Sunrise Medical Center

Name _____
Last First Middle Initial Birthdate

Home Address _____
City ST Zip

Permanent Address _____
City ST Zip

Home Phone: _____ Cell: _____ Work: _____

SS# _____ Male/Female Marital Status S M D W

Pharmacy Name: _____

Address or Cross Streets _____

Email: _____@_____

Who referred you? _____
Who is your Primary Care Doctor? _____ Phone: _____
In an emergency please notify: _____ Phone: _____

What is the insured's name that carries your primary insurance? _____

If someone other than yourself, what is their date of birth? _____

What is their SS#? _____

What is the insured's name that carries your secondary insurance? _____

If someone other than yourself, what is their date of birth? _____

What is their SS#? _____

IS YOUR INJURY WORK RELATED? YES NO
Name of person who can authorize treatment: _____
Insurance Carrier: _____ Phone: _____

INSURANCE RELEASE
I authorize and request that payment under my insurance program be made directly to Sunrise Medical Center for any services furnished for me. I also authorize the provider to release any medical information needed for payment of claims.

Signature _____ Date _____

SUNRISE MEDICAL CENTER
HISTORY AND PHYSICAL

Name:_____ **Date:** _____

DRUG ALLERGIES

_____
_____
_____
_____
_____

HOSPITALIZATIONS

Date Reason

_____
_____
_____
_____

SURGERIES

Date Reason

_____
_____
_____
_____
_____

CURRENT MEDICATIONS & STRENGTHS

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

[ ] **see attached list**

Pharmacy Name, Location, Phone # _____

_____

Primary Care Physician: _____

FAMILY HISTORY	Any Diseases that run in the family?
Father	
Mother	
Spouse	
Son(s)	
Daughter(s)	
Siblings	
Pets	

SOCIAL INFORMATION

Alcohol Use

Type of alcohol _____

How much daily? _____

How many years? _____

Tobacco Use Yes/No (circle one)

How much daily? _____

How many years? _____

When did you stop? _____

EXPOSURES

(have you been exposed to any of the following?)

Asbestos? Yes/No

Sandblasting? Yes/No

Toxic Fumes? Yes/No explain:_____

Past Medical History

[ ] Asthma
[ ] Bronchitis
[ ]Valley Fever
[ ]COPD
[ ]Emphysema
[ ]Pneumonia
[ ]Hemoptysis
[ ]T.B. Skin Test
[ ]Tuberculosis
[ ]Lung Cancer
[ ]Fluid in lungs
[ ] Shortness of breath

[ ] Heart Attack
[ ]Rheumatic Fever
[ ]Headaches
[ ]Congestive Heart Failure
[ ]Heart Palpitations
[ ]Irregular heart rate
[ ]Diabetes
[ ]Heart Murmur
[ ]Allergies/Hay Fever
[ ]Arthritis

[ ] Seizures
[ ] Ulcer
[ ]High Cholesterol
[ ]Dizziness/Fainting
[ ] Stroke
[ ] TIA
[ ] Anemia
[ ] Chest pain
[ ] Angina
[ ] Blood clot in legs
[ ]Nervous Breakdown
[ ] High Blood Pressure

PERMISSION FORM TO RELEASE MEDICAL INFORMATION

I _____, hereby grant permission to:
(Patient Printed Name)

_____
(Name of friend, relative, spouse, attorney, etc. granting to release medical information to)

To receive (**mark YES or NO on the items you are granting permission to be released**)

_____ medical information on my behalf

_____ pick up prescriptions on my behalf

_____ verify appointments on my behalf

_____ receive copies of medical records on my behalf

_____ I authorize permission to leave messages on my voice mail

_____ I authorize permission to fax my medical information to my home

I am providing my physician a copy of the following documentation to keep in my medical file. **(mark YES or NO if you have the following documentation)**

ADVANCED DIRECTIVES: _____
HEALTH POWER OF ATTORNEY: _____
LIVING WILL: _____

This form will remain in effect until I revoke permission with a written notification.

Effective Date: _____

Signature of Patient: _____

Printed Name of Patient: _____

Sunrise Medical Center

Patient Name: _____ DOB: ____/____/_____

Pharmacy: _____ Phone: _____

Address: _____

Medication	Strength	Take	Frequency
Example: Cipro	250mg	1 tablet	3 x day

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1966, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

Obtain payment from designated third party payers.

Conduct normal healthcare operations such as quality assessments or evaluations and physician certifications.

I have been informed by you or your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. It is available in your office in print form or on the office website www.sunrisemedicalaz.com. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions but if the organization does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time except to the extent that the organization has taken action relying on this consent.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient/Legal Representative Signature Legal Representative Relationship to Patient

Sunrise Medical Center