Patient Information

Patient Full Name:		
Reason for Visit:		
Date of Birth:	Gender:	
Address:		
City:	State:	Zip:
Primary Phone #:	Secondary Phone #:	
Email Address:	By providing your email address, you consent to our Privacy Policy	
Marital Status:	Spouse's Full Name:	
Emergency Contact 1:	Phone #:	Relationship:
Emergency Contact 2:	Phone #:	Relationship:
Health Insurance:		

I am interested in: ☐ Monthly membership ☐ Travel clinic only

Today's method of payment: We do not submit claims to insurance companies. We do not accept cash or check at this time.

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ ACH debit from bank account

Current Medications *List all supplements, prescription & non-prescription medications*	**Allergies** *List food or drug allergy & interaction*
Occupation:	Alcohol (drinks/week):
Do you use tobacco? ☐ No ☐ Yes Packs/day _____	Exercise (times/week):

Past Medical History *Circle any of the following that relate to you*

Heart Disease	Asthma	Kidney Stones	Depression	Arthritis
High Blood Pressure	COPD/Emphysema	Kidney Disease	Anxiety	Skin Disease
Stroke	Diabetes	Thyroid Disease	Substance Abuse	Gall Bladder Disease
Blood Clots	Severe Headaches	Seizures	Insomnia	Hepatitis
Anemia	Cancer	Ulcer Disease	STD	Other: _____

Past Surgical History *List surgery & year*

Family History *Please circle*

Heart Disease Diabetes Stroke Mental Illness Cancer Other: _____

Guardian's Full Name:	
Guardian's Contact #:	Relationship to Patient:

Signature:	Date:
Patient / Guardian Name:	

The Family Doctor, PLLC Privacy and Billing Procedures
Authorization and Acknowledgement

These authorizations/acknowledgements cover all services rendered to me, or to the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing The Family Doctor, PLLC (hereinafter "The Family Doctor") in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by The Family Doctor.

Acknowledgement of Receipt of Notice of Privacy Practices
Authorization to Release Information to Family/Friends or Others

I have received a copy of The Family Doctor's Notice of Privacy Practices. I authorize The Family Doctor to release any information regarding my treatment, including lab results, x-rays, and medical records, to the following individuals/entities:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Notice of Medicaid/AHCCCS Enrollment Status

The Arizona Health Care Cost Containment System (AHCCCS, or Arizona's Medicaid program), do not permit direct payments from patient to physician. The Family Doctor, PLLC is not at this time able to treat patients enrolled in AHCCCS.

I affirm that I, or the patient I am signing for, am/is not enrolled Medicaid/AHCCCS at this time. I understand that if I do become enrolled in Medicaid/AHCCCS, I am required to notify The Family Doctor of my change in status. I furthermore understand that if I do enroll in Medicaid/AHCCCS, I may be required to transfer my care to another physician.

Authorization to Treat and Bill

I consent to be treated and billed (including all memberships and/or ancillary services such as labs or procedures) by The Family Doctor. If I am not the patient being treated today, I am authorized to consent to treatment and billing for the patient identified below.

I acknowledge that neither The Family Doctor, nor its Physician(s) participate in any health insurance or HMO plans or panels (with the sole exception of Medicare as a non-participating provider). I understand that payment is due in full at time of service or treatment. I understand that if I fail to pay The Family Doctor for services provided to me, the balance owed may be sent to collection and I may incur collection fees in addition to the amount owed for services/treatment rendered.

Signature of Patient or Guardian _____ Today's Date _____

Patient Name _____ Patient's Date of Birth _____

Name of Patient Representative* _____ Relationship to Patient* _____

*Required if the patient is a minor or if the patient is unable to sign this form