DIVINE GRACE
FAMILY PRACTICE

Address: 4494 W. Peoria Ave #115A
Suite 6 Glendale, AZ 85302
Email: sharonj@divinegracefamilypractice.com
Cellphone: 602-621-7561 Office: **602-428-7666**

DEMOGRAPHIC INFORMATION

Patient Name: _____DOB___/___/___Age_____

Address: _____SS#:___/___/____

Secondary address: _____

Home Phone Number: _____Cell:_____

Email Address: _____

Marital status: M/D/W/S Emergency contact: _____

Phone: _____Relationship: _____

Pharmacy name: _____Location: _____

INSURANCE INFORMATION (Self- pay patients please skip this section)

Primary: _____Secondary_____

ID#: _____ID#: _____

Are you the policy holder? Y/N

Relationship to patient: self/spouse/ child/parent

Name of policy holder: _____DOB:___/___/___

Effective date:___/___/___Place of employment:_____

CONSENT TO TREATMENT

1. I hereby voluntarily consent to outpatient care at Divine Grace Family Practice encompassing routine diagnostic procedures, examinations and medical treatments. I consent to the performance of those tests and treatments by Divine Grace Family Practice provider assistants as is necessary in the medical provider's judgment.

I understand that this consent form will be valid and remain in effect until the time that I no longer require Services from Divine Grace Family Practice

_____ ___/___/___
Patient/Guardian Signature Date

Do you have a living will? Yes/No
Do you have a Durable Power of Attorney for medical care? Yes/No

*Notice of Privacy Practices

I acknowledge that I have been given a copy of Divine Grace Family Practice. This notice explains to me how Divine Grace Family Practice has set policies in place to protect my personal medical information and the restrictions on the use and disclosure of my healthcare information and the rights that I have regarding my protected health information.

_____ ___/___/___
Patient/guardian signature

*Release of Medical information and assignment of benefits****required****

I authorize Divine Grace Family Practice to release my medical records when requested by my insurance company for the purpose of processing my claims. I understand that the filing of claims by Divine Grace Family Practice is done as a courtesy and does not in any way guarantee payment by my insurance company. I understand that I am fully responsible for these charges when/if my insurance company does not pay.

_____ ___/___/___
Patient/Guardian signature Date

*Cancellation Policy

I acknowledge that Divine Grace Family Practice will charge me a $30.00 non-cancellation fee for all missed appointments that are not cancelled at least 24 hours in advance.

_____ ___/___/___
Patient/guardian signature Date

*Medication refill policy

I acknowledge that I am responsible to request medication refills prior to running out of my medications. I acknowledge that refill requests should first be made through my pharmacy so that the pharmacy can contact Divine Grace Family Practice to obtain refills. I acknowledge that the turn- around time for refills are 2448 hours of initial request. (certain medications require prior-authorization and take longer to process pending insurance approval.) * Controlled substances such as narcotics require office visits in order to be refilled. I acknowledge that new medications will not be prescribed over the phone and require an office visit.

_____ ___/___/___
Patient/Guardian signature Date

REASON FOR VISIT/CHIEF COMPLAINT

Please let us know why you are here today.

_____

PAST MEDICAL HISTORY have you had/have the following conditions (please circle all that apply to you).

1. High Cholesterol Yes/ No
2. Heart Attack Yes/ No if yes, who is your cardiologist: _____.
3. Heart Disease Yes/ No
4. High Blood Pressure Yes/ No
5. A-Fib or Arrhythmia Yes/ No
6. Pacemaker Yes/ No if yes, which brand is your pacemaker: _____.
7. Diabetes/Hypoglycemia Yes/ No
8. . Kidney Disease Yes/ No

   Dialysis patient? Yes/ No if yes, which dialysis center:_____.
9. Thyroid disorder Yes/No
10. Stroke/TIA Yes/No if yes, when was your event: _____.
11. Blood Clots Yes/ No if yes, where was the clot/clots: _____
12. Asthma Yes/ No
13. C.O.P.D. Yes/ No
14. Lung disease Yes/ No
15. Migraine/headaches Yes/ No
16. Spine or disk problems Yes/ No
17. Osteoporosis Yes/ No
18. Arthritis Yes/No if yes, which part of your body is effected: _____
19. Anxiety/Depression Yes/No
20. Cancer /Tumor Yes/ No if yes, which type_____
21. GERD Yes/No
22. Allergies (sinus/skin) Yes/No
23. Hepatitis Yes/No if yes, which type: _____
24. Uterine/Ovary issues Yes/No if yes, which problem: _____
25. Hormonal Imbalance Yes/No
26. Sleep Apnea Yes/No

PAST SURGICAL HISTORY (please circle all surgeries that you have had)

Heart Bypass Surgery Yes/No if yes, what year: _____
Coronary Angiogram/stenting Yes/No
Cancer /Biopsy Yes/No if yes, what type of surgery: _____
Hysterectomy Yes/No
Orthopedic Surgery Yes/No if yes, what type of surgery: _____
Tonsils Yes/No
Thyroid Yes/No
Other: _____ _____

FAMILY HISTORY (please indicate who had this condition)

Heart Disease: father/mother/grandparent/sibling
MI before 50yrs old: father/ mother/ grandparent/ sibling
Stroke: father/ mother/grandparent/ sibling
Diabetes: father/ mother/ grandparent/ sibling
Breast Cancer: father/ mother/ grandparent/ sibling
Prostate Cancer: father/ mother/ grandparent/ sibling
Skin Cancer: father/ mother/ grandparent/ sibling
Osteoarthritis: father/ mother/ grandparent/ sibling Asthma: father/ mother/ grandparent/ sibling

SOCIAL HISTORY

Do you currently smoke? Yes/ No if yes, how many per day: ___x how many yrs.___ Are you a former smoker? Yes/No if yes, how long did you smoke?_____
Do you chew tobacco? Yes/ No
Do you live with a smoker? Yes/No
Do you drink alcohol? Yes/No if yes, how much? ___daily ___weekly___ monthly Are you a recovering alcoholic? Yes/No

RECREATIONAL DRUG USE

Marijuana currently/past
Stimulants (speed, etc.) currently/past
Inhalants currently/past
Methamphetamine currently/past
IV Drugs (heroin etc.) currently/past

DO YOU HAVE ANY DRUG ALLERGIES? YES/NO If yes, please list them

_____
_____
_____

CURRENT MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY

(Please feel free to attach your own current list of medications)

REVIEW OF SYSTEMS

1. Headaches, dizziness, lightheadedness Yes/No
2. Sudden changes in vision Yes/No
3. Weak, numb, or inability to talk Yes/No
4. Neck pain, swollen glands or lymph node Yes/No
5. Chest pain, shortness of breath, wheezing Yes/No
6. Chronic or recurrent cough Yes/No
7. Heartburn, stomach or abdominal pain Yes/No
8. Change in urine stream, strength or flow Yes/No
9. Excessive urination Yes/No
10. Blood in stool or urine Yes/No
11. Menstrual problems, irregular or painful Yes/No
12. Sexual desire or performance issues Yes/No
13. Joint or back pain Yes/No
14. Mole changes in color or size Yes/No
15. Sleeping problems in the past month Yes/No
16. Feeling depressed or hopeless Yes/No
17. Problems with falling down or performing routine tasks Yes/No

PREVENTATIVE

Pap smear in the past year Yes/No
Mammogram in the past year Yes/No
Bone Density scan in the past 2 yrs. Yes/No
Colonoscopy in the past 10 yrs. Yes/No
Tetanus shot in the past 10yrs. Yes/No
Pneumonia shot in the past 10 yrs. Yes/No
Flu shot in the past year Yes/No