INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions and bring this record to your first examination. It will help your physician to know not only about your health but also about your family and relatives. **PLEASE PRINT LEGIBLY.**

Date ____________________________

Your full name ______________________________ Telephone Number ____________________

Age ____________ Place of Birth ______________________________ Race or nationality of parents ______________________________

Religion ________________________ Education ________________________ (Highest level attained) Age on completion __________ Occupation ______________________________ How Long? __________

Where and when have you lived or traveled outside the U.S. and Canada ______________________________

	Living		Age or age at death
Father	Yes	No	__________________
Mother	Yes	No	__________________
Spouse	Yes	No	__________________

Present marriage - year ________________________ Previous marriage - year and duration ______________________________

Brothers No. living __________ Health ______________________________

No. dead __________ Cause of death ______________________________

Sisters No. living __________ Health ______________________________

No. dead __________ Cause of death ______________________________

Children living __________ Ages and health ______________________________

Children dead __________ Ages and cause ______________________________

Please circle illnesses which have occurred in any of your *blood relatives:*

Diabetes	Cancer	Bleeding tendency	Kidney disease	Thyroid problems
Heart disease	Stroke	High blood pressure	Nervous illness	

Please circle illnesses or conditions you have had:

Diabetes	Glaucoma	Heart trouble	High Blood Pressure	Vein trouble
Diabetes, insulin taking	Asthma	Liver Disease	Rheumatic fever	Bleeding tendencies
Cancer	COPD	Kidney disease	Nervous disorder	Valley Fever

Please list other illnesses not requiring operation for which you were hospitalized:

____

____

Have you had serious injuries, broken bones, etc? ______ List ______________________________

____

____

Have you had allergy or sensitivity to medicines or other substances? _______ Please describe ______________________________

____

Do you use tobacco now? ______________ In the past? ____________ Type and daily amount ______________________ How Long? ______________

Do you use alcoholic beverages? __________ Type? ________________ Weekly amount ________________________ How Long? ______________

Please check the diseases against which you have been immunized:

Hepatitis B __________ Tetanus __________ Typhoid __________ Polio ____________ Influenza ___________ Chicken Pox/Shingles __________ Other ____________________

Previous operations. Please list, giving dates, hospital where performed and name of surgeon.

____

____

____

Previous x-ray therapy or similar treatment ______________________________

____

Menstrual History. Last period ________________ (Date onset) Periods are: O Regular O Irregular Number of pregnancies___________ Number of miscarriages ___________

Have you taken Cortisone-type drugs? _________ Oral contraceptives? _________ Have you received a blood transfusion__________ Date?__________________________

Your weight dressed______________________ How long have you been at this weight? ____

Please write the reason you came to the doctor at this time:____

____

What is your main medical problem now and how long have you had it?

____

What is your main symptom? (For example: pain in chest, shortness of breath)

____

Pharmacy Information:

1st Choice

PHARMACY NAME	PHONE	FAX

ADDRESS or CROSS STREET	CITY, STATE

2nd Choice

PHARMACY NAME	PHONE	FAX

ADDRESS or CROSS STREET	CITY, STATE

Prescription Information:

MEDICATION	STRENGTH	INSTRUCTIONS
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Patient Information

NAME:_______________ AGE:________ DATE OF BIRTH:_______________

ADDRESS:_______________SEX:__________MARITAL STATUS: S M W SEP D

CITY:_______________ST:_______ZIP:_________ SOCIAL SECURITY NO:_______________

EMAIL:_______________ DRIVER'S LICENSE NO:_______________STATE:___________

HOME PHONE:_______________ CELL PHONE:_______________

WORK PHONE:_______________EXT:__________OCCUPATION:_______________

EMPLOYER NAME:_______________EMPLOYER PHONE:_______________

EMPLOYER ADDRESS:_______________ CITY:_______________ ST: ZIP:_______________

PRIMARY CARE PHYSICIAN:_______________ PHONE:_______________

Emergency Contact Information

NAME/RELATIONSHIP TO PATIENT:_______________

PHONE:_______________WORK PHONE:_______________EXT:__________

Responsible Party Information

NAME/RELATIONSHIP TO PATIENT: _______________

ADRESS:_______________DATE OF BIRTH:_______________

CITY:_______________ST:_______ZIP:_____________SOCIAL SECURITY NO:_______________

PRIMARY PHONE:_______________ SECONDARY PHONE:_______________

EMPLOYER:_______________ EMPLOYER PHONE:_______________

EMPLOYER ADDRESS:_______________ CITY:_______________ST:_______ZIP:_______________

Primary Insurance ID#:_______________GROUP #:_______________

INSURANCE CO:_______________

POLICY HOLDER NAME/RELATIONSHIP TO PATIENT:_______________

POLICY HOLDER PHONE NO:_______________POLICY HOLDER DOB:_______________

POLICY HOLDER EMPLOYER:_______________POLICY HOLDER SOCIAL SECURITY NO:_______________

Secondary Insurance ID#:_______________GROUP #:_______________

INSURANCE CO:_______________

POLICY HOLDER NAME/RELATIONSHIP TO PATIENT:_______________

POLICY HOLDER PHONE NO:_______________POLICY HOLDER DOB:_______________

POLICY HOLDER EMPLOYER:_______________POLICY HOLDER SOCIAL SECURITY NO:_______________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I hereby authorize Valley Endocrine Associates, P.C. to apply for benefits on my behalf. I request that payment from my insurance company be made directly to Valley Endocrine Associates, P.C. for medical benefits otherwise payable to me. I understand that I am financially responsible for the charges not covered by my insurance. I hereby certify that the information I have reported with regard to my insurance coverage is correct.

Date:_______________ Signature:_______________

Notice of Privacy Practices Written Acknowledgment
AND
Authorization for Release of Protected Health Information

I authorize the following individual(s) to obtain information regarding my medical records and health history information.

Name: ___________________________________ Relationship to Patient:___________________________
DOB:_____________________________________ Phone Number:__________________________________

Name: ___________________________________ Relationship to Patient:___________________________
DOB:_____________________________________ Phone Number:__________________________________

Name: ___________________________________ Relationship to Patient:___________________________
DOB:_____________________________________ Phone Number:__________________________________

Name: ___________________________________ Relationship to Patient:___________________________
DOB:_____________________________________ Phone Number:__________________________________

My signature below also indicates that I have received a copy of the Notice of Privacy Practices for Valley Endocrine Associates, P.C.

Print patient Name:____
Date of Birth

Patient Signature:____
Today's Date

Valley Endocrine Associates, P.C.
OFFICE POLICIES

The physicians and staff at Valley Endocrine Associates strive to provide you with the very best quality care and ensure you a pleasant patient experience. Your cooperation with the policies listed below will assist us in providing that care.

OFFICE HOURS: Our office is open Monday through Friday from 7:00 AM-5:00 PM. Our phone lines are open from 8:00 AM-12:00 PM and 1:30 PM-5:00 PM

LAB HOURS: Our on-site lab is open from 7:00 AM until 4:30 PM. No appointment is necessary. You must be a patient of our office in order to utilize the lab. Outside orders will be drawn as a courtesy, ONLY if presented in conjunction with our order.

INSURANCE: In order for us to bill your insurance, you must present a current insurance card at each visit. If we do not have a valid card on file, you will be treated as a cash-pay patient and payment of our full fee will be expected at the time of service. When the card is furnished, we will file your insurance and reimburse you if your claim is paid.

REFERRALS: If your insurance requires a referral to see a specialist, a valid referral must be on file when you check-in for your appointment. It is your responsibility to ensure that your referral has been received. This must include a valid number of visits and a valid date range authorized by your primary care doctor. If your referral is not here at the time of check-in you will be asked to reschedule your appointment.

ESTABLISHING CARE: Once you have established care in our practice you will be expected to continue with the physician who saw you in consultation. If at any point you decide to discontinue the physician-patient relationship we require that you seek care outside of our practice.

COPAYS: Our insurance contracts require us to collect copays at the time of service. If your insurance plan requires a copay, it will be due at the time of your visit.

BALANCE DUE: If there is a balance due on your account, this must be paid in full prior to being seen. If you are unable to pay your balance you may ask to setup an agreement for a payment plan. Please be advised that a default on this agreement will result in your account being sent to our collection agency and further appointments will not be scheduled. Accounts that reach **90 days past due** will be sent to our **collection agency.**

APPOINTMENT CONFIRMATION/CANCELLATION: We require confirmation of all appointments. Our automated system and staff will continue to call until we hear back from you. In the event that you do not return our calls, your appointment may be cancelled and given to another patient. We require a (24) hour notice for appointment cancellation. Our 24-hour appointment confirmation line is 480-626-6830. We reserve the right to charge a $50 fee for missed appointments.

PRESCRIPTION REFILLS: Requests for prescription refills should be directed to your pharmacy. Prescription refills will be processed within 48-72 hours; please plan ahead and request your refills in a timely manner. Refills will only be approved if follow up visits have been kept.

LAB ORDERS: Lab orders are sent electronically to the rendering lab in accordance with your insurance. If you misplace your order, please contact the draw station to confirm whether or not they have an order on file. If it is necessary for us to mail or resend the order, you may be assessed a $5 fee.

EMERGENCIES: Our office has an on-call physician who will be available for emergency coverage 24 hours a day. For questions and minor problems, please call the office during regular office hours. Prescription refills WILL NOT be addressed after hours.

MEDICAL RECORDS/FORMS: We require a minimum of 5 days to complete these requests. There may be a $30 fee and payment is expected at the time the service is requested. If you prefer to pick up your records/forms we will notify you when they are ready.

Signature:____ Date:_______________________________