

# CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_ PCP: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Why are you seeing a pulmonary (lung) doctor? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Have you ever had any of the following problems:

- Shortness of breath
- Wheezing
- Rattling in the chest
- Recurrent episodes of bronchitis
- Coughing  
Any phlegm? \_\_\_\_\_  
What color? \_\_\_\_\_  
How often? \_\_\_\_\_
- Coughing up any blood
- Weight loss
- Heartburn
- Post-nasal drip
- Heart murmur
- Blue fingers or lips
- Swollen legs
- Lung nodule (or spots on lung)

## Have you ever had the following, please note when and where:

- Chest x-ray      When \_\_\_\_\_ Where \_\_\_\_\_
- CT of Chest      When \_\_\_\_\_ Where \_\_\_\_\_
- EKG      When \_\_\_\_\_ Where \_\_\_\_\_
- Echocardiogram      When \_\_\_\_\_ Where \_\_\_\_\_
- Lung Surgery      When \_\_\_\_\_ Where \_\_\_\_\_
- Lung Cancer      When \_\_\_\_\_ Where \_\_\_\_\_
- Exposure to TB      When \_\_\_\_\_ Where \_\_\_\_\_

## Have you:

- Worked around Chemicals/Solvents  
Which ones \_\_\_\_\_ How long \_\_\_\_\_
- Worked around Asbestos  
Which ones \_\_\_\_\_ How long \_\_\_\_\_

## **REVIEW OF SYSTEMS**

Pulmonary Medicine

### **CONSTITUTIONAL** None

- Chills
- Fatigue
- Fever
- Malaise (general unwellness)
- Night Sweats
- Weight Gain
- Weight Loss

### **HEENT** None

- Ear drainage
- Ear pain
- Eye discharge
- Eye pain
- Hearing loss
- Hoarseness\*
- Nasal drainage
- Post nasal drainage\*
- Sinus pressure
- Sore throat
- Visual changes

### **RESPIRATORY** None

- Chronic cough
- Cough
- Known TB Exposure
- Shortness of breath
- Frequent Upper Respiratory Infections\*
- Hemoptysis\* (Coughing up blood)
- Snoring\*
- Wheezing

### **CARDIOVASCULAR** None

- Chest pain
- Claudication (Cramping in legs)
- Edema (Leg swelling)
- Palpitations
- Orthopnea\* (Shortness of breath when lying down)

### **GASTROINTESTINAL** None

- Abdominal pain
- Blood in stool
- Change in stools
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Vomiting

### **GENITOURINARY** None

- Dysuria (Painful urination)
- Hematuria (Blood in urine)
- Polyuria (Excessive urination)
- Urinary Frequency
- Urinary Incontinence
- Urinary retention (Inability to urinate)

### **PSYCHIATRIC** None

- Anxiety
- Depression
- Insomnia

### **INTEGUMENTARY (Dermatology)** None

- Brittle hair
- Brittle nails
- Hair loss
- Hives
- Mole changes
- Rash
- Skin lesion(s)

### **NEUROLOGICAL** None

- Dizziness
- Extremity numbness
- Extremity weakness
- Gait disturbance (Unusual problems when walking)
- Headache
- Memory loss
- Seizures
- Tremors

### **METABOLIC / ENDOCRINE** None

- Cold intolerance
- Heat intolerance
- Polydipsia (Excessive thirst)
- Polyphagia (Excessive hunger)
- Generalized weakness\*

### **MUSCULOSKELETAL** None

- Back pain
- Joint pain
- Joint swelling
- Muscle weakness
- Neck pain

### **HEMATOLOGIC / LYMPHATIC** None

- Easy bleeding
- Easy bruising
- Lymphadenopathy (Swollen lymph nodes)
- Thrombosis\* (Blood clots)

### **IMMUNOLOGIC** None

- Contact allergy
- Environmental allergies
- Food allergies
- Seasonal allergies
- Bee sting allergy
- Hay fever

**MEDICAL HISTORY**

No Medical Problems

PROBLEM

- Allergies\*
- Alpha 1 Antitrypsin Deficiency
- Anemia\*
- Angina
- Anxiety
- Asbestosis
- Asthma\*
- Atrial Fibrillation
- Blood Clots/DVT
- Bronchitis
- Bipolar Disorder
- Cancer\* *Type* \_\_\_\_\_
- Cardiac Arrhythmia\*
- Coccidioidomycosis  
(Valley Fever)

PROBLEM

- Congestive Heart Failure
- COPD
- Coronary Artery Disease
- Depression
- Diabetes\* *Type* \_\_\_\_\_
- Elevated Lipids\*  
(Cholesterol, Triglycerides, Lipids)
- Emphysema
- Fibromyalgia
- Heart Murmur
- Hepatitis *Type* \_\_\_\_\_
- Heart Valve Disorder
- HIV/ AIDS
- Hypertension
- Insomnia

PROBLEM

- Lung Nodules
- Myocardial Infarction  
(heart attack)
- Osteoarthritis
- Pneumonia
- Pulmonary Embolism
- Pulmonary Fibrosis
- Restless Leg Syndrome
- Rheumatoid Arthritis
- Sarcoidosis
- Sleep Apnea
- Stroke
- Systemic Lupus  
Erythematosus
- Thyroid Disease
- Tuberculosis

Please list if you have any other Medical Problems not listed above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SURGICAL HISTORY**

No Surgeries or Procedures

SURGERY/PROCEDURE

YEAR

- Adenoidectomy \_\_\_\_\_
- Angioplasty\* \_\_\_\_\_
- Appendectomy \_\_\_\_\_
- Arthroscopy\* *Site* \_\_\_\_\_
- Back Surgery\* \_\_\_\_\_
- Blood Transfusion \_\_\_\_\_
- Bronchoscopy \_\_\_\_\_
- CABG \_\_\_\_\_
- Cardiac Pacemaker \_\_\_\_\_
- Cardiac Stent \_\_\_\_\_
- Cholecystectomy \_\_\_\_\_

SURGERY/PROCEDURE

YEAR

- Dialysis \_\_\_\_\_
- Gastric Bypass \_\_\_\_\_
- Hernia Repair \_\_\_\_\_
- Hip Replacement *Side* \_\_\_\_\_
- Hysterectomy \_\_\_\_\_
- Knee Replacement *Side* \_\_\_\_\_
- Lung Biopsy \_\_\_\_\_
- Lymph Node Biopsy \_\_\_\_\_
- Mastectomy \_\_\_\_\_
- Thyroidectomy \_\_\_\_\_
- Tonsillectomy \_\_\_\_\_

Please list if you have had any other Surgeries/Procedures not listed above, please include the Year: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HISTORY

Adopted

No Family History Known

<u>ILLNESS/ DISEASE</u>	<u>BLOOD RELATIVE</u>	<u>CAUSE OF DEATH</u>	<u>ILLNESS/ DISEASE</u>	<u>BLOOD RELATIVE</u>	<u>CAUSE OF DEATH</u>
<input type="checkbox"/> Alcoholism _____	_____	_____	<input type="checkbox"/> Depression _____	_____	_____
<input type="checkbox"/> Allergies _____	_____	_____	<input type="checkbox"/> Diabetes _____	_____	_____
<input type="checkbox"/> Alpha1 Antitrypsin Deficiency _____	_____	_____	<input type="checkbox"/> Elevated Lipids _____ (Cholesterol, Triglycerides, Lipids)	_____	_____
<input type="checkbox"/> Alzheimer's Disease _____	_____	_____	<input type="checkbox"/> Emphysema _____	_____	_____
<input type="checkbox"/> Arthritis _____	_____	_____	<input type="checkbox"/> Genetic Disease _____	_____	_____
<input type="checkbox"/> Asthma _____	_____	_____	<input type="checkbox"/> Hypertension _____	_____	_____
<input type="checkbox"/> Autoimmune Disease _____	_____	_____	<input type="checkbox"/> Obesity _____	_____	_____
<input type="checkbox"/> Blood Disease _____	_____	_____	<input type="checkbox"/> Renal Disease _____	_____	_____
<input type="checkbox"/> Cancer Type _____	_____	_____	<input type="checkbox"/> Rheumatoid Arthritis _____	_____	_____
_____	_____	_____	<input type="checkbox"/> Sarcoidosis _____	_____	_____
_____	_____	_____	<input type="checkbox"/> Seizure Disorder _____	_____	_____
<input type="checkbox"/> Cardiovascular Disease _____	_____	_____	<input type="checkbox"/> Sleep Apnea _____	_____	_____
<input type="checkbox"/> COPD _____	_____	_____	<input type="checkbox"/> Stroke _____	_____	_____
<input type="checkbox"/> Coronary Artery Disease _____	_____	_____	<input type="checkbox"/> Systemic Lupus Erythematosus _____	_____	_____
			<input type="checkbox"/> Thyroid Disorder _____	_____	_____

Please list if there is any other Family History Illnesses or Diseases not listed above; please include the Blood Relative and if it what the cause of death: \_\_\_\_\_

## SOCIAL HISTORY

**Do you use Tobacco:**

No  Yes  
 Formerly

**Tobacco Type: Use Daily:**

Cigarettes  Cigar  Chewing  
 Smokeless  Pipe  Snuff

**Tobacco Usage Per Day:** # \_\_\_\_\_  Units  Packs

Years Used: \_\_\_\_\_ Age Quit: \_\_\_\_\_

**Do you drink Alcohol:**

No  Yes  
 Formerly

**Alcohol Type:** \_\_\_\_\_

**Date Quit:** \_\_\_\_\_

**How Much:** # \_\_\_\_\_ Drinks / Glasses / Beers

**How Often:**  Daily  Weekly  Monthly  
 Yearly  Occasionally  Rarely  Socially

**Do you drink Caffeine:**

No  Yes

**Caffeine Type:**

Coffee  Soda  Tea  Energy drinks

**Caffeine per Day:** # \_\_\_\_\_  Cups  Ounces

**Do you use Recreational Drugs:**

No  Yes  Formerly

**Drug Type:** \_\_\_\_\_

**Drug Use Frequency:**

Daily  Occasionally  Weekly

**Date Quit:** \_\_\_\_\_

**Do you Exercise:**

No  Yes

**Exercise Type:** \_\_\_\_\_

**Exercise Frequency:** # \_\_\_\_\_ Times per week

Daily  Occasionally  Never

**Occupation:** \_\_\_\_\_

**Domestic Partner:**  Opposite Sex  Same Sex

**Employment Status:** \_\_\_\_\_

**Marital Status:**  Single  Married  Life Partner

**How long have you lived in Arizona:** \_\_\_\_\_

Widow  Divorced

**Has Children:**  No  Yes # \_\_\_\_\_ Sons # \_\_\_\_\_ Daughters

**Any pets in your household:**  No  Yes Type(s): \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## CURRENT MEDICATION LIST

If more space is needed, please use the backside.

<u>MEDICATIONS</u>	<u>Strength</u>	<u>How Often Taken</u>	<u>Reason for Taking Medication</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____
11. _____	_____	_____	_____
12. _____	_____	_____	_____
13. _____	_____	_____	_____
14. _____	_____	_____	_____
15. _____	_____	_____	_____
16. _____	_____	_____	_____
17. _____	_____	_____	_____
18. _____	_____	_____	_____
19. _____	_____	_____	_____
20. _____	_____	_____	_____

<u>VITAMINS &amp; SUPPLEMENTS</u>	<u>Strength</u>	<u>How Often Taken</u>	<u>Reason for Taking Medication</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

ALLERGIES TO MEDICATIONS: \_\_\_\_\_ Check here if NO Allergies

### What is your reaction to this medication?

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |

# CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

NAME(First, Middle, Last) \_\_\_\_\_  MALE  FEMALE

ADDRESS, CITY, STATE, ZIP CODE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

May we leave a message?  Yes  No

May we leave a message?  Yes  No

PCP NAME \_\_\_\_\_ REFERRING SPECIALIST \_\_\_\_\_  
(Primary Care Physician)

Single  Married  Divorced  Life Partner  Widowed NAME OF SPOUSE \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ EMPLOYER PHONE NUMBER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION:

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

*Per CMS regulations we are required to ask for the following data. If you prefer not to share this information, please select the option 'I Decline'.*

I DECLINE TO REPORT

### RACE

- AFRICAN AMERICAN  
 AMERICAN INDIAN OR ALASKAN NATIVE  
 ASIAN  
 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER  
 WHITE  
 OTHER \_\_\_\_\_

### ETHNICITY

- NOT HISPANIC OR LATINO  
 HISPANIC OR LATINO

### PREFERRED LANGUAGE:

- ENGLISH  
 OTHER \_\_\_\_\_

## PRIMARY INSURANCE

INSURANCE NAME \_\_\_\_\_

ID # \_\_\_\_\_

GROUP # \_\_\_\_\_

COPAY AMOUNT \$ \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_

SUBSCRIBER'S DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SUBSCRIBER'S EMPLOYER \_\_\_\_\_

RELATIONSHIP:  SELF  SPOUSE  PARENT  CHILD

## SECONDARY INSURANCE

INSURANCE NAME \_\_\_\_\_

ID # \_\_\_\_\_

GROUP # \_\_\_\_\_

COPAY AMOUNT \$ \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_

SUBSCRIBER'S DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SUBSCRIBER'S EMPLOYER \_\_\_\_\_

RELATIONSHIP:  SELF  SPOUSE  PARENT  CHILD

**INSURANCE AUTHORIZATION:** I HEREBY AUTHORIZE CENTRAL ARIZONA MEDICAL ASSOCIATES TO FURNISH INFORMATION TO INSURANCE CARRIERS REGARDING MY ILLNESS AND TREATMENTS AND ALSO ASSIGN TO THE MEDICAL PROVIDERS PAYMENTS FOR MEDICAL SERVICES FOR MYSELF OR DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COPAYMENTS, COINSURANCE AND DEDUCTIBLES.

**NO-SHOW/LATE CANCELLATION POLICY:** I UNDERSTAND THAT IN THE EVENT I AM UNABLE TO KEEP MY SCHEDULED APPOINTMENT, I MUST GIVE 24 HOURS NOTICE AND THAT FAILURE TO DO SO WILL RESULT IN A \$35.00 FEE.

\_\_\_\_\_  
PATIENT, PARENT, OR GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

# CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

PATIENT NAME: \_\_\_\_\_

## PART 1 – CONSENT TO APPOINTMENT REMINDERS:

Central Arizona Medical Associates partners with TeleVox® to provide appointment reminders via your telephone. As an added feature, you are able to confirm or cancel your appointment when you receive your appointment reminder. Please initial one of the selections below:

I CONSENT to receiving courtesy  
appointment reminders:

OR

I PREFER NOT to receive courtesy  
appointment reminders:

\_\_\_\_\_ - Your Initials

\_\_\_\_\_ - Your Initials

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## PART 2 – NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I am aware that Central Arizona Medical Associates is HIPAA compliant and that I was given the opportunity to review the Notice of Privacy Practices. I understand that I may request a written copy of the Notice of Privacy Practices at any time.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

---

## PART 3 – DISCLOSURE OF YOUR HEALTH CARE INFORMATION:

This section allows you to decide who has access to discuss your Health Care Information, Treatment Plans, and Financial Billing Information or you may select that no one has access to your information. Please select one of the following and sign below.

\_\_\_\_\_ No one has access to my Health Care Information.

OR

\_\_\_\_\_ I hereby grant permission to Central Arizona Medical Associates to discuss my Health Care Information with the following individual(s):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

# **CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.**

## **Notice of Privacy Practices**

*To our patients:* This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can obtain access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### **Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

### **Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

### **Your rights regarding your health information.**

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals' involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however if we do agree, we are bound by our agreement except otherwise required by law, in emergencies, or when the information is necessary to treat you.



3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical record and billing records, but not including psychotherapy notes. You must submit your request in writing to *Central Arizona Medical Associates / Dr. George Parides, Privacy Officer, 3638 E. Southern Ave Ste C108 - Mesa AZ 85206.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Central Arizona Medical Associates / Dr. George Parides, Privacy Officer, 3638 E. Southern Ave Ste C108 - Mesa AZ 85206.* You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact *Central Arizona Medical Associates / Dr. George Parides, Privacy Officer, 3638 E. Southern Ave Ste C108 - Mesa AZ 85206.* All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law.

If you have any questions regarding this Notice or our health information privacy policies, please contact *Dr. George Parides* at 480-834-0771.