GILBERT INTERNAL MEDICINE

Patient Name:____

Birth Date:______________ **Sex: M**____ **F**_____ **SS#**____________________

Address____

City/State/Zip____

Phone #(___)__________________ **Cell#(___)**____________________

Email____________________**Okay to leave detailed test results on voicemail? Yes/No**

May we leave a detailed messages with someone other than you?

Name:______________________________Relationship:__________

Phone:______________________________

Employer______________________________**Address**______________
City________________**State**______**Zip**__________**Phone#(___)**__________

Spouse's Name______________________________**SS#**____________
Birth Date____________________**Employer**______________________
Employer Address__________________________**Phone#(____)**________

Primary Insurance Carrier____________________________________
Policy Holder Name__________________________**Birth Date**__________
Employer____
Group#____________________**Policy or ID #**______________________
Medical Claims Address (back of card)_________________________

Secondary Insurance Co______________________________________
Policy Holder Name__________________________**Birth Date**__________
Employer____
Group#____________________**Policy or ID #**______________________
Medical Claims Address (back of card)_________________________

Emergency Contact (not living with you)______________________
Phone #(____)______________**Address**__________________________
City______________________________**State**__________**Zip**________

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with Gilbert Internal Medicine in accordance with the regular rates and payment terms of this office. If my account is referred for collection, I agree to pay reasonable collection expenses including attorney's fees. In the event that I am entitled to health insurance or other benefits relating to my medical condition and it is available to cover the costs of treatment provided by this office, I hereby assign those benefits to Gilbert Internal Medicine to be applied to my bill. Gilbert Internal Medicine may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges.

______________________________________ ________________

Patient/Parent/Guardian Signature **Date**

Patient's Name:__________________________**Date of Birth:**_____________

Past Medical History

__Deep Venous Thrombosis __Kidney Problems/Stones __Valley Fever __Epilepsy
__Mitral Valve Prolapse __Rheumatic Fever __Allergies __Peptic Ulcer
__Tuberculosis/+Skin Test __Asthma/Emphysema __Diabetes __Stroke
__Rheumatoid Arthritis __Degenerative Arthritis __Osteoporosis __Migraine
__Thyroid Problems __High Cholesterol __Menopause/ERT
__Chicken Pox __High Blood Pressure __Prostate Problems
__Hepatitis/Liver Problems __Cancer______________ __Other________________________

Past Surgical History

___Tonsillectomy ___Appendectomy ___Gallbladder
___Knee/Shoulder/Hip Surgery ___Thyroid Surgery ___Hysterectomy/BSO
___Breast Surgery/Biopsy ___Prostate Surgery ___Vasectomy
___Heart Bypass ___Cataract ( )R ( )L ___Hernia
___Back Surgery ___C-Section ___Gastric Bypass
___Other______________________ ___Other__________________Other________________

Drug Allergies & Reaction

_________________________ _________________________ __________________
_________________________ _________________________ __________________
_________________________ _________________________ __________________

Immunizations & Year Given

___Tetanus __________ ___Influenza (within last year) ___Hepatitis B ____________
___Pneumovax _________ ___Chicken Pox Vaccine ________ ___Other_________________

Social History

Occupation:____________________ Marital Status: ___Single ___Married ___Widowed ___Divorced

Tobacco __Now __Never __In the Past (Amount____________) Year Quit________Age Started___
Alcohol __Never __Rare __Occasional __Moderate __Heavy Amount/type per day___________

Family History

	Major Medical Problems	Age of Death	Cause of Death
Father	____________________	_________	____________________
Mother	____________________	_________	____________________
Brothers #___	____________________	_________	____________________
Sisters #___	____________________	_________	____________________
Children #___	____________________	_________	____________________

Family History of: ___Breast Cancer ___Colon Cancer ___Diabetes ___High Blood Pressure __Early Heart Attack

Preventative Medicine

Last Pap (month/year)_____/_____ Last Mammogram_____/_____ Last Protoscopic Exam_____/_____

Systems Review
Patient Name:__________________________**DOB:**______________________**Today's Date**________

Indicate by circling "Yes" or "No" to any symptoms you have had in RECENT months.
Circle the symptoms you have had when multiple symptoms are listed.

1. Skin rash, sore, excessive bruising or change of a mole?	Y	N	____________
2. Excessive thirst or urination?	Y	N	____________
3. Change in sexual drive or performance?	Y	N	____________
4. Significant headaches, slurred speech, difficulty moving or numbness in arm or leg?	Y	N	____________
5. Eye problems such as double/blurred vision, cataracts/glaucoma?	Y	N	____________
6. Diminished hearing, dizziness, hoarseness or sinus problem?	Y	N	____________
7. Nosebleeds, ringing in ears?	Y	N	____________
8. Cough, shortness of breath, wheezing or asthma?	Y	N	____________
9. Coughing up sputum or blood?	Y	N	____________
10. Exposed to anyone with tuberculosis?	Y	N	____________
11. "Blacked out", lost consciousness or had a seizure?	Y	N	____________
12. Chest pain/pressure, rapid/irregular heartbeat, valve problem?	Y	N	____________
13. Awakening at night short of breath?	Y	N	____________
14. Abnormal swelling in the legs or feet?	Y	N	____________
15. Pain in the calves of your legs when you walk?	Y	N	____________
16. Difficulty swallowing, heartburn, nausea, vomiting, bloating?	Y	N	____________
17. Significant constipation/diarrhea, blood or changes in bowels?	Y	N	____________
18. Past history of yellow jaundice or colon polyps?	Y	N	____________
19. Difficulty starting urination, emptying bladder or losing urine?	Y	N	____________
20. Burning, pain or blood when urinating?	Y	N	____________
21. Pain, stiffness or swelling in back, joints, muscles?	Y	N	____________
22. Hot flashes or night sweats?	Y	N	____________
23. Enlarged glands (lymph nodes)?	Y	N	____________
24. Do you feel you are at risk for HIV or AIDS?	Y	N	____________
25. History or anemia, elevated cholesterol or blood sugar?	Y	N	____________
26. Experiencing a stressful situation or depressed mood?	Y	N	____________
27. Weight gain or loss of 10 pounds during last 6 months?	Y	N	____________
28. Problems falling asleep, sleep apnea or disruptive snoring?	Y	N	____________
29. Abnormal nipple discharge or breast lump?	Y	N	____________
30. Have you felt a need to cut down on alcohol consumption?	Y	N	____________
31. Do relatives/friends worry/complain about your alcohol consumption?	Y	N	____________
32. Have you been physically, sexually or emotionally abused?	Y	N	____________

For Female Patients Only

33. Have you ever had an abnormal Pap Smear?	Y	N	____________
34. Have you experienced menopause or had a hysterectomy?	Y	N	____________
If "no": are you concerned about your periods?	Y	N	____________
Might you be pregnant at this time?	Y	N	____________
Date of onset of your last period _______________			

35. Number of: Pregnancies_____ Live births____ Miscarriages/Abortions____

Gilbert Internal Medicine
3420 S. Mercy Rd. Suite 101
Gilbert, AZ 85297
480-899-4420 Fax: 480-219-3214

POLICIES

A $40.00 fee will be assessed for any no show appointment. A no show visit is a missed scheduled visit. Same day cancellations are allowed with no fee as long as the cancellation is made **BEFORE** the appointment time. **Initials** ______

Prescription refills can take up to **48 HOURS** for our office to process them. Please plan accordingly. Do not wait for your prescriptions to run out before calling our office. Certain controlled substances require appointments for refills. Lost, stolen, misplaced or miswritten controlled substance prescriptions **absolutely CANNOT** be replaced.

Initials______

Co-pays are due at check-in. If your co-pay is not paid at check-in, our office will charge you for a **$10 service charge in addition** to your co-pay amount.

Initials______

A charge of $**75.00** for any letters that are requested by the patient for purposes including, but not limited to: **insurance claims, letters to a lawyer regarding a law suit, or extensive chart reviews for disability/social security claims.**
Sick letters for work/school, return to work/school letters, public service letters (ie. jury duty), and release of information to other offices **ARE NOT subject to this fee**.

Initials______

I have received a copy of GIM, L.L.C. 'Notice of Privacy Practices.' This notice describes how GIM, L.L.C. may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

______________________________ ______________
(Signature of patient or personal representative) (Date)

MEDICATION LIST

**** Please list all your current medications (either prescribed or over the counter) and the prescribing doctor****

Date:____________________

Patient Name:______________________________ D.O.B:_______________________

Preferred Pharmacy Name: __________________________ Pharmacy Location:_______________________

Pharmacy Phone #: ________________________________

Name of Medication	Dose	Directions	Prescribing Dr. or OTC

(Office Use Only)

Date Entered:________________________________ Completed By:____________________________

GILBERT INTERNAL MEDICINE

3420 S. MERCY RD. SUITE 101
GILBERT, AZ 85297
480-899-4420(PHONE) 480-219-3214(FAX)

Medical Records Release Authorization: I certify the below request is accurate and hereby authorize the release of these records. I understand this may include information relating to acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) infection, and behavioral health services/psychiatric care of treatment for alcohol and drug abuse.
As a patient, my right to healthcare treatment in not conditioned on this authorization. If the person of faculty receiving this information is not a healthcare or insurance provider covered by privacy regulations, this information stated above could be re-disclosed.

Patient: ______________________________ DOB: ______________

Address: ______________________________ Phone:______________

Records Requested:

__ Progress Notes
__ Labs
__ Imaging
__ Consult Notes
__ ALL

I, the undersigned, do herby authorize and direct you to:

__ Furnish records **TO** Gilbert Internal Medline
__ Release records **FROM** Gilbert internal Medicine

1. Provider: ____

Address: ____

City /State______________ Phone: ____________ Fax: ____________

2. Provider: ____

Address: ____

City /State______________ Phone: ____________ Fax: ____________

Records are to be received by: Mail _______ Fax _______ Pick-up _______
(*If all records are requested, a PDF disc will be issued*)

Signature of Patient: ______________________________ Date: ______________