



All Information must be filled out completely:

PLEASE PRINT CLEARLY

Patients Last Name _____ First Name _____ Middle Initial _____ Telephone _____

Mailing Address (PO Box) _____ City _____ State _____ Zip _____

Street Address –if different from above _____ Marital Status: _____

Social Security Number _____ Date of Birth _____ Sex _____
 () Female () Male

Patients Employer Information

Employer Name _____ City _____ State _____ Zip _____

Employer Address _____ Employer Phone _____
 () _____ - _____

Emergency Info you must list an alternate name and phone number
 (Someone other than you, not you or your home)

Emergency Phone Number: _____
 () _____ - _____

Winter visitor Only please list your permanent address:

Mailing Address (PO Box) _____ City _____ State _____ Zip _____

Phone Number () _____ - _____

This must be filled out completely in order to file your claim.

Primary Insurance Company Name/Address/City/State and Zip:	ID #	Group #
Secondary Insurance Company Name/Address/City/State and Zip:	ID #	Group #

Responsible Party Information –The guarantor information is the person that is the primary card holder such as your spouse, if a minor child who is this child insured under such as the mother or father.

Guarantor Last Name _____ Guarantor First Name _____ Middle Initial _____ Telephone _____
 () _____ - _____

Guarantors Street address _____ City _____ State _____ Zip _____

Guarantors Social Security Number _____ Guarantors Date of Birth _____ Sex _____
 () Female () Male

Guarantors Employer Name _____ Guarantors Employer Phone Number _____
 () _____ - _____

Guarantors Employer Address _____ City _____ State _____ Zip _____

I hereby authorize Dynamite Creek Medical Center to treat the above named patient. I authorize release of medical information necessary to process insurance claims concerning my illness and treatment. Photocopies are valid as original. I authorize payment of medical benefits for medical care rendered to my dependents or myself. I understand that I am financially responsible for any amounts not covered by my health insurance. It is your responsibility to notify us of changes to the above information.

Signature: _____

Date: _____

General Information and Medical History

Patient Name: _____

DOB: _____

Medications you are currently taking - *List dosage*

Prescription Medications: _____

Over the Counter Medications: _____

Supplements: _____

Advanced Directive Living Will Power of Attorney for healthcare

*****If you would like a copy of an advanced directive please ask one of the receptionists for a copy. If you have an advanced directive please supply us with a copy.

Social History: This section is about you the patient and not family members. Please place a mark next to the appropriate items.

Child No History _____

Alcohol No Yes How Much _____ How Often _____
 Caffeine No Yes How Much _____ How Often _____
 Exercise No Yes How Much _____ How Often _____
 Children _____ How many _____
 Drug Use Past History _____ Present No History _____
 Employment Full Time _____ Part Time Retired _____ Disabled Unemployed
 Marital Status Married _____ Divorced Single _____ Widowed Significant Other
 Tobacco Use Chew _____ Cigars Less than 1 PPD _____ Greater than 1 PPD Never smoked
 Previous Smoker Date Stopped _____

Place a check next to items below that pertain to **your** health only!

No Serious Illnesses

	Date Diagnosed		Date Diagnosed		Date Diagnosed
ADHD	_____	Fainting	_____	Rheumatic Fever	_____
Alcoholism	_____	Fatigue/dizziness	_____	Rheumatoid Arthritis	_____
Allergies	_____	Gallbladder	_____	Seizure Disorder	_____
Alzheimer	_____	Glaucoma	_____	Skin Problems	_____
Anemia	_____	Headaches	_____	Stroke	_____
Aneurysm	_____	Heart Disease	_____	Suicide Attempt	_____
Arrhythmia	_____	Heart Murmur	_____	Swelling of the Feet	_____
Arthritis	_____	Hepatitis A	_____	Thyroid Disease	_____
Asthma	_____	Hepatitis B	_____	Ulcers	_____
Birth Defects	_____	Hepatitis C	_____	Varicose Veins	_____
Bleeding Disorders	_____	High Cholesterol	_____	Cancer _____	_____
Breast Cancer	_____	High Blood Pressure	_____		
Cerebral Palsy	_____	HIV/AIDS	_____		
Chest Pain	_____	Irritable Bowel	_____		
Chronic Cough	_____	Kidney Disease	_____		
Chronic Diarrhea	_____	Liver Disease	_____		
Colon Cancer	_____	Low Back Pain	_____		
Constipation	_____	Mental Illness	_____		
Depression	_____	Migraine	_____		
Diabetes	_____	Panic Disorder	_____		
Dizziness	_____	Polio	_____		
Drug Addiction	_____	Renal Disease	_____		

Illnesses not listed :

Please list your surgical history along with dates:

Family History: List medical history about your family members!

Adopted No Family History _____

Father Living: Yes No Age _____ Disease(s): _____

Mother Living: Yes No Age _____ Disease(s): _____

List other family members diagnosed with illnesses below (example brother, sister, aunt, uncle, cousin, grandparents)

Family Member	Family Member	Family Member
ADHD	Fainting	Rheumatic Fever
Alcoholism	Fatigue/dizziness	Rheumatoid Arthritis
Allergies	Gallbladder	Seizure Disorder
Alzheimer	Glaucoma	Skin Problems
Anemia	Headaches	Stroke
Aneurysm	Heart Disease	Suicide Attempt
Arrhythmia	Heart Murmur	Swelling of the Feet
Arthritis	Hepatitis A	Thyroid Disease
Asthma	Hepatitis B	Ulcers
Birth Defects	Hepatitis C	Varicose Veins
Bleeding Disorders	High Cholesterol	Cancer _____
Breast Cancer	High Blood Pressure	
Cerebral Palsy	HIV/AIDS	Illnesses not listed :
Chest Pain	Irritable Bowel	_____
Chronic Cough	Kidney Disease	_____
Chronic Diarrhea	Liver Disease	_____
Colon Cancer	Low Back Pain	_____
Constipation	Mental Illness	_____
Depression	Migraine	_____
Diabetes	Panic Disorder	_____
Dizziness	Polio	_____
Drug Addiction	Renal Disease	_____

Do you have allergies to any medication(s)?

No _____

Yes _____ (please list what you are allergic to below as well as what type of reaction the allergy causes?)

Do you have allergies to food?

No _____

Yes _____ (please list what you are allergic to below as well as what type of reaction the allergy causes?)

**Privacy Notice Acknowledgment and
Patient Communication and Consent**

Date: _____

Pharmacy Name you would like to use and the cross streets:

Patient Name: _____ DOB _____

We must call on occasion to discuss confidential protected health information. Below is a list of ways for us to communicate this information with you. Please check how you would like us to get this information to you:

_____ Okay to call my home and leave a message. Phone Number: _____

_____ Do not call home phone, call only this number (_____) _____ - _____

- Due to the privacy rules ***if you do not*** list anyone below we ***will not*** be able to discuss anything regarding your health with anyone other than you. I give permission to the following individuals listed below to discuss information regarding my health.

- If a ***minor child*** please list who may bring your child to the doctor and make medical decisions in your absence.

Must Sign Below for all information given:

My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Notice of Privacy Practices from Dynamite Creek Medical Center.

Patient Name (please print)

Date

Patient or Person Authorized to Signed

If not patient relationship to patient (parent, legal guardian, personal representative, etc.)

Dynamite Creek Medical Center

Financial Policy

We are dedicated to providing the best possible care and service to you and your family. Your complete understanding of your financial responsibilities is an essential element of care and treatment.

Missed appointments: Our office requires a 24-hour notification if you need to cancel or reschedule an appointment. Failure to contact our office in advance prohibits our provider's from treating other patients who are in need of care, creating a hardship on the practice. Consequently, you may be charged a no-show fee of \$50. Continued no-show appointments will result in a practice discharge.

Covered and Non-covered Services: Patients with medical insurance plans are asked to pay their co-payment, co-insurance, deductibles or any non-covered services at the time of their visit. As a courtesy, we will file your insurance claim for you. If the insurance does not pay the physician in a reasonable length of time, we will have to look to you for payment. Patients are expected to know the benefits provided by their insurance company. Please contact your insurance company to review your benefits for preventive care, routine immunizations and employment or Department of Transportation physicals prior to making an appointment. You will be responsible for all non-covered services provided to you and your family. Services for your care and treatment that are not paid by an insurance plan will be billed to you. You are responsible for all charges regardless of insurance coverage. You agree to pay your account with this office in accordance with the standard rates and payment terms of this office. If it is deemed necessary, in the sole discretion of this office, to refer your account to a collection agency as a result of nonpayment, you agree to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%. Such contingency fee is to be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

Change in Insurance Plan: You are expected to notify our office if your insurance coverage changes. Our office will periodically ask you to update your records. You will be expected to provide full and complete information to our office in order to bill the correct insurance company.

Minor patients: For all services rendered to minor patients a consent form will be required before we can treat a child in the absence of the parent or guardian. In addition, we will look to the parent or guardian with custody for payment of services.

Payment Method: For your convenience, we accept Visa/Mastercard/Discover/American Express, in addition to cash or check. Any returned check will constitute a \$25 fee.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient or Responsible Party if a minor

Date

Printed Name of Patient (or Minor)

Date

IMPORTANT INFORMATION FOR OUR VALUED PATIENTS

To serve you better and more efficiently, we need your understanding and cooperation on the following:

Treatments and prescriptions:

Treatment for illnesses and prescriptions will not be done over the phone. Requests for prescriptions are handled during regular office hours. If you need to obtain a prescription refill, please call your pharmacy and have them fax a refill request to us at 480-342-7077. They will contact our office for authorization. Please allow at least 72 hours to complete your refill.

Lab, X-rays Results:

Please do not call us for your x-ray or lab results for at least 5 business days after you have had the test. If after the 5 business days you have not heard from us then call us to get the results. We make every effort to get them to you within this time frame.

Referrals: Many managed care plans require a written referral or prior authorization for visits to specialists, X-rays, lab procedures or other medical care outside our office. Our referral department can help you with the requirements of your plan. Please allow 10 working days for the completion of this process. Our referral department may be reached at 480-342-8711.

After Hour calls:

Please do not call during non business hours which are prior to 8 a.m. and after 5 p.m. for routine issues, medication refills or treatment questions. If you are ill and feel you need to be seen during non-business hours you can call our extended hours located at Saguaro Family Practice, 18404 N. Tatum Blvd., #101, Phoenix AZ. The phone number is 602-992-1900. When you call extended hours inform them that you are a patient at Dynamite Creek Medical Center. They are open Monday-Friday from 5:30pm-9:30pm and Saturdays from 8am-4pm. Saguaro Family Practice extended hours is **NOT** a walk-in clinic. You must call and schedule an appointment. If you are having an emergency you will need to go to the closest emergency room or if life threatening call 911. If you have an emergent need to speak with a doctor, the answering service will page the on-call doctor and give them your phone number to return the call.

NOTICE TO OUR PATIENTS

In order to comply with accepted guidelines of the Arizona Board of Medical Examiners and the Federal Drug Enforcement Agency, Dynamite Creek Medical Center will operate under the following policy regarding the prescribing of narcotics analgesic (pain relieving medication):

1. If a patient is seen at our extended care hours facility or emergency room and are prescribed narcotic pain medications, all future refills if needed must be obtained by your primary care doctor or specialist. A follow up appointment will need to be scheduled.
2. Patients of Dynamite Creek Medical Center who require chronic pain medications must schedule an appointment for all refills. Narcotics will not be filled on weekends and holidays.

