbeat
- ☐ ☐ Chest pain/pressure
- ☐ ☐ Leg cramping when walking
- ☐ ☐ Swelling (hands, feet, etc.)
- ☐ ☐ High blood pressure
- ☐ ☐ Dizziness
- ☐ ☐ Difficulty breathing when lying down
- ☐ ☐ Forceful heartbeat
- ☐ ☐ Severe shortness of breath when sleeping
- ☐ ☐ Fainting

Respiratory:
- ☐ ☐ Asthma
- ☐ ☐ Chest tightness
- ☐ ☐ Cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Coughing up blood
- ☐ ☐ Pain when breathing
- ☐ ☐ Exposure to TB
- ☐ ☐ Wheezing

Y N

Genitourinary:
- ☐ ☐ Painful urination
- ☐ ☐ Genital lesions
- ☐ ☐ Bloody urine
- ☐ ☐ Impotence
- ☐ ☐ Bed wetting
- ☐ ☐ Frequent urination
- ☐ ☐ Urinary incontinence
- ☐ ☐ Urinary retention/hesitancy
- ☐ ☐ Acute renal failure
- ☐ ☐ Chronic renal failure

Musculoskeletal:
- ☐ ☐ Joint pain
- ☐ ☐ Back pain
- ☐ ☐ Muscle weakness
- ☐ ☐ Muscle pain
- ☐ ☐ Neck pain
- ☐ ☐ Osteoporosis
- ☐ ☐ Low back pain
- ☐ ☐ Shoulder pain
- ☐ ☐ Stiffness

Dermatological:
- ☐ ☐ Acne
- ☐ ☐ Eczema
- ☐ ☐ Mole change
- ☐ ☐ Rash
- ☐ ☐ Skin cancer
- ☐ ☐ Skin lesions
- ☐ ☐ Sores

Neurological:
- ☐ ☐ Difficulty speaking
- ☐ ☐ Loss of coordination
- ☐ ☐ Tremor
- ☐ ☐ Gait abnormality
- ☐ ☐ Headache
- ☐ ☐ Memory loss
- ☐ ☐ Generalized pain
- ☐ ☐ Numbness/tingling

Y N

Neurological (Cont.):
- ☐ ☐ Seizure
- ☐ ☐ Spasms
- ☐ ☐ Fainting
- ☐ ☐ Vertigo
- ☐ ☐ Weakness

Psychiatric:
- ☐ ☐ Alcohol abuse
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Dementia
- ☐ ☐ Difficulty concentrating
- ☐ ☐ Drug abuse
- ☐ ☐ Eating disorder
- ☐ ☐ Hallucinations
- ☐ ☐ Mania
- ☐ ☐ Suicidal thoughts

Endocrine:
- ☐ ☐ Diabetes type I
- ☐ ☐ Diabetes type II
- ☐ ☐ Enlarging hands/feet
- ☐ ☐ Unexpected lactation
- ☐ ☐ Obesity

Hematologic:
- ☐ ☐ Abnormal bleeding/bruising
- ☐ ☐ Anemia
- ☐ ☐ Swollen lymph nodes
- ☐ ☐ Prolonged bleeding time

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Medical History:

Surgical History: (List any major operations and approximate dates):

Drug Allergies: (Penicillin, Iodine, Tape, Latex, etc.):

Medications: (List names or types of medications you are currently taking):

Marital Status: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced ☐ Separated

Number of Children or Dependents living in your home: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Do you Smoke and or use Tobacco: ☐ No ☐ Yes
If yes, how often? _____ How many years? _____

Do you drink Alcoholic Beverages: ☐ No ☐ Yes
If yes, what type? _____ How often? _____ How many years? _____

Family History: (List illnesses that run or have occurred in your family - example: Cancer, Diabetes, etc.):

Review of Systems: (Are you presently having problems with any other systems in your body?):

Is there any other information which you would like the doctor to know or be aware of?

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A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Email: _____

***Minors or Users Requriing Caregivers - Acknowledgement of Consent to Contact:**

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Email: _____

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AUTHORIZATIONS AND CONSENT

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one- time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a “no show” and may be subject to a “no show” charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

_____

Patient or Parent/Guardian if Minor Date of Birth Date

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PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care of financial matters. This is to acknowledge that you authorize Digestive Institute of Arizona to disclose you PHI to the following individuals (Check all that apply):

_____ _____
Name Relationship to Patient

_____ _____
Telephone Email

_____
Date

Types of information: ☐ Appointment Reminders ☐ results (Lab test, x-Ray, etc.) ☐ Financial ☐ Other

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Email ☐ Text ☐ Other

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies 1. How medical information about you may be used or disclosed. 2. Your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information and request additional restrictions on our uses and disclosures of that information. 3. Your rights to complain if you believe your privacy rights have been violated. 4. Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing and may review/receive a copy of the Notice of Privacy Practices and is the patient or the patients representative.

_____ _____
Name of Patient Signature

_____ _____
Name of Representative Signature of Representative

_____
Date