

SONORAN MEDICAL CENTERS NEW PATIENT HEALTH HISTORY

Date _____ Date of Birth: _____

Name: _____

Name you prefer to be called: _____

Race: American Indian or Alaska Native Asian
 Black or African American Native Hawaiian or
 Other Pacific Islander White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Preferred Language: _____

Pharmacy Name: _____

Pharmacy Cross Streets _____

Pharmacy Phone Number (_____) _____

Mail Order Pharmacy Name: _____

Mail Order ID # _____

Allergies to Medications:	Reaction:

Chronic Medical Problems:	Year diagnosed:

When was your last:	Result:	Date:
Physical Exam		
Colonoscopy		
Glaucoma check		
Bone Density (DEXA)		
Mammogram (females)		
Abnormal Mammogram		
Pap Smear (females)		
Abnormal Pap Smear		

When was your last:	Date:
Influenza Vaccine (Flu)	
Pneumonia Vaccine	
Tetanus Vaccine <input type="checkbox"/> with Pertussis?	
Hepatitis A Vaccine	
Hepatitis B Vaccine	
HPV? (3 shots)	
Zoster (Shingles) Vaccine (over 60)	
Have you had the chicken pox?	

Do you have allergies? Yes No

Religious Affiliation (optional)

Do you have a religious affiliation?

_____ Do you practice your religion? Yes No

List Past Surgeries:	Year:
Any blood transfusions?	

List Past Hospitalizations:	Year:

Family History: (blood relatives only)	Relationship:	Was cause of death?
Heart Disease		
Cancer Breast		
Cancer Colon		
Cancer of Lung		
Cancer of Ovaries		
Cancer of Prostate		
Cancer of Uterus		
Stroke		
Depression		
Diabetes		
High Cholesterol or Triglycerides		
High Blood Pressure		
Thyroid Disease		
Other		

Social History: Marital Status: (S,M,D,W): _____

Occupation: _____

of Children: Sons _____ Daughters _____

Who do you live with? _____

Tobacco?	Type?	How much?	How long?
Current			
Past			
Alcohol?			
Caffeine?			
Illegal Drugs?			
IV Drugs?			

If past smoker, what age did you quit? _____

Activity level: low _____ average _____ high _____

Do you have a DNR (do not resuscitate)? _____

Do you have a living will? _____

Do you have a power of attorney? _____

Do you have a health care proxy? _____

Any tattoos? _____

If you are a patient of Dr. Belen, please complete Gyn Patient Health History also.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____
 Phone: _____ Address: _____
 City: _____ State: _____ Zip Code: _____

I hereby authorize

Name of facility: _____
 Address: _____ City: _____
 State: _____ Zip Code: _____ Phone: _____ Fax: _____

to disclose the following Protected Health Information pertaining to the patient listed above to Sonoran Medical Centers.

Options below must be completed in order to release records.

For the Following Purpose:

- New Primary Care Physician
- Personal Records
- Consultation with Specialist
- Insurance Company
- Other (Specify) _____
- Other (Specify) _____

Information to be Released:

- All Records
- Records from _____ to _____
- Office Note
- Radiology Report Lab result
- Billing Statements

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.

I understand that Sonoran Medical Centers will not condition treatment on whether I sign this Authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that the above-named facility has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the mailing address listed above. I understand the revocation will not apply to information that has already been released in response to this Authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives this information.

I understand that this authorization will expire one (1) year from date of signing unless specified below.

Desired Expiration Date _____

Signature

Date

Print Name

Relationship to Patient (if not patient)

SONORAN
MEDICAL CENTERS
19875 N 51st Avenue
Glendale, AZ 85308

Dear Patient:

We are very pleased that you have scheduled for a Physical or Wellness Exam. It is important for you to have the recommended preventative testing in order to stay as healthy as possible.

Since the time set aside for this visit is to specifically focus on your wellness, we will be unable to address any other unrelated illnesses or complaints that you may have at this same time. This includes any chronic medical problems we are following, as well as any acute illnesses or injuries you may have. If you feel that you have a non-wellness visit issue that must be addressed, we ask that you schedule a separate appointment on another day to address these problems, so that we can go over these concerns in detail with you. NOTE: If your provider determines that your visit includes services outside of the scope of a Physical and these services are provided during the visit today, an additional office visit charge may be submitted to your insurance along with your physical exam.

In the past, we have tried to address any concerns that a patient had during their wellness exam. This resulted in time delays and frustration for both the patient and provider. This change is in hopes of allowing us to better serve you in a timely manner.

A wellness visit may consist of any of the following depending on your needs and age as determined by your Provider:

- ✓ Female breast exam if not provided by another healthcare provider
- ✓ Female pelvic exam if not performed by another healthcare provider
- ✓ Male prostate exam
- ✓ Age-appropriate cancer screening
- ✓ Review of systems screening for significant disease
- ✓ Order of age-appropriate routine labs, radiology, mammograms, and DEXA bone density testing
- ✓ Referrals for colon screening if needed
- ✓ Immunizations or injections as needed
- ✓ Any paperwork presented at the exam needed to document that you have completed your wellness exam today

Please note that some insurance companies may not cover services recommended by your provider to keep you healthy. Some charges may be your responsibility. There are many different insurance companies and plans within an insurance company. As you may have experienced, it is difficult, if not impossible, to keep track of all of the changes that insurance is experiencing. Please check with your insurance company if you are not sure of your benefits.

We want to ensure that we are providing the best possible care for you in the time that we have allowed. Thank you for your acceptance and understanding of this policy.

Sincerely,

Sonoran Medical Centers