



New Patient Intake and Medical History

PATIENT INFORMATION

Patient Name: _____ Gender: Male Female DOB: _____

Marital Status: Married Divorced Widowed Single

Race: White American Indian Asian Black/African American Pacific Islander Other Decline

Ethnicity: Not Hispanic/Latino Hispanic/Latino Decline

SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

FINANCIALLY RESPONSIBLE PARTY (If different than above)

| | |
|----------------|--------------------------|
| Name: | Relationship to Patient: |
| SSN: | DOB: |
| Primary Phone: | Work Phone: |
| Address: | |

PRIMARY INSURANCE

| | |
|--------------------|--------------------------|
| Name of Insured: | Relationship to Patient: |
| Insurance Company: | Group #: |
| Insurance Address: | Policy ID: |
| Insurance Phone: | DOB: |
| Employer: | |

SECONDARY INSURANCE

| | |
|--------------------|--------------------------|
| Name of Insured: | Relationship to Patient: |
| Insurance Company: | Group #: |
| Insurance Address: | Policy ID: |
| Insurance Phone: | DOB: |
| Employer: | |

Patient Name: _____

DOB: _____

MEDICAL HISTORY

Previous Primary Care Physician: _____ Phone: _____

Please provide names and specialty of any medical specialists you see for your healthcare needs:

Do you have ANY ALLERGIES to medications? _____ If yes, please list medications and your reaction to the medication: _____

Patient Initials: _____

Pharmacy (name/cross streets): _____ Phone: _____

Our office uses an E-Prescribe program, which allows us to electronically send prescriptions to pharmacies and to share prescription information with other providers involved in your healthcare. This program reduces medication errors, enhances patient safety, and gives us information on which medications are covered under your drug benefit coverage.

I give Tatum Highlands Medical Associates permission to enroll me in their E-Prescribe program at the pharmacy indicated above. _____ Yes _____ No Patient Signature: _____

Please list ALL medications and supplements you are currently taking:

| Have you ever had, or do you currently have any of the following medical conditions? (Please check) | | |
|---|--|---|
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis/Joint Pain | <input type="checkbox"/> Hearing/Vision Problems | <input type="checkbox"/> Migraines/Headaches |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Heart/Vascular Disease | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Stroke/CVA/TIA |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Urinary Tract Disorder |
| <input type="checkbox"/> Diabetes/High Blood Sugar | <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Uterine or GYN Problems |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Vascular Disease |

If cancer was listed, please indicate type: _____

Please list any other medical concerns or problems not listed above: _____

Patient Name: _____

DOB: _____

| Do you have a family history of the following conditions? (Please check) | |
|--|---------------------|
| Cancer, if so type: _____ | Relationship: _____ |
| Diabetes | Relationship: _____ |
| Heart Disease | Relationship: _____ |
| Kidney Disease | Relationship: _____ |
| Obesity | Relationship: _____ |
| Psychiatric Disorder | Relationship: _____ |

Please indicate any other family or medical history, which is not listed above and you feel is pertinent:

SURGICAL HISTORY

| PROCEDURE | DATE | PROCEDURE | DATE |
|-----------|------|-----------|------|
| | | | |
| | | | |
| | | | |

SOCIAL HISTORY

| | |
|---|--------|
| Do you currently use tobacco? | YES NO |
| If yes, how much do you currently smoke/chew on a daily basis? | |
| Did you use tobacco in the past? | YES NO |
| If yes, when did you quit? | |
| If yes, how much did you smoke/chew on a daily basis? | |
| Do you drink alcohol? | YES NO |
| If yes, how much do you drink per day/per week? | |
| Do you use ILLICIT or RECREATIONAL drugs? | |
| If yes, which drugs? | |
| If yes, how much per week? | |
| Have you ever been treated for drug or alcohol addiction? | YES NO |
| How would you describe your diet? (Health & Balanced, Average, or Poor) | |
| Do you currently exercise? | YES NO |
| If yes, how many days per week do you exercise? | |
| If yes, what activities do you do to exercise? | |
| If no, is there a physical reason why you do not? | |

I consent to medical treatment and agree to pay all charges, deductibles, and/or copayments at the time of service. Tatum Highlands Medical Associates may release any necessary medical information to my insurance company to process claims. I authorize my health insurance company to make payments directly to Tatum Highlands Medical Associates for applicable medical benefits and costs associated with my care. I give Tatum Highlands Medical Associates authorization to receive and provide medical information from hospitals, urgent care facilities, and medical specialists who are involved in my medical care.

PRINT Patient's Name

SIGNATURE of Patient or Guardian

Date



RELEASE OF MEDICAL INFORMATION AND PATIENT COMMUNICATON

Patient Name: _____ **Date of Birth:** _____

I authorize Tatum Highlands Medical Associates to relay any and all communications regarding my lab results, medical testing, referral information, billing/account information, and other pertinent health information in the following manner.

VERBAL COMMUNICATION:

Home Phone: _____ **May we leave a detailed message?** ____ Yes ____ No

Cell Phone: _____ **May we leave a detailed message?** ____ Yes ____ No

In addition, I give Tatum Highlands Medical Associates permission to disclose medical and billing/account information to the following individuals on my behalf. If left blank, we will speak with patient only.

Name: _____ **Relationship to Patient:** _____ **Phone:** _____

Name: _____ **Relationship to Patient:** _____ **Phone:** _____

PATIENT PORTAL

Our office uses a patient portal as a means of communication with our patients. Our portal is a secure communication link between you and our practice. You may utilize the portal to send messages to our staff, view health records, and lab and diagnostic tests. In addition, you can view medication history and request refills on existing prescriptions.

However, please be advised that the patient portal is for routine matters and NOT for URGENT or EMERGENT requests or questions. Information left on the portal will be addressed within 48 hours. If a request is left after normal business, the request will be addressed the next business day.

Patient Initials _____

PRIVACY PRACTICES AND OFFICE AND FINANCIAL POLICIES:

I have had the opportunity to review and/or receive a copy of Tatum Highlands Medical Associates Privacy Practices, which are part of the yearly update packet. _____ Yes ____ No

If I wish to change my release and communication information at any time in the future, I must complete and sign a new Release of Medical Information and Patient Communication form.

PRINT Patient's Name

SIGNATURE of Patient or Guardian

Date

Tatum Highlands Medical Associates
OFFICE AND FINANACIAL POLICIES

Thank you for choosing Tatum Highlands Medical Associates and trusting us with your healthcare needs. Please review the following office and financial policies and complete the bottom of this document.

1. **FINANCIAL POLICY:** Please bring your insurance card to each office visit and have it when scheduling appointments over the phone. If your insurance changes, please verify that we are contracted with your new plan. If your insurance plan requires a copayment for office visits or you have an unmet deductible, **payment is due at the time of service**, and no exceptions will be made. Your insurance company may not cover all your healthcare costs, and your policy is a contract between you and your insurance company. It is your responsibility to know your policy and benefits, and know that **you are required to pay out of pocket for non-covered or denied services**. In addition, if you have an unpaid account balance for more than 90 days and your account is turned over to our outside collection agency, a collection transfer fee of \$45.00 will be added to your account.

2. **CANCELLATION POLICY:** Patients are seen by appointment only and that time is reserved for you. When you don't show for an appointment or cancel with less than 24 hour notice, it is a financial loss for our practice and more importantly is an appointment we could have used for another patient. **Therefore, if we do not receive 24 hour notice for a cancellation or you no show for an appointment, you will be charged a \$25.00 fee.**

3. **MEDICATION REFILLS:** We do not prescribe medications over the phone. You must be a patient of record and be seen by one of our providers in order to receive a prescription. It is your responsibility to keep track of your medication supply. For refills of existing prescriptions, you should call your pharmacy directly or call our office during normal business hours. **Messages left for our Medical Assistants will be handled within 48 hours.** If a request is left after normal business hours, it will be addressed the next business day.

Please note, many medications and all controlled substances require an appointment with your provider at least every 90 days, so scheduling routine visits will be necessary if you are prescribed any of these medications.

4. **PATIENT PORTAL:** Our online patient portal is available for you to access patient information, ask clinical questions, and request prescription refills. However, **the patient portal is for routine matters and NOT for URGENT or EMERGENT requests or questions.** Information left on the portal will be addressed within 48 hours. If a request is left after normal business hours, the request will be addressed on the next business day.

5. **AFTER HOURS:** The provider on call is available for urgent and emergent problems only, and is not available for routine matters such as discussing labs, x-rays, or refilling prescriptions. If you require urgent medical attention you should call 911 or go to your nearest Emergency Department or Urgent Care.

6. **TREATMENT OF MINORS:** Patients under 18 must be accompanied by their parent or legal guardian.

7. **MEDICAL RECORDS:** If you request copies of your medical records, we provide the first 5 pages free of charge. However, if your records exceed 5 pages you will be charged a \$25.00 fee.

8. **FORMS:** Your provider is willing to complete medical forms you may need for FMLA, Worker's Compensation, Short or Long Term Disability, and other medically necessary forms, however there will be a \$25.00 fee to complete these forms and payment will be collected when forms are dropped off. Completed forms will be available 48 hours after the forms and the payment is received in our office.

I acknowledge that I have read and understand Tatum Highlands Medical Associates' Office and Financial Policies and agree with the policies as outlined above.

PRINT Patient's Name

SIGNATURE of Patient or Guardian

Date



Civility Policy

To our valued patients,

At Tatum Highlands Medical Associates, we train our staff to be respectful and courteous to each other and to our patients. Our employees play an important role in your care and as an extension of our providers they too need to be treated with respect.

Our *Civility Policy* is intended to promote a culture based upon mutual respect and professional communication. As your healthcare team we understand the importance of our relationship with our patients. Our goal is to provide exceptional patient care for the overall health and well-being of our patients and to provide a safe and respectful work environment for our staff and patients.

Our *Civility Policy* has no tolerance for disrespect. Therefore, we expect all parties to speak and act in a respectful manner. This policy does not permit the use of disrespectful or condescending language to staff, providers, or patients. Minor issues will be addressed in the spirit of conflict resolution, but egregious violations may result in patients or staff being dismissed from our practice.

We recognize you have a choice in your healthcare provider and we appreciate that you have chosen our practice. However, to continue our healthcare relationship we need our patients and staff to agree to our policy. If for some reason our *Civility Policy* is not agreeable for you, we will be happy to forward your records to a practice that is more suitable to your needs.

We look forward to working together and addressing the healthcare needs for you and your family.

Respectfully,

Peter F. Levins, M.D.

Peter F. Levins, M.D.
Medical Director
Tatum Highlands Medical Associates

I acknowledge that I have read, understand, and agree to abide by Tatum Highlands Medical Associates' Civility Policy. Failure to abide by the policy as outlined above may result in dismissal from this practice.

PRINT Patient's Name

SIGNATURE of Patient or Guardian

Date



Dr. Peter Levins, MD Cari Montoya, FNP Ashley Hatch, FNP Warner Coelho, FNP

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Name: _____ **Date of Birth:** _____

I authorize the facility listed below to release my records to Tatum Highlands Medical Associates. Please send the following: (check all that apply):

- Complete Medical Records
- Progress Notes
- Lab/Pathology Reports
- Immunization Records
- Cardiology/EKG Reports
- Imaging Reports

| | |
|------------------------------|--|
| Practice/Facility | |
| Street Address | |
| City, State, Zip Code | |
| Phone Number | |
| Fax Number | |

I understand that authorizing the release of medical records and personal health information is voluntary and therefore I release Tatum Highlands Medical Associates, their providers, and their employees from any and all liabilities, damages, and claims which may arise from the release of information. In addition, I understand that disclosure of this information may not be protected by federal confidentiality rules and my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, human immunodeficiency, behavioral or mental health services, and treatment for alcohol and drug abuse. This authorization may be revoked at anytime, however the revocation must be submitted in writing to Tatum Highlands Medical Associates and does not apply to health information previously released.

Patient Signature: _____ **Date:** _____

Please send records via mail, fax, or secure email:

Option 1 MAIL

Tatum Highlands Medical Associates
26224 N Tatum Blvd. Suite 15A
Phoenix, Arizona 85050

****PAPER COPIES ONLY****

We CANNOT process records sent on a CD.

Option 2 EMAIL

If you wish to send electronic records, please EMAIL attachments in **PDF FORMAT** to our secure email at:

admin@secure.tatummedical.com

Option 3 FAX

FAX 480-419-6782