HEAVENS URGENT CARE

95 S Idaho Rd #140, Apache Junction, AZ 85119

NEW PATIENT REGISTRATION

Patient Information:

Last Name:	First Name: MI:	Date of Birth:
Main Address: Apt #:		
City/State/Zip:		Sex: ☐ Male ☐ Female
Home Phone: *(Land Line)*	Cell Phone:	Social Security #:
Preferred method of Contact for Reminders? ☐ Email ☐ Phone - Home ☐ Phone - Cell	Email Address:	
Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced/Separated ☐ Widowed		Sign up for the patient portal? ☐ Yes ☐ No
Emergency Contact:	Emergency Phone #: (MUST be different #)	Relationship to Patient:
Race: ☐ American Indian ☐ Afro American / Black ☐ Asian ☐ Caucasian/White ☐ Hispanic ☐ Other _____ ☐ Decline		Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic or Latino ☐ Decline

Alternate Address:

Address: Apt #:	
City/State/Zip:	Phone # for this address:

For Pediatric Patient

Patient Resides with:	Primary:	Secondary:
Occupation of:	Father:	Mother:
Phone # of:	Father:	Mother:

Parents Relationship: ☐ Married ☐ Divorced/Separated ☐ Single	Tobacco Exposure: ☐ Yes ☐ No	Smokers at home: ☐ Yes ☐ No

If *UNDER* the age of 18 and/or person responsible for the bill *(IF DIFFERENT FROM THE PATIENT)*

Last Name:	First Name:	Date of Birth:
Phone #:	Social Security #:	Relationship:
Address of Person Responsible:		
City/State/Zip:		

Chief Complaint:

Reason for Visit Today:

☐ Establish Care w / PCP ☐ Refills ☐ Problems / Complaints

Advanced Directives

☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy ☐ None / Not Interested

Have you registered your information with the Secretary of State Registry? ☐ Yes ☐ No

Family Notified of your choices? ☐ Yes ☐ No Date Reviewed: _____

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Patient Name: _____ DOB: _____

Consent to Release Medical Information

I, _____, hereby consent to have my information released to the following Individuals. This consent will stay in efffect until otherwise notified by me in writing. Any person signing as the representative of the patient must present documentation of legal authority to sign for that patient.

Name: *(first, last)*	Phone:	Relationship:
Name: *(first, last)*	Phone:	Relationship:

Information to Release: ☐ Appointment Info ☐ Billing Information ☐ Medical Records

Signature of Patient, Guardian or Authorized Personal Representative	Date	Witness (office personnel)

HIPAA Privacy

A copy of Health Information Portability and Accountability Act of 1996 (HIPAA)of 1996 Privacy and Security Rules is displayed at the front desk for you to read. If you need or would like a copy to take with you, please ask the front desk and you will be given a exact copy of the display. This form is to be signed by you in acknowledgement that you have been given the opportunity to read and/or received a copy a copy of the HIPAA Privacy Rules.

I, _____ acknowledge that I have been given the opportunity to read or take a copy of the HIPAA Privacy Rules and understand my rights under the HIPAA Guidelines of Patient Privacy and Security.

Signature of Patient, Guardian or Authorized Personal Representative	Date	Witness

Primary Insurance:		**Secondary Insurance:**	
Name of insurance:		Name of insurance:	
Policy Holder Name:		Policy Holder Name:	
Policy Holder Social Security #:	Date of Birth:	Policy Holder Social Security #:	Date of Birth:
Patient Relationship to Holder:		Patient Relationship to Holder:	

** **PLEASE** indicate the lab your insurance company uses: ☐ Sonora ☐ Lab Corp ☐ Other: _____

I understand that if my choice for lab directive is incorrect, **I am** financially responsible for the bill that the lab sends me. If no lab is chosen we will send it to which ever lab we have a pick up for.

Consent to Bill Insurance:

I authorize and request that payments from Authorized Medicare, Medicaid and any commercial healthcare, primary or secondary, be made to Heavens Medical, PLC and/or their providers, for services furnished to me to the extent of the permitted law. I also authorize any holder of medical or other information about me to be released to Medicare, Medicaid and/or any commercial healthcare carriers and their agents, any information needed to determine the benefits payable for the services provided by Heavens Medical, PLC and/or their providers.

Signature of Responsible Party	Date	Witness

Pharmacy Information

	Name	Cross Streets
First Choice:		
Second Choice:		

Mail Order: ☐ Yes ☐ No _____

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PAYMENT POLICY

Thank you for choosing Heavens Medical, PLC as your primary care provider. We are committed to providing you with quality and affordable health care. Our practice financial policy is as follows:

INSURANCE: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit may be required until we can verify your coverage. ***Knowing your insurance benefits is your responsibility***. Contact your insurance company directly for any questions regarding your coverage. By signing this form you authorize Heavens Medical, PLC to release the necessary information in order to complete and process your insurance claims.

CO-PAYMENTS AND DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

NON-COVERED SERVICES: I understand that some, and perhaps all, of the services I received may not be covered by my insurance or not considered reasonable or necessary by Medicare or other insurers. I agree to pay for any services which have been determined by my insurance plan to be "non-covered". Payment in full for these services is due at each visit.

PROOF OF INSURANCE: All patient must complete our patient form **BEFORE** seeing the doctor. We must obtain a copy of your driver's license and current insurance card at ***every*** visit. If you do not provide us with the correct insurance information in a timely manner, you may be held responsible or the balance of a claim.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your clams paid. Your insurance company may need you to supply certain information directly. It is your responsibility to clams paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. *Your insurance benefit is a contract between you and your insurance company.*

COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be billed to you.

NONPAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will be able to treat you on an emergency basis only.

MISSED APPOINTMENTS: You may be charged for a missed appointment if you do not notify us at least 24 hours prior to your scheduled appointment time. These charges will be billed directly to you and you will be responsible for these charges. Help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient, Guardian or Authorized Representative Date

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Patient Name: _____ DOB: _____

Non-Prescription Medications - Please give the Medical Assistant your medicine bottles when asked.

Medication Name	☐ I do not take any medications	Strength and Dosage

Allergies - List ALL known Food and Medication Allergies

Allergy	☐ No Known Allergies	Reaction

Surgical/Hospitalizations History

Reason	Date	Hospital

Preventative

	Date		Date		Date
H&P (Physical Exam)		Pulmonary Function		Mammogram	
Blood Work (Labs)		Echocardiogram		Pap Smear	
Podiatry/Foot Exam		Colonoscopy		EKG	
Eye Exam		os		A1C Test	
Fecal Occult Blood Test		Bone Density		Other:	

Immunizations

	Date		Date		Date
DTaP *(Tetanus/Diphtheria)*		Zoster (Shingles)		Hepatitis A	
Pneumococcal Pneumonia		Influenza		Hepatitis B	
Varicella *(Chicken Pox)*		HPV/Gardasil		MMR	

Social History

Occupation: | Employer:

Do you have children? ☐ Yes ☐ No | How Many: | # of Females: | # of Males: | Do they reside with you: ☐ Yes ☐ No

Do you prefer: ☐ Men ☐ Women ☐ Both | Are you married/committed: ☐ Yes ☐ No ☐ Divorced ☐ Widowed ☐ Separated

Any history of communicable illnesses/STDs? (please list)

Sleep Pattern: ☐ Changes ☐ No Changes | Tobacco Use: ☐ Daily ☐ Weekly ☐ Less | Former / Year Quit:

Exercise Activity: ☐ Moderate ☐ Vigorous ☐ Sedentary | Caffeine Use: ☐ Daily ☐ Weekly ☐ Less | Former / Year Quit:

Days per week/length of Workout: | Alcohol Use: ☐ Daily ☐ Weekly ☐ Less | Former / Year Quit:

Diet History: ☐ Diabetic ☐ High Fiber ☐ High Protein ☐ Low Sodium ☐ Vegan ☐ Vegetarian ☐ Other:

Do you currently use recreational or street drugs? ☐ Yes ☐ No | If used in past please list the year quit:

Any history of illicit drug use? ☐ Yes ☐ No | Type of Drug: | If used in past please list the year quit:

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Personal and Family History of Illnesses:

	Age	Deceased	Deceased Age
Mother		☐ Yes ☐ No	
Father		☐ Yes ☐ No	

Check the box of your past or present and family members for have had each illness

	Patient		Mother	Father	Sister	Brother	Aunt	Uncle	Pat GM	Pat GF
Alcoholism	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Anemia/Blood Disorder	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Cancer ***(detail type below)***	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
COPD/Emphysema	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Coronary Artery Disease	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Dementia/Alzheimer's	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes ***(detail type below)***	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
GERD (heartburn)	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Headaches / Migraines	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Heart Failure (CHF)	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis ***(detail type below)***	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Myocardial Infarction (Heart Attack)	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Prostate	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐
Other ***(detail below)***	☐ Past	☐ Present	☐	☐	☐	☐	☐	☐	☐	☐

Cancer (Type, Location, Date) _____

Diabetes (Type, Date) _____

Hepatitis (Type A, B or C) _____

Other: _____

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REVIEW OF SYSTEMS - PRESENT PROBLEMS

For new patients or our patients who we haven't seen for a while, we need to update our records to reflect any changes. If you are not having any difficulties, please check "No Problems." In each area, if you are having problems, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed.

If you have any questions about this, please ask one of the Medical Assistants, or your doctor.

Const. (Health in General) ☐ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnoses of Cancer
Other: _____

Ears, Nose, Mouth & Throat ☐ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness
Other: _____

C-V (Heart & Blood Vessels) ☐ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking
Other: _____

Resp. (Lungs & Breathing) ☐ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray
Other: _____

GI (Stomach & Intestines) ☐ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence
Other: _____

GU (Kidney & Bladder) ☐ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence
Other: _____

MS (Muscles, Bones, Joints) ☐ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain
Other: _____

Integ. (Skin, Hair & Breast) ☐ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes
Other: _____

Neurologic (Brain & Nerves) ☐ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled emotions, episodes of visual loss
Other: _____

Psychiatric (Mood & Thinking) ☐ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions
Other: _____

Endocrinologic (Glands) ☐ No Problems Intolerance to heat or cold, menstrual irregularities frequent hunger/ urination/thirst, changes in sex drive
Other: _____

Hematologic (Blood/Lymph) ☐ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas
Other: _____

Allergic/Immunologic ☐ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.
Other: _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:	Date of Birth:
City/State/Zip:	Social Security #:

I authorize Heavens Medical, PLC to:

☐ Request ☐ Release

Healthcare Information of the patient named above from / to:

Name (Physician, Hospital, Family Member, Self)

City/State/Zip:

Phone:	Fax:

For the Purpose of:

Other: _____

Type and amount of informtion to be disclosed is as follows:

☐ Complete Medical Record
☐ Complete Medical Record from _____ to _____
☐ Laboratory Results from _____ to _____
☐ Billing Information
☐ Other: _____

I understand that the medical information released by this authorization may include confidential information concerning my treatment of physical and/or mental illness, alcohol/drug abuse, HIV/AIDS and past medical history.

I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Heavens mediccal, PLC cannot condition treatment, payment enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient, Guardian or Authorized Personal Representative	Date	Witness (office personnel)
/		
Patient, Guardian or Personal Represent. Name (print) and Relationship (Please attach legal documentation of authority)	Date	Witness (office personnel)