Dr. Adam J. Farber

PHOENIX SHOULDER & KNEE

PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

Patient Information:

Name: _____

(First) (Middle) (Last)

Name you prefer to go by: _____

Height: _____ **Weight:** _____ **Age:** _____

SEX: M F **Date of Birth:** ____ /____ /____ **Marital Status:** *(circle one)* Single Married Divorced Widow(er)

Race: (i.e., Caucasian, Native American, etc.) _____ **Ethnicity:** (Hispanic, Latino, N/A, etc.) _____

Language: (i.e., English, Spanish, etc.) _____ **Dominant Hand:** *(circle one)* Left Right Ambidextrous

Patient's Social Security Number: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____ - _____

Street Address *(if different from above)*: _____

City: _____ **State:** _____ **Zip Code:** _____ - _____

Please circle which phone number is to be called first: Home Cell Work Other

Home phone: (_____) _____ **Work phone:** (_____) _____

Cell number: (_____) _____ **Other phone:** (_____) _____

Email Address: _____

How did you hear about us *(please circle below and fill in if necessary)*:
ER/Urgent Care Doctor _____ Friend/Relative_____ Employer Attorney _____
Internet *(circle one)*: Google Yahoo Insurance company web site ZocDoc Yelp
Other: _____

Responsible Party *(if patient is minor or dependent)*: _____
Relationship to Patient: _____

Health Insurance Information:

Primary Insurance Name: _____ **Relationship to Insured:** _____

Policy Holder Name: _____ **Policy Holder DOB:** _____ / _____ / _____

Secondary Insurance Name: _____ **Relationship to Insured:** _____

Policy Holder Name: _____ **Policy Holder DOB:** _____ / _____ / _____

CURRENT CONDITION:

Reason for Visit Today: _____

How long ago did this problem start? _____Days _____Weeks _____Months _____Years

Current problem is a result of:
□ No injury: If no, please state how your symptoms began: _____

□ Injury (□ Work Accident □ Car Accident □ Sport) _____ □ Other_____
Date of accident: _____ Specify where and how it happened: _____
□ Injury occurred from a □ Lift □ Twist □ Fall □ Bend □ Pull □ Reach □ Hit by object □ Unknown □ Other _____

Comments: On a scale of 0-10 (10=worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? □ Sharp □ Dull □ Stabbing □ Throbbing □ Aching □ Burning

The pain is now: □ Constant □ Comes and goes

Does your pain wake you from sleep? □ Yes □ No

Do you have the following (check all that apply):
□ Bruising □ Joints giving way □ Locking/catching □ Numbness □ Swelling □ Tingling □ Weakness □ Painful popping

Since the problem started, it is: □ Better □ Worse □ Same

What makes your problem worse? (check all that apply): □ Bending □ Exercise □ Kneeling □ Lifting □ Sitting □ Standing □ Squatting
□ Twisting □ Walking □ Overhead activities □ Other: _____

What is your single most painful activity? _____

What makes your problem better? (check all that apply): □ Heat □ Elevation □ Ice □ Rest □ Other: _____

Have you had a prior problem with this same condition in the past? □ No □ Yes
If yes, please describe: _____

Current Medications (include medication name, dosage, and frequency of use):
□ NONE □ Additional sheet attached
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Allergies to food and/or medications (include name of food and/or medication and your reaction):
□ NONE □ Additional sheet attached
1. _____ 3. _____
2. _____ 4. _____

Social History:
Do you use tobacco? □ No □ Previously, but quit ____ /_____ /_____ □ Yes _____/day
Do you drink alcohol? □ No □ Yes (If yes, how much do you drink/week): _____
Recreational/Illicit Drugs? □ No □ Yes □ In past only

Occupation: _____
Employer _____ Work Phone: (_____) _____
Current employment status: □ Disabled □ Full-time □ Light-duty (how long? _____) □ Unemployed
If unemployed or on disability, what was the date you last worked: _____/_____/_____

PERSONAL MEDICAL HISTORY:

Check "Yes" or "No" if you are currently having problems or if you have had any of these problems in the past. **If yes, please explain.**

Medical History:

Contacts/Prescription Glasses	□No	□Yes _____	Eating Disorder	□No	□Yes _____
Sinusitis	□No	□Yes _____	Peptic Ulcers	□No	□Yes _____
Sleep Apnea	□No	□Yes _____	Diverticulitis	□No	□Yes _____
Blindness/Cataracts	□No	□Yes _____	Kidney Stones (Current or past)	□No	□Yes _____
Glaucoma	□No	□Yes _____	Bladder Problems	□No	□Yes _____
Heart Arrhythmia	□No	□Yes _____	Kidney Failure (Acute/Chronic)	□No	□Yes _____
Palpitations	□No	□Yes _____	Sciatica	□No	□Yes _____
Syncope (Fainting)	□No	□Yes _____	Osteoporosis	□No	□Yes _____
High Blood Pressure	□No	□Yes _____	Gout	□No	□Yes _____
Low Blood Pressure	□No	□Yes _____	Anemia	□No	□Yes _____
Heart Attack	□No	□Yes _____	Pulmonary Embolism	□No	□Yes _____
High Cholesterol	□No	□Yes _____	Deep Vein Thrombosis (DVT)	□No	□Yes _____
Asthma	□No	□Yes _____	Hyperlipidemia	□No	□Yes _____
COPD	□No	□Yes _____	Diabetes (Type I or Type II)	□No	□Yes _____
Pneumonia	□No	□Yes _____	Overactive Thyroid	□No	□Yes _____
Tuberculosis (TB)	□No	□Yes _____	Underactive Thyroid	□No	□Yes _____
Valley Fever	□No	□Yes _____	Speech impairment	□No	□Yes _____
Anxiety	□No	□Yes _____	Vertigo	□No	□Yes _____
Depression	□No	□Yes _____	Seizures	□No	□Yes _____
GERD	□No	□Yes _____	Stroke/Transient Ischemic Attack	□No	□Yes _____
Hepatitis	□No	□Yes _____	Rash / Non-Healing Ulcers	□No	□Yes _____
Alcohol / Drug Abuse	□No	□Yes _____	Cancer of: _____	□No	□Yes _____

Review of Systems:

Night Sweats / Fever	□No	□Yes _____	Weight Loss or Gain	□No	□Yes _____
Chills	□No	□Yes _____	Indigestion/Heartburn/Reflux	□No	□Yes _____
Recent Illness	□No	□Yes _____	Abdominal Pain	□No	□Yes _____
Fatigue/ Malaise (discomfort)	□No	□Yes _____	Diarrhea	□No	□Yes _____
Visual Changes	□No	□Yes _____	Difficulty Swallowing	□No	□Yes _____
Trauma or Cancer of Head/Neck	□No	□Yes _____	Vomiting Blood	□No	□Yes _____
Hearing Loss	□No	□Yes _____	Jaundice	□No	□Yes _____
Ringing in Ears	□No	□Yes _____	Painful or Frequent Urination	□No	□Yes _____
Chest Pain/Pressure	□No	□Yes _____	Blood in Urine	□No	□Yes _____
Dyspnea (Shortness of Breath)	□No	□Yes _____	Bone Fractures	□No	□Yes _____
Edema	□No	□Yes _____	Abnormal or Prolonged bleeding	□No	□Yes _____
Congestion/Cough/Wheezing	□No	□Yes _____	Altered Level of Consciousness	□No	□Yes _____

Surgeries/Hospitalizations (include type of surgery and year of occurrence):

□ NONE □ Additional sheet attached

1. _____ 3. _____
2. _____ 4. _____

FAMILY MEDICAL HISTORY

Father: □Alive □Deceased Mother: □Alive □Deceased

Medical Conditions: _____ Medical Conditions: _____

Brother(s): □Alive □Deceased Sister(s): □Alive □Deceased

Medical Conditions: _____ Medical Conditions: _____

Grandmother(s): □Alive □Deceased; cause: _____

Grandfather(s): □Alive □Deceased; cause: _____

I _____ verify that the above information is true to the best of my knowledge.
I agree to immediately inform the office if there are any changes to my address, phone numbers, or insurance plan.

Signature: _____ Today's Date: _____/_____/_____

Patient Name:_____ **Date of Birth: _____/ _____/_____**

Contact Information:

Emergency Contact Name: _____

Emergency Contact Phone: (_____) _____ Relationship: _____

May staff members in our office speak to this person on your behalf regarding your medical condition? *(circle one)* Yes No

Primary Care Physician

Name _____ Phone (_____) _____

Address _____

City _____ State _____ Zip _____

Preferred Pharmacy _____ Phone (_____) _____

Cross Streets _____

Address _____

City _____ State _____ Zip _____

Please Read and Sign this Form:

I hereby authorize ***Phoenix Shoulder and Knee*** and my physician to furnish information to insurance carriers concerning my illness, and treatment.

Assignment of Benefits: I hereby assign ***Phoenix Shoulder and Knee*** and to my physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance company. I agree to pay all outstanding balances either on the day of service or within 30 days of receiving a statement detailing my financial responsibility. I understand that I am ultimately responsible for any unpaid amount, and I agree to pay court costs, including any attorney fees, which may be incurred in the collection process.

As the patient or patient representative, I recognize the need for care and consent to all or any services as ordered by the physician. These services may include exams, lab procedures, x-rays, medical treatment, minor or emergency surgical treatment, or other services rendered under the specific instruction of the physician.

Signature of Responsible Party: _____ Today's Date: _____/_____/_____

Adam J. Farber, MD
1215 W Rio Salado Parkway
Suite #105
Tempe, AZ 85281

IMPORTANT OFFICE POLICIES: ***Please Read and Sign this Form***

PATIENT NAME _____ DATE OF BIRTH _____

RELEASE OF MEDICAL INFORMATION

I authorize ***Phoenix Shoulder and Knee*** to release and receive the medical records concerning myself/son/daughter to any physician, hospital, insurance carrier, or other agency involved in the care of the patient listed.

RELEASE OF ELECTRONIC MEDICAL INFORMATION

I authorize ***Phoenix Shoulder and Knee*** to release and receive, through the CCHIT software that meets or exceeds the Federal standard for encrypted electronic medical records concerning myself/son/daughter to/from any pharmacy, physician, hospital, insurance carrier, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS

I request payment under the insurance policy of the card that was presented at the time of service be made directly to the provider listed on any claim for services furnished to myself/son/daughter during the effective period of this authorization. I authorize ***Phoenix Shoulder and Knee*** to release to the Social Security Administration, its intermediaries or carriers, any information required for this claim or any related Medicare or Medicaid claim. I authorize the release of any information necessary to determine these benefits or benefits payable for related services.

HIPAA POLICY

I have either read or received a written copy of ***Phoenix Shoulder and Knee*** notice of Health Information Portability and Accountability Act, and I understand that my health information will be protected by this act according to the written policy of ***Phoenix Shoulder and Knee*****.** If further information is needed, I will request to speak with the office HIPAA Policy Officer at (480) 219-3342.

PAYMENT POLICY

I understand that co-payments are to be collected at the time services are received. The office accepts cash, checks, Visa, Master Card and Discover cards. The office reserves a right to charge for any NSF checks that are returned. All medical services provided are directly charged to the patient or responsible party. If a physician is contracted with my insurance carrier, the office will accept their negotiated rate for the charges billed. However, I will be responsible for any balance deemed patient responsibility/non-payable/non-covered by my insurance, and I will be billed accordingly. Payment is expected in full upon receipt of statement, or payment arrangements must be made with the billing office.

CANCELLATION POLICY

I understand that ***Phoenix Shoulder and Knee*** requests that if I need to cancel a scheduled appointment, or reschedule an appointment, I will provide 4 hours notice prior to the appointment. The office reserves the right to charge $35.00 for a “no show” appointment, which will be billed to me or collected on my next appointment.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician’s office if required by my insurance carrier. I understand that if I fail to procure the proper referral that the charges will become my responsibility.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION REGARDING TREATMENT, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Today’s Date: _____/_____/_____