DEMOGRAPHICS

HOW DID YOU HEAR ABOUT US? _____ FAMILY DOCTOR: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #:_____

SEX: M F MARITAL STATUS: S M D W RACE: _____ ETHNICITY: _____

PHONE #:_____ WORK#_____ CELL #:_____

DO YOU GIVE CONSENT FOR AUTOMATED PHONE CALLS? _____ CONSENT FOR TEXT MESSAGES? _____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

EMAIL ADDRESS: _____

CONTACT PREFERENCE:☐HOME PHONE/☐CELL PHONE/☐ WORK PHONE/ ☐EMAIL

EMERGENCY CONTACT: _____ PHONE#:_____

GUARANTOR NAME(IF PATIENT IS MINOR): _____ PHONE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CARRIER: _____ ID#:_____
POLICY HOLDERS NAME: _____ GROUP#:_____
POLICY HOLDERS DOB: _____ SS#_____
RELATIONSHIP TO POLICY HOLDER: _____

SECONDARY INSURANCE INFORMATION

INSURANCE CARRIER: _____ ID#:_____
POLICY HOLDERS NAME: _____ GROUP#:_____
POLICY HOLDERS DOB: _____ SS#_____
RELATIONSHIP TO POLICY HOLDER: _____

INDUSTRIAL INSURANCE INFORMATION

NAME OF INDUSTRIAL CARRIER: _____
CONTACT PERSON: _____ PHONE#:_____
FAX #: _____CLAIM#:_____
DATE OF INJURY: _____ STATE INJURY OCCURRED IN: _____

PERSONAL INJURY/ AUTO ACCIDENT INSURANCE INFORMATION

INSURANCE CARRIER: _____ CLAIM#:_____
RESPONSIBLE PARTY NAME: _____ DATE OF INJURY: _____
STATE INJURY OCCURRED IN: _____

ATTORNEY INFORMATION
NAME: _____ LAW FIRM: _____
PHONE: _____ FAX: _____

_____ _____

Patient Signature (Patient's Parent/Guardian if under 18) Date

HEALTH HISTORY

CURRENT PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PATIENT INFORMATION

PATIENT'S NAME: _____ DOB: _____ AGE: _____

PREFERRED PHARMACY (PHONE & CROSS STREETS):_____

HISTORY OF CHIEF COMPLAINT

WHAT BODY PART ARE YOU SEEING THE DOCTOR FOR TODAY? ☐RIGHT ☐LEFT _____

WHAT ARE YOUR SYMPTOMS? ☐PAIN ☐STIFFNESS ☐WEAKNESS ☐NUMBNESS ☐OTHER: _____

HOW DID IT START? _____

WHEN DID IT START? _____ WORK RELATED? ☐YES ☐NO AUTO ACCIDENT? ☐YES ☐NO

HOW SEVERE IS IT? ☐MILD ☐MODERATE ☐SEVERE PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10

WHAT CAUSES SYMPTOMS TO WORSEN? _____

_____

WHAT HELPS TO RELIEVE THE SYMPTOMS? _____

_____

HAVE YOU HAD SIMILAR PROBLEMS IN THIS AREA BEFORE? ☐ YES ☐NO IF YES, DESCRIBE: _____

_____

HAVE YOU HAD PREVIOUS SURGERY IN THIS AREA? ☐YES ☐NO IF YES, DESCRIBE: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. (INCLUDE OVER THE COUNTER MEDICATIONS)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

ARE YOU ALLERGIC TO ANY MEDICATIONS: ☐YES ☐NO IF YES, PLEASE LIST: _____

_____

PAST MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No		Yes	No
ANXIETY DISORDER	☐	☐	GOUT	☐	☐	LUNG DISEASE	☐	☐	SEIZURES/EPILEPSY	☐	☐
ARTHRITIS	☐	☐	HEART ATTACK	☐	☐	MIGRAINES	☐	☐	STROKE	☐	☐
BLEEDING DISORDER	☐	☐	HEPATITIS	☐	☐	OSTEOPOROSIS	☐	☐	TUBERCULOSIS	☐	☐
BLOOD CLOTS	☐	☐	HIV/AIDS	☐	☐	PACEMAKER	☐	☐	ULCERS	☐	☐
HEART DISEASE	☐	☐	HYPERTENSION	☐	☐	LIVER DISEASE	☐	☐	DIABETES(TYPE 1/TYPE 2)	☐	☐
DEPRESSION	☐	☐	KIDNEY DISEASE	☐	☐	SLEEP APNEA	☐	☐	THYROID PROBLEMS	☐	☐
PULMONARY EMBOLISM	☐	☐	RHEUMATOID ARTHRITIS				☐	☐			

CANCER ☐ ☐ .....IF YES, TYPE? BREAST ☐ THYROID☐ LUNG☐ PROSTATE☐ KIDNEY☐ MELANOMA☐

OTHER MEDICAL CONDITIONS*(please list)*:

SURGICAL HISTORY ☐NO SURGICAL HISTORY

	YES	YEAR		YES	YEAR		YES	YEAR
KNEE REPLACEMENT	☐	_____	BACK SURGERY*	☐	_____	PLASTIC SURGERY*	☐	_____
HIP REPLACEMENT	☐	_____	FRACTURE SURGERY*	☐	_____	HEART SURGERY*	☐	_____
SHOULDER REPLACEMENT	☐	_____	KNEE ARTHROSCOPY	☐	_____	HYSTERECTOMY(partial/full)	☐	_____
ROTATOR CUFF REPAIR	☐	_____	SHOULDER ARTHROSCOPY	☐	_____	AMPUTATION*	☐	_____
CARPAL TUNNEL RELEASE	☐	_____	ELBOW ARTHROSCOPY	☐	_____	OTHER*	☐	_____

*PLEASE SPECIFY:_____

_____

FAMILY HISTORY (M=MOTHER, F=FATHER)

	M	F		M	F		M	F		M	F
ARTHRITIS	☐	☐	ASTHMA	☐	☐	BLOOD COAGULATION DISORDER	☐	☐	DIABETES TYPE 1	☐	☐
DISORDER OF BACK	☐	☐	MUSCULOSKELETAL DISEASE	☐	☐	HEART DISEASE	☐	☐	DIABETES TYPE 2.....	☐	☐
HIGH BLOOD PRESSURE	☐	☐	CANCER	☐	☐	HEART ATTACK	☐	☐	OSETOARTHRITIS	☐	☐
OSTEOPROSIS	☐	☐	PULMONARY EMBOLISM	☐	☐	RHEUMATOID ARTHRITIS	☐	☐	HIGH CHOLESTEROL	☐	☐

☐**ADOPTED**

SOCIAL HISTORY (MUST BE COMPLETED FOR ALL PATIENTS)

MARTIAL STATUS ☐SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

HAVE YOU EVER USED **TOBACCO**? ☐ YES ☐ NO ☐ CURRENT USE ☐ PAST USE {QUIT ___YEARS AGO}

IF SO, WHICH TYPE(S)? ☐ CIGARETTES ☐ CIGARS ☐ PIPES ☐ CHEWING TOBACCO ☐E-CIGATETTES/VAPOR

HOW MUCH PER DAY? _____ FOR HOW MANY YEARS? _____

DO YOU CONSUME **ALCOHOL**? ☐ YES ☐ NO HOW OFTEN? ☐ OCCASIONALLY ☐ MODERATELY ☐ HEAVY

DO YOU CONSUME **CAFFEINE**? ☐ YES ☐ NO HOW OFTEN? ☐OCCASIONALLY ☐MODERATELY ☐HEAVY

DO YOU **EXERCISE**? ☐ YES ☐ NO HOW OFTEN? ☐OCCASIONALLY ☐MODERATELY ☐HEAVY

DO YOU USE **RECREATIONAL DRUGS**? ☐ YES ☐ NO

REVIEW OF SYSTEMS {CHECK ONLY IF YOU NOW HAVE OR RECENTLY HAD}

CONSTITUTIONAL

FEVER..... ☐ YES ☐ NO

NIGHT SWEATS..... ☐ YES ☐ NO

SIGNIFICANT WEIGHT GAIN (__LBS)

SIGNIFICANT WEIGHT LOSS (__LBS)

EYES

DRY EYES..... ☐ YES ☐ NO

IRRITATION..... ☐ YES ☐ NO

VISION CHANGE..... ☐ YES ☐ NO

EARS

DIFFICULTY HEARING..... ☐ YES ☐ NO

EAR PAIN..... ☐ YES ☐ NO

NOSE

FREQUENT NOSE BLEEDS..... ☐ YES ☐ NO

NOSE/SINUS PROBLEMS..... ☐ YES ☐ NO

MOUTH/THROAT

SORE THROAT..... ☐ YES ☐ NO

BLEEDING GUMS..... ☐ YES ☐ NO

SNORING..... ☐ YES ☐ NO

DRY MOUTH..... ☐ YES ☐ NO

MOUTH ULCERS..... ☐ YES ☐ NO

ORAL ABNOMALITIES..... ☐ YES ☐ NO

TEETH PROBLEMS..... ☐ YES ☐ NO

CARDIOVASCULAR

CHEST PAIN..... ☐ YES ☐ NO

ARM PAIN ON EXERTION..... ☐ YES ☐ NO

SHORTNESS OF BREATH WHEN WALKING

☐ YES ☐ NO

SHORTNESS OF BREATH WHEN LYING DOWN

☐ YES ☐ NO

PALPITATIONS..... ☐ YES ☐ NO

KNOWN HEART MURMUR..... ☐ YES ☐ NO

LIGHT HEADED ON STANDING ☐ YES ☐ NO

SKIN

ABNORMAL MOLE..... ☐ YES ☐ NO

JAUNDICE..... ☐ YES ☐ NO

RASH..... ☐ YES ☐ NO

DRY SKIN..... ☐ YES ☐ NO

RESPIRATORY

COUGH..... ☐ YES ☐ NO

WHEEZING..... ☐ YES ☐ NO

SHORTNESS OF BREATH..... ☐ YES ☐ NO

COUGHING UP BLOOD..... ☐ YES ☐ NO

SLEEP APNEA..... ☐ YES ☐ NO

GASTROINTESTINAL

ABDOMINAL PAIN..... ☐ YES ☐ NO

VOMITING..... ☐ YES ☐ NO

NORMAL APPETITE..... ☐ YES ☐ NO

FREQUENT DIARRHEA..... ☐ YES ☐ NO

VOMITING BLOOD..... ☐ YES ☐ NO

GERD..... ☐ YES ☐ NO

BLACK/TARRY STOOL..... ☐ YES ☐ NO

GENITOURINARY

DIFFICULTY URINATING..... ☐ YES ☐ NO

HEMATURIA(BLOOD IN URINE)..... ☐ YES ☐ NO

INCREASED URINARY FREQUENCY. ☐ YES ☐ NO

LOSS OF URINARY CONTROL..... ☐ YES ☐ NO

INCOMPLETE EMPTYING..... ☐ YES ☐ NO

WOMEN ONLY

NORMAL MENSTRAL PERIODS ..... ☐ YES ☐ NO

DATE OF LAST MENSTRAL PERIOD _____

MUSCULOSKELETAL

MUSCLES ACHES..... ☐ YES ☐ NO

MUSCLE WEAKNESS..... ☐ YES ☐ NO

JOINT PAIN..... ☐ YES ☐ NO

BACK PAIN..... ☐ YES ☐ NO

SWELLING IN EXTREMITIES..... ☐ YES ☐ NO

NEUROLOGIC

LOSS OF CONSCIOUSNESS..... ☐ YES ☐ NO

WEAKNESS..... ☐ YES ☐ NO

NUMBNESS..... ☐ YES ☐ NO

SEIZURES..... ☐ YES ☐ NO

DIZZINESS..... ☐ YES ☐ NO

FREQUENT HEADACHES..... ☐ YES ☐ NO

MIGRAINES..... ☐ YES ☐ NO

RESTLESS LEGS..... ☐ YES ☐ NO

PSYCHIATRIC

DEPRESSION..... ☐ YES ☐ NO

SLEEP DISTURBANCES..... ☐ YES ☐ NO

FEELING SAFE IN RELATIONSHIP☐ YES ☐ NO

ALCOHOL ABUSE..... ☐ YES ☐ NO

ENDOCRINE

FATIGUE..... ☐ YES ☐ NO

INCREASED THIRST..... ☐ YES ☐ NO

HAIR LOSS..... ☐ YES ☐ NO

INCREASED HAIR GROWTH..... ☐ YES ☐ NO

COLD INTOLERANCE..... ☐ YES ☐ NO

HEMATOLOGIC/LYMPHATIC

SWOLLEN GLANDS..... ☐ YES ☐ NO

EASY BRUISING..... ☐ YES ☐ NO

EXCESSIVE BLEEDING..... ☐ YES ☐ NO

IMMUNOLOGIC

RUNNY NOSE..... ☐ YES ☐ NO

SINUS PRESSURE..... ☐ YES ☐ NO

ITCHING..... ☐ YES ☐ NO

HIVES..... ☐ YES ☐ NO

FREQUENT SNEEZING..... ☐ YES ☐ NO

PRESCRIPTION POLICY

The office staff will gladly take your requests and help you as much as possible. Please remember not to wait until you are out of medication before you call as we may require time to get approval for the prescription. The **office staff cannot write or approve** any refills. Please note that **lost**, **stolen**, **miss placed** and **accidental loss** of medications **will not** be replaced. Medications prescribed by our office can only be refilled (if applicable) after the appropriate time frame has passed. **Prescription history will be monitored using the Arizona State Board of Pharmacy and via Surescripts.** Please review the following guidelines our office uses for medication, effective 3/01/19.

- The maximum single dose of Oxycodone is 10 mg.
- The maximum duration of opioid treatment after surgery, a fracture, or a significant injury will be 14 days, although some insurance plans limit this to 5 or 7 days. The typical unit dose will be Oxycodone 5 mg or Norco 5/325 unless there are extenuating circumstances which support the need for a higher dose, but never above 10 mg Oxycodone or Norco 10/325. Patients requiring dosages above these limits or beyond the 14 day duration will be automatically referred to a Pain Medicine Specialist to take over this aspect of care, as this office is not designed to practice Pain Management.
- No benzodiazepines or Soma can be administered with an opioid medication. This includes Ambien, Klonopin, Valium, etc.
- Adderall **will not** be prescribed.
- Dilaudid, Demerol, or Morphine **will not** be prescribed.
- Extended release opioids, such as Oxycontin and MS Contin, **will not** be prescribed.

Please forgive any inconvenience for those taking more medication than is now permissible, but the above guidelines are necessary to be in compliance with State and Federal guidelines.
We will refer anyone needing it to a Pain Clinic to continue this aspect of their care.

Please apply your signature below to signify your understanding and compliance with these guidelines. Failure to sign will disqualify you from being seen in this office.

_____ _____

Patient Signature (Patient's Parent/Guardian if under 18) Date

FINANCIAL POLICY/ ASSIGNMENT OF BENEFITS/ RELEASE OF BILLING INFORMATION

- I understand that I have medical insurance which when billed on my behalf should pay for their portion of my office visits and treatment charges.
- I will inform Scott J. Ellis, MD of a change in my insurance coverage. If I fail to provide changes of my insurance, I will be liable for services rendered but not covered.
- I understand the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my contract.
- I understand that it is my responsibility to pay all co-pay, deductible and co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company.
- I understand that if for any reason my insurance company does not pay for the covered services within 90 days of the services provided, I shall assume responsibility for the total amount owed.
- I thereby assign all medical benefits directly to Scott J. Ellis, MD for services rendered at his facilities.
- I understand I may request a copy of this document.

I hereby authorize Scott J. Ellis, MD to release any information required in the course of my examination(s) and/or treatments(s) to my insurance company or referring physician's office. I authorize this office, if indicated; to file claims directly to my insurance companies and that payment for services rendered is made directly to the physician.

A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

_____ _____

Patient Signature (Patient's Parent/Guardian if under 18) Date

PRIVACY PRACTICE

This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review it carefully.
We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information that will be described in this notice

Ways in Which We May and Disclose Your Protected Health Information

The following describes the different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways are permitted to use and disclose your health information fall within one of these categories.

- **Treatment**: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician that we have requested to be involved in your care. For example- we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.
- **Payment:** We will use and disclose your protected health information to obtain payment for the health care services we provide to you. For example- we may include information with a bill to a third party payer that identifies you, you diagnosis, procedures performed, and supplies used in rendering the service.
- **Health Care Operations**: We will use and disclose your protected health information to support the business activity of our practice. For example- we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting or transcription services.
- **Appointment reminders**: We will use and disclose your protected health information to contact you as a reminder about your scheduled appointments.
- **Treatment Alternatives:** We will use and disclose your protected health information to alternative treatments that may be of interest to you.
- **Others Involved in Your Care**: We will use and disclose your protected health information to a family member, close friend, or any person you identify as being involved in your medical care or payment for care.
- **Research:** We will use and disclose your health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist or request a copy to be mailed to you.

Inspect and Copy: You have the right to inspect and copy the protected health information that we have maintained about you in our designated record. This designated record set includes your medical and billing records, as well as any other records that we use for making decisions about you. Any psychotherapy notes that may have been included in our records will not be available for inspection or copy by law. We may charge a fee for the cost of copying, mailing, or any supplies used to fulfill your request. If you wish to inspect or copy your medical information, please submit in writing your request to our office. We will have 30 days to respond to your request; if the information requested is stored off-site, we are allowed up to 60 days to complete such request.

Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must submit a request in writing, to our practice, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We are permitted to deny your request if reason to support request is not submitted; the information was not created by us (or the person who created it is no longer available to make amendment); information was part of record which you were not permitted to inspect and copy; information is not part of record kept by this practice; or if the information is accurate and correct.

Request Restrictions: You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. For example- you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your payment for care. Your request must be submitted in writing to our office. We are not required to agree to your request if we feel that it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures: You have the right to request a list of disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be submitted in writing and state the time period for the requested information. You may not request any information prior to April 14, 2003 (the compliance date for the federal regulations) nor for a period of greater than six years (our legal obligations to retain information).

Confidential Communications: You have the right to request how we communicate with you to preserve your privacy. For example- you may request that we only call you at your work number, or only mail to a specific address. Your request must be submitted in writing and specify how/where we are to contact you.

File a Complaint: If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice, or directly to the Secretary of Health and Human Services. To file a complaint, you must submit in writing within 180 days of suspected violation to our practice. Please provide as much detail as you can about the suspected violation. You should know there will be no retaliation for filing a complaint.

_____ _____

Patient Signature (Patient's Parent/Guardian if under 18) Date