

Patient Registration Information

Patient's Personal Information	Marital Status: Single Married Dive	orced Widowed Sex: N	fale
Ethnicity: Hispanic Not Hispanic D	ative American	Native Pacific Islander	
Name: last name		first name	initial
Date of Birth: / /	Social Security #:	-	
Home Phone: ()		Cell Phone: () _	
Address:	Apt. #: City:	State:	Zip:
Patient's / Responsible Party Info	ormation Relationship to Patient:	elf Spouse Child Oth	er:
Name:			
lest name		first name	initial
Date of Birth: / /			
	Work 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:		- OHIO HILLIAN AND AND AND AND AND AND AND AND AND A	
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? No			
Name:	R	elationship:	
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 defaultl 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:	Vour Signature	
Date.	Your Signature:	

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



Constitutional: Chills	Y N	W A1	
Chills		Y N	Y N
Excessive sweating Genital lesions Spasms Fever Bloody urine Fainting Weight gain Frequent urination Weight loss Urinary incontinence Anxiety Alcohol abuse Acute renal failure Depression Dementia Depression Dementia Depression Dementia Depression Dementia Depression Dementia Depression Dementia Difficulty concentrating Drug abuse Glaucoma Back pain Drug abuse			, , , , , , , , , , , , , , , , , , ,
Fever	lament lament		hammend to the state of the sta
Insomnia	harvesteri fermanand		Annual Business P
Night sweats			power property and the second
Weight gain			
Weight loss Urinary incontinence Urinary retention/hesitancy Eyes: Blindness Cataract Eye discharge Eye pain Glaucoma Sensitivity to light Wision change Waculoskeletal: Difficulty concentrating Exercise pain Sensitivity to light Wiscle pain Cardiovascular: Cardiovascular: Chest pain/pressure Chest pain/pressure Chest pain/pressure Difficulty concentrating Drug abuse Eating disorder Hallucinations Wania Suicidal thoughts Endocrine: Chest pain/pressure Chest pain/pressure Chest pain/pressure Chest pain/pressure Diziness Diziness Diziness Difficulty concentrating Difficulty concentrating Drug abuse Eating disorder Hallucinations Wania Suicidal thoughts Endocrine: Chest pain/pressure Diabetes type I Diabetes	parameter programmy		Weakness
Eyes: Urinary retention/hesitancy	WATERWAY AND		
Blindness Chronic renal failure Depression Dementia Dementia Dementia Dementia Dementia Difficulty concentrating Dementia Difficulty concentrating Dorug abuse Dor	Weight loss	Windowski Windowski	
Blindness Cataract Eye discharge Musculoskeletal: Difficulty concentrating Eye pain Glaucoma Back pain Sensitivity to light Muscle weakness Muscle pain Neck pain Neck pain Suicidal thoughts Cardiovascular: Drug abuse Eating disorder Hallucinations Mania Suicidal thoughts Cardiovascular: Drug abuse Eating disorder Hallucinations Mania Suicidal thoughts Cardiovascular: Dirfregular heartbeat Leg cramping when walking Swelling (hands, feet, etc.) High blood pressure Dizziness Dizziness Acne Difficulty breathing when Dizziness Acne Difficulty breathing when Forceful heartbeat Rash Mole change Forceful heartbeat Skin cancer Mole change Fainting Respiratory: Neurological: Difficulty speaking Chest tightness Loss of coordination			Alcohol abuse
Cataract Eye discharge Musculoskeletal: Difficulty concentrating Drug abuse Eating disorder Muscle weakness Muscle pain Neck pain Neck pain Neck pain Neck pain Cardiovascular: Dosteoporosis Irregular heartbeat Low back pain Leg cramping when walking Swelling (hands, feet, etc.) High blood pressure Dizziness Dirficulty breathing when Iproceful heartbeat Nole change Mole change Hematologic: Forceful heartbeat Skin cancer Wole pain Neck pain Diabetes type I Enlarging hands/feet Unexpected lactation Obesity Difficulty breathing when Skin cancer Mole change Hematologic: Anemia Abnormal bleeding/bruising Severe shortness of breath Skin cancer When sleeping Skin lesions Sovelen lymph nodes Fainting Neurological: Asthma Difficulty speaking Loss of coordination	processory processory	Acute renal failure	Anxiety
Eye discharge	Secretary processes	Chronic renal failure	Depression
Eye pain			Dementia
Glaucoma Sensitivity to light Muscle weakness Muscle pain Neck pain Steroprosis Irregular heartbeat Cardiovascular: Chest pain/pressure Chest pain		Musculoskeletal:	Difficulty concentrating
Sensitivity to light Vision change Muscle pain Neck pain Neck pain Suicidal thoughts Cardiovascular: Osteoporosis Irregular heartbeat Low back pain Shoulder pain Diabetes type I Leg cramping when walking Swelling (hands, feet, etc.) High blood pressure Dizziness Acne Difficulty breathing when Severe shortness of breath when sleeping Fainting Respiratory: Neurological:	to the same of the	Joint pain	Drug abuse
Vision change	Glaucoma	Back pain	Eating disorder
Cardiovascular: Neck pain	Sensitivity to light	Muscle weakness	Hallucinations
Cardiovascular: Irregular heartbeat	Vision change	Muscle pain	Mania Mania
Irregular heartbeat		Neck pain	Suicidal thoughts
Chest pain/pressure Shoulder pain Diabetes type Leg cramping when walking Stiffness Diabetes type Swelling (hands, feet, etc.) Enlarging hands/feet High blood pressure Dermatological: Unexpected lactation Dizziness Acne Obesity Difficulty breathing when Eczema Iying down Mole change Hematologic: Forceful heartbeat Rash Abnormal bleeding/bruising Severe shortness of breath Skin cancer Anemia when sleeping Skin lesions Swollen lymph nodes Fainting Sores Prolonged bleeding time Respiratory: Asthma Difficulty speaking Chest tightness Loss of coordination Chest tightness Loss of coordination Diabetes type Diabetes type	Cardiovascular:	Osteoporosis	
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when sleeping Skin lesions Swollen lymph nodes Fainting Sores Prolonged bleeding time Respiratory: Neurological: Difficulty speaking Loss of coordination	Severe shortness of breath		
Fainting Sores Prolonged bleeding time	when sleeping		Succession Succession State of the State of
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Asthma Difficulty speaking Chest tightness Loss of coordination	Respiratory:	Neurological:	
Chest tightness Loss of coordination	Asthma		
CoughTremor	Chest tightness		
	Cough	Tremor	
Shortness of breath Gait abnormality	Shortness of breath	Gait abnormality	
Coughing up blood Headache	Coughing up blood		
Pain when breathing Memory loss	Pain when breathing		
Exposure to TB Generalized pain	Exposure to TB		
Wheezing Numbness/tingling			

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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.):
Pavious of Systems: (Are you presently beging problems with any other systems in your body?):
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.

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

PHI DISCLOSURE TO FAMILY MEMBERS

•	nember regarding your medical care of financial matters. This is to acknowledge rizona to disclose you PHI to the following individuals (Check all that apply):
Name	Relationship to Patient
Telephone	Email
Date	
Types of information: Appointmen	t Reminders ☐ results (Lab test, x-Ray, etc.) ☐ Financial ☐ Other
Okay to contact via: Telephone	l Leave a Voice Mail □ Email □ Text □ Other
NOTICE OF PRIVACY PRACTICES (NE	PP) ACKNOWLEDGMENT
information about you may be used or disinformation, request an accounting of dis	vided to all patients. This Notice of Privacy Practices identifies 1. How medical sclosed. 2. Your rights to access your medical information, amend your medical sclosures of your medical information and request additional restrictions on our 3. Your rights to complain if you believe your privacy rights have been violated. a privacy of your medical information.
The undersigned certifies that he/she has Practices and is the patient or the patient	read the foregoing and may review/receive a copy of the Notice of Privacy is representative.
Name of Patient	Signature
Name of Representative	Signature of Representative
Date	