3769 Crossings Dr., Suite B
Prescott, AZ 86305
928.888.9750● Phone
928.888.9790 ● Fax
info@1stchoicemed.center

PATIENT INTAKE AND MEDICAL INFORMATION

PATIENT INFORMATION:

Patient Name: _____ **Todays Date:** _____

DOB: _____ **GENDER:** □ **M** □ **F** **SSN (*required*):** _____

Marital Status: □ **Divorced** □ **Married** □ **Separated** □ **Single** □ **Widowed**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone (H): _____ **Phone (C):** _____ **Phone (W):** _____

Email Address: _____

Emergency Contact: _____ **Relationship:** _____ **Contact #:** _____

Primary Language Spoken in your Household: _____

Race: □ American Indian or Alaska Native □ Asian □ Native Hawaiian □ Black or African American □ White □ Hispanic □ Other Race □ Other Pacific Islander □ Refused to Report

Ethnicity: □ Hispanic or Latin □ Not Hispanic or Latin □ Refused to Report

Do you have advanced directives in place?	**(Please Circle) Yes or No**
Please bring copies of advanced directives to your	**Appointment for your chart.**
Medical Power of Attorney? Yes / No	**Name of person(s) listed:**
Do not Resuscitate? Yes/No	**Do you have a Living Will? Yes/No**

FINANCIALLY RESPONSIBLE INDIVIDUAL (If different than above):

Name of Insured:	**Relationship to Patient:**	
SSN:	**DOB:**	**Gender:** □ **M** □ **F**
Phone (H):	**Phone (W):**	
Address:		

PRIMARY INSURANCE:

Insurance Company:	**Group #:**	**SSN:**
Name of the insured:	**Policy ID:**	**DOB:**
Address of the insured:		

SECONDARY INSURANCE:

Insurance Company:	**Group #:**	**SSN:**
Name of the insured:	**Policy ID:**	**DOB:**
Address of the insured:		

*****Please note that if you have a secondary insurance and it is not identified, the patient will be financially responsible for any claims not paid.**

Patient Name: _____

Pharmacy:

(Name & Location): _____Phone:_____

Current Medications and/or Supplements:

Medication/Supplement & Strength:	Frequency:	Medication/Supplement & Strength:	Frequency:
1.)		6.)	
2.)		7.)	
3.)		8.)	
4.)		9.)	
5.)		10.)	

Medical History:

Have you ever had, or do you currently have, any of the following medical problems? (Please Check)		
□ Abnormal Pap Smear	□ Emphysema / COPD	□ Immune Disorders Type: _____
□ Anxiety	□ Environmental Allergies	□ Irregular Heart Beat
□ Arthritis Type: _____	□ Fibromyalgia	□ Irritable Bowel Disorder
□ Asthma	□ Hearing loss	□ Kidney Disease
□ Bulging Disc	□ Heart Disease Type: _____	□ Migraines
□ Cancer Type: _____	□ High Cholesterol	□ Prostate Disorder
□ Chronic Fatigue Syndrome	□ High Blood Pressure	□ Seizure Disorder
□ Depression	□ High Blood Sugar	□ Stroke / CVA
□ Diabetes Type: _____	□ Hyperthyroid	□ Urinary Tract Disorders Specify: _____
□ Eczema	□ Hypothyroid	□ Uterine or GYN Problems Specify: _____
□ Vascular Disease	□ Abnormal Mammogram	□ Other: _____

Patient Name: _____

Allergies/ Intolerance (Medication or Supplements):

Agent /Substance	Reaction:	Agent /Substance:	Reaction:
1.)		6.)	
2.)		7.)	
3.)		8.)	
4.)		9.)	
5.)		10.)	

Surgical History:

Date:	Surgery:

Patient Name: _____

Hospitalization:

Date:	Reason:	Date:	Reason:

Family History:

Type Of Disease	Yes or No	Relationship
Diabetes:	□ **YES** □ **NO**	□ Mother □ Father □ Sibling □ Children □ Paternal Grandmother □ Paternal Grandfather □ Maternal Grandmother □ Maternal Grandfather □ Other Family Member
High Blood Pressure:	□ **YES** □ **NO**	□ Mother □ Father □ Sibling □ Children □ Paternal Grandmother □ Paternal Grandfather □ Maternal Grandmother □ Maternal Grandfather □ Other Family Member
High Cholesterol:	□ **YES** □ **NO**	□ Mother □ Father □ Sibling □ Children □ Other Family Member □ Paternal Grandmother □ Paternal Grandfather □ Maternal Grandmother □ Maternal Grandfather □ Other Family Member
Heart Disease: Type: _____	□ **YES** □ **NO**	□ Mother □ Father □ Sibling □ Children □ Paternal Grandmother □ Paternal Grandfather □ Maternal Grandmother □ Maternal Grandfather □ Other Family Member
Cancer: Type: _____	□ **YES** □ **NO**	□ Mother □ Father □ Sibling □ Children □ Paternal Grandmother □ Paternal Grandfather □ Maternal Grandmother □ Maternal Grandfather □ Other Family Member
Chronic Mental Illness: Type: _____	□ **YES** □ **NO**	□ Mother □ Father □ Sibling □ Children □ Paternal Grandmother □ Paternal Grandfather □ Maternal Grandmother □ Maternal Grandfather □ Other Family Member
Other: _____ Type: _____	□ **YES** □ **NO**	□ Mother □ Father □ Sibling □ Children □ □ Paternal Grandmother □ Paternal Grandfather □ Maternal Grandmother □ Maternal Grandfather □ Other Family Member

Patient Name: _____

Social History:

Tobacco Section:	
Do you currently use Tobacco:	□ **YES** □ **NO**
If yes, how much do you currently smoke (packs/ cigarettes a day) or chew:	How many **Cigarettes a day**: _____ How many **Packs a day**: _____ How much **Chewing Tobacco** a day:_____
Did you use Tobacco in the past:	□ **YES** □ **NO**
If yes, when did you quit:	
Drug Section:	
Do you use any **Illicit Drugs**:	□ **YES** □ **NO**
If yes, which drug(s):	□ **Marijuana** □ **Cocaine** □ **Meth.** □ **Heroin** □ **Other:**_____
How much per week:	
Alcohol Section:	
Do you drink **Alcohol**: □ **YES** □ **NO**	If yes, how often:_____day/month/week How many drinks do you have at one sitting?_____
In the last year have you had more than 6 alcoholic drinks in one sitting? _____	If so, how many times in a month does this occur? _____
Caffeine Section:	
Do you drink Caffeine:	□ **YES** □ **NO**
If yes, how many cups/ ounces per day:	□ None □ 1-2 cups per day □ 2-3 cups per day □ 3-4 cups per day □ more than 4 cups per day
Miscellaneous Section:	
How would you describe your **Diet**: Does your diet contain prepackaged or processed foods? _____ If yes, how often? _____	Is it 2000 or less calories per day? _____ How many average grams of sugar per day in your diet? _____ How many carbohydrates per day? _____
Do you currently **Exercise**:	□ **YES** □ **NO**
If yes, how many days per week do you exercise:	**Hobbies**: _____
House Hold Section:	
Are your Married, Separated or Single: How many children do you have:	□ **Married** □ **Separated** □ **Single** **Number of Children:** _____

Patient Name: _____

GYN History (Female Only):

Symptoms/ Question	Notes/ Dates
Periods:	□ **Regular** □ **Irregular**
Sexual Activity	□ **YES** □ **NO**
Last Mammogram:	**Date:**_____
Last Pap Smear:	**Date:**_____
Abnormal Pap Smear:	□ **YES** □ **NO**
Date of last Period:	**Date:**_____
Menopause Began at Age:	**Age:**_____

O/B History (Female Only):

Symptoms/ Question	Notes/ Dates
Gravida (Number of Pregnancies):	
Para (Number of Viable Births):	
Stillbirth(s):	
Miscarriage(s):	
Abortion(s):	
C-Section(s):	

Patient Name: _____

Immunizations:

Vaccines	Yes or No	Date/Who administered
Tetanus/ Tdap:	□ **YES** □ **NO**	
Pneumoccocal:	□ **YES** □ **NO**	
Influenza:	□ **YES** □ **NO**	
Shingles (Zostavax)	□ **YES** □ **NO**	
Other:_____	□ **YES** □ **NO**	

Preventative Medicine:

Screening Test	Yes or No	Date
Vision Screen:	□ **YES** □ **NO**	
Osteoporosis Screen:	□ **YES** □ **NO**	
Colorectal Cancer Screen:	□ **YES** □ **NO**	
Last Cholesterol Lab Test:	□ **YES** □ **NO**	
Last Glucose (blood Sugar) Lab Test:	□ **YES** □ **NO**	
Last Hemoglobin A1c Lab Test:	□ **YES** □ **NO**	

RELEASE OF TEST INFORMATION & PATIENT COMMUNICATION

Patient Name: _____ Date of Birth: _____

I request and give consent to First Choice Medical Center and/or its staff to relay any and all communications regarding my lab results, radiological testing, referral information or any other pertinent information to be handled in the following manner.

WRITTEN COMMUNICATION:

Address: _____ City: _____ State: _____ Zip:

_____

VERBAL COMMUNICATION:

Home Number: _____ May we leave a detailed message? □ Yes □ No

Phone Number: _____ May we leave a detailed message? □ Yes □ No

Please provide my medical information to individual(s) other than myself or state NONE.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

APPOINTMENT REMINDERS:

Please indicate what your preferred contact is for your Appointment Reminders:

□ **CALL** – Phone Number: _____ (Home, Cell, Work)

□ **TEXT** – Phone Number: _____

□ **EMAIL** – Email Address: _____

PATIENT PORTAL:

Please indicate if you would like NFM to establish Patient Portal access: □ Yes □ No

Email Address: _____

Signature: _____ Date: _____

OFFICE & FINANCIAL POLICY

Thank you for choosing First Choice Medical Center (FCMC) for your healthcare needs. Our Office and Financial Policy is an important part of your healthcare. Please review the following Office and Financial Policy.

1. **OFFICE & PHONE HOURS**: Our normal office hours are Monday – Friday from 8:00 a.m. – 5:00. Phones will be answered during this time with the exception to 12:00 p.m. – 1:00 p.m., while the practice is closed for lunch.

2. **APPOINTMENTS**: Patient appointments are scheduled Monday - Friday from 8:00 a.m. – 4:00 p.m.

3. **ON-TIME**: All attempts are made by our office to keep your scheduled appointments on time, however, unforeseen issues may come up that may cause delays and we apologize, in advance, when this occurs, however, each of our patients are important to us and are given the attention that is needed to address each patient's medical needs.

4. **CANCELLATIONS/NO SHOWS**: FCMC offers Appointment Reminder Calls as a **courtesy** to our patients. If you arrive more than 15 minutes late for your scheduled appointment, we may ask that you reschedule your appointment. If you No Show an appointment or Cancel and do not notify us at least 24 hours prior to your scheduled appointment, you will be charged $70.00. Any early or extended appointments missed will be charged $130.00.

5. **MEDICATIONS**: We do not prescribe any medications over the phone. You must be seen by a provider in order to receive a prescription of any nature. For any medication refills, please contact your pharmacy first, however, if you request a refill and leave a message with one of our MA staff then please allow a minimum 72 hours' notice. For requests after 4:00 p.m. on Fridays, these requests will be addressed the following business day. Please note, our providers do not refill medications after-hours for ANY reason, this includes pain medications. It is your responsibility to keep track of the level of your medications and call our office during normal business hours to request medication refills.

6. **AFTER HOURS ON-CALL SERVICES**: First Choice Medical does not have after hour's on-call services between the hours of 5:00 p.m. and 8:00 a.m. During this time period, if you require urgent medical services, we recommend that you proceed directly to your nearest Emergency Department or Urgent Care Center. We have conveniently placed the names and phone numbers of some of these facilities on our website.

7. **TREATMENT OF MINORS:** Patients under the age of 18 must be accompanied by a responsible adult or have written permission, for treatment, from a parent or guardian.

8. **PATIENT PORTAL**: FCMC offers a Patient Portal service for patients to receive non-urgent lab, radiology, and other diagnostic test results, request appointments, medication refill, and referrals, and contact FCMC staff for billing and non-urgent medical questions. This service is not intended to treat or obtain care for urgent or emergency conditions. Patient Portal is offered through FCMC's electronic medical record vendor, e-CW ®. Both, FCMC and e-CW maintains this portal utilizing appropriate technical safeguards and encryption as required by HIPAA. FCMC will not have any access to your portal user ID and password due to HIPAA regulations. It is your responsibility to keep your portal user ID and password secure.

9. **LABORATORIES**: FCMC houses a Laboratory in our office for our patient's convenience and we will automatically send lab testing to this lab unless otherwise directed by you **before the draw**. If your insurance company requires

the use of a specific laboratory, you must notify the phlebotomist in order to ensure your blood is sent to the correct lab. If you are unsure, we suggest that you contact your insurance carrier **prior** to having any labs drawn to ensure your labs are sent to the correct laboratory. Please note that there may be some labs ordered by our providers that are not a covered benefit on your insurance plan as our providers order what they deem as medically necessary and not based on insurance coverage. The lab will bill your insurance company directly for any lab testing done in our office. It is your responsibility to provide your current insurance and billing information to the Phlebotomist. If you receive any bill(s) from the lab for any lab testing done in our office, please contact the lab directly, which is listed on the invoice, and they will contact our office for assistance, if needed, as FCMC does not have access to lab Patient Billing. If you experience any issues related to the service you received from the phlebotomist, please make sure you tell our check-out desk immediately.

10. **INSURANCE PARTICIPATION**: Although FCMC is contracted with most insurance companies, it is **your** responsibility to make sure that our physician is an in-network provider in your specific plan and knowing your insurance coverage and benefits. The qualifying TIN's that you should verify is 47-3062253. We ask that your contact your insurance company directly if you have any questions regarding your coverage. FCMC is not contracted with any State-funded plans, including Medicaid or AHCCCS.

11. **BILLING**: I request and authorize FCMC to bill my insurance company on my behalf. FCMC agrees to invoice my insurance company in a timely manner and will assist in any way reasonably to help get claim(s) paid by my insurance. I authorize FCMC to release the necessary information in order to complete and process my claim(s). At times, your insurance may request that you supply certain information to them directly. It is your responsibility to comply in a timely manner as well. Please be aware that the balance of your claim(s) is your responsibility, whether or not your insurance company pays your claim(s).

12. **CO-PAYS, DEDUCTIBLES, & PAYMENTS**: I agree to pay my co-pay, coinsurance, and deductible **AT TIME OF SERVICE**. We collect for the office visit portion **ONLY**, and will bill your insurance for all services rendered during the appointment. Any additional services (EKG, Urinalysis, etc) provided on the date of service that your insurance determines patient responsibility, will be billed to you after FCMC has received payment by your insurance company for your claim(s). If you are **CASH PAY** and do not have insurance, payment for **ALL** services rendered will should be collected **AT TIME OF SERVICE**.

13. **"NON-COVERED" SERVICES**: I understand that some, and perhaps all, of the services I receive may not be covered by my insurance or deemed "not medically necessary or considered experimental" by my insurance company. I agree to pay for any services that my insurance determines as "non-covered."

14. **UPDATES & COVERAGE CHANGES**: Our staff may ask you to verify your insurance and billing information at each and every visit and may request a copy of your insurance card each time. Current information is crucial in order for FCMC to obtain timely payment from your insurance information. We ask that you notify us as soon as possible if your medical coverage changes so we can make the appropriate changes. If your insurance company does not pay a claim within 90 days, the full balance will be billed to you.

15. **RETURNED CHECKS**: Any returned checks for Non-Sufficient Funds will be charged a processing fee of $45.00.

I hereby acknowledge that I have reviewed and understand First Choice Medical Center's Office & Financial Policy.

Signature: _____ Date: _____

Patient Name: _____

I understand how medical information about me may be used and disclosed, and how I can get access to my information as described under the **HIPAA Notice**. At any time, I can request a copy of the updated HIPAA Notice from FCM and it is also available on our website.

Signature: _____ Date: _____

Patient Name: _____