PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: ______________________________ Birth Date: ______________________________

Signature: ____

Date: ______________________________

COMMUNICATION AUTHORIZATION

Patient Name: ____________________ DOB: ____________________

What number(s) may we contact you at? May we leave a message?

____________________ ☐ Yes ☐ No

____________________ ☐ Yes ☐ No

Is there anyone other than yourself that you authorize AZI to speak with on behalf of your medical care? If so please list below:

Name	Phone	Relationship

Do you authorize AZI to communicate with your Pharmacy? ☐ Yes ☐ No

Local Pharmacy: ____________________ Phone: ____________________

Address: ____________________ Fax: ____________________

Mail Order Pharmacy: ____________________ Phone: ____________________

May we communicate with you via Email? ☐ Yes ☐ No

Email: ____________________

Patient Signature ____________________ Date: ____________________

CONFIDENTIAL BILLING INFORMATION

You were referred to us by: ______________________________

Your primary care physician Is: ______________________________

Patient Name: ______ ______ ______________________________
Last First Middle

Address: ______________________________
Address City State ZIP

Phone: ______________________ Cell: ______________________

Age: ________ Birth Date: ________________ Sex: ☐ Male ☐ Female

Marital Status: ________________ Social Security #: ________________

Employer: ________________ Business Phone: ________________

Employer Address: ______________________________

Parent/Spouse's Name: ________________ Parent/Spouse's SS#: ________________

Parent/Spouse's Birth Date ________________

Parent/Spouse's Employer: ________________ Business Phone: ________________

Student: ☐ Yes ☐ No ☐ Full Time ☐ Part Time

School Name: ______________________________

Emergency Contact - other than a relative in the same home:

Name: ______________________________

Address: ______________________________

Phone: ______________________________

Address correspondence to:
7200 W. Bell Road
#100
Glendale, AZ 85308
FAX: 602-482-9563

Patient's Name: ______________________________ Date: ______________________

I hereby authorize my insurance company to make direct payment to:

AZ Integrated Neuro Spine & Pain

And I understand I am financially responsible for any co-payments, deductibles, coinsurance and all charges which are considered to be not a covered benefit by my insurance company. I understand that verification of coverage is not a guarantee of benefits. Actual plan coverage and benefit payments are determined when a claim is received.

I understand that I am financially responsible for all charges if it is determined that the insurance information I have provided is no longer in effect.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Signed: ______________________________

RELEASE OF INFORMATION:

I hereby authorize release of medical Information to my referring physician and/or to any other physicians who have been or may become Involved in my medical care. I also authorize release of Information that may be necessary in the processing of any Insurance claims.

Signature: ______________________________ Date: ______________________

A photostatic copy of this authorization shall be considered as effective and valid as the original

AZ Integrated Neuro
Spine & Pain

PATIENT HISTORY

Patient Name: ____________________ ____________________ ____________________ Age: ______________
Last First Middle

Main complaint and symptoms (briefly describe what and where it hurts):

When did this problem first start? (please fill-in date): ______________________________________

Describe the frequency and duration of symptoms:

Please describe treatments tried and how effective they are:

Have you consulted other doctors for this problem? ☐ Yes ☐ No

If yes, please mentioned name: ____

Have you been treated by a physical or occupational therapist? ☐ Yes ☐ No

If yes, by whom? ____

PLEASE CHECK ALL SYMPTOMS THAT YOU HAVE

1. Constitutional:	☐ Weight Gain	☐ Weight Loss	☐ Fatigue	☐ Fever
	☐ Chills			
2. Eyes:	☐ Vision Loss	☐ Blurred Vision	☐ Double Vision	☐ Eye Pain
3. ENT:	☐ Ringing In Ears	☐ Hearing Loss	☐ Ear Pain	☐ Jaw Pain
	☐ Jaw Popping/Clicking			
4. Cardiovascular:	☐ Lightheadedness	☐ Passing Out	☐ Chest Pain/Pressure	
	☐ Palpitations			
5. Respiratory:	☐ Wheezing	☐ Coughing		
6. Gastrointestinal:	☐ Belly Pain	☐ Nausea	☐ Vomiting	
	☐ Constipation	☐ Diarrhea		
7. Genitourinary:	☐ Kidney Stones	☐ Urinary Retention Or Urgency		
	☐ Urinary Incontinence			
8. Musculoskeletal:	☐ Neck Pain	☐ Mid Or Lower-back Pain		
	☐ Sore Muscles	☐ Cramps		
9. Integument:	☐ Skin Ulcerations	☐ New Rashes	☐ Hair Loss	
10. Cardiovascular:	☐ Anxiety	☐ Panic Attacks	☐ Depression	
	☐ Visual or Auditory Hallucinations			
10. Hematology/ Lymphatic:	☐ Easy Bleeding	☐ Easy Bruising	☐ Recurrent Infections	

PAST MEDICAL HISTORY: (All illnesses diagnosed, controlled or not)

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

OPERATIONS: (Please list all, even minor ones such as tonsillectomy)

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________

ALLERGIES: (For example: IV contrast dye, penicillin, latex, etc.)

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

MEDICATIONS: (Including supplements and herbs)

	Medication	Dose	Times per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(Continue on the back of page if necessary)

Personal and Social History:

Are you presently working? ☐ Yes ☐ No Occupation: ______________________

If disabled:

Date of disability began: ______________________

Cause of disability: ______________________

Highest level of education: ______________________

How many steps to the entrance of your home? ______________________

How many floors in your home? ______________________

Have you ever smoked? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No How long: __________ How much: __________

If you quit, what year did you quit? __________ How long did you smoke?: __________

Do you drink alcohol? ☐ Yes ☐ No Weekly amount? ______________________

Caffeinated? ☐ Yes ☐ No

Do you drink soda? ☐ Yes ☐ No Weekly amount? ______________________

Caffeinated? ☐ Yes ☐ No

Have you used illegal drug? ☐ Yes ☐ No If yes, what? ______________________

Family History: Please circle all diseases anyone in your family has

☐ Stroke ☐ TIA ☐ Seizures/Epilepsy ☐ Headaches/Migraine ☐ Multiple Sclerosis

☐ Heart Disease ☐ Diabetes ☐ Hypertension ☐ High Cholesterol ☐ Cancer

Other neurological disease (please explain):

Do any diseases run in your family? ______________________

PLEASE FILL-OUT FAMILY MEMBER HEALTH INFORMATION BELOW:

	Age	Living	Medical issues (if deceased please state cause)
Father:	________	☐	________________________
Mother	________	☐	________________________
Brother(s)	________	☐	________________________
Sisters(s)	________	☐	________________________
Son(s)	________	☐	________________________
Daughter(s)	________	☐	________________________