



Patient Registration Information

Patient's Personal Information		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Pacific Islander Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Decline to answer					
Name: _____ <small style="display: flex; justify-content: space-between; width: 100%;"> last name first name initial </small>					
Date of Birth: ____ / ____ / ____		Social Security #: ____ - ____ - ____			
Home Phone: (____) _____		Work Phone: (____) _____		Cell Phone: (____) _____	
Address: _____		Apt. #: _____	City: _____	State: ____	Zip: _____
Patient's / Responsible Party Information		Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			
Name: _____ <small style="display: flex; justify-content: space-between; width: 100%;"> last name first name initial </small>					
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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Policy #: _____		Group #: _____	Copay: \$ _____		
SECONDARY Insurance Name: _____					
Address: _____		City: _____	State: ____	Zip: _____	
Name of insured: _____		Date of Birth: _____	Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name: _____		Relationship: _____			
Address: _____		City: _____	State: ____	Zip: _____	
Home Phone: (____) _____		Work Phone: (____) _____		Cell Phone: (____) _____	

Assignment of Benefits • Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Digestive Institute of Arizona, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original and understand that Digestive Institute of Arizona utilizes dictation services or AI powered scribing. I have been notified and authorize.

Date: _____ Your Signature: _____



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



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?



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



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 Requiring Caregivers - Acknowledgement of Consent to Contact:**

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Email: _____



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	