[ ] ALAN S. WALTERS, M.D.
[ ] THOMAS H. HIRASA, M.D.
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GENERAL SURGERY
NEW PATIENT REGISTRATION & MEDICAL HISTORY

PATIENT INFORMATION

Name _____ SS#_____ DOB: _____
Last First Middle

Gender: Male □ Female **Marital Status:** □ Single □ Married □ Divorced □ Widowed

Spouse Name:_____

Mailing Address_____ City _____ State _____ Zip _____

If different from physical address

Physical Address _____City _____ State _____ Zip _____

Phone (check □ preferred contact number)

Home □ _____Cell □ _____ Work □_____

e-Mail _____ May we send information to you at this email address? □ Yes □ No

Employer _____ Employer's Address _____
Street City State Zip

Primary Care Physician _____ PCP Phone_____

Other Physician Name(s) _____, _____Phone _____,_____

General Surgery has my permission to give Medical Results or other Messages**:**

□ To other Family Members _____ □ On my answering machine

□ To my Spouse _____ □ All of the Above

Reason for today's visit: _____

These questions are Ethnicity (Check one) □ Hispanic or Latino □ Not Hispanic or Latino □ Declined or Unspecified

Included to comply with new Federal Health guidelines – we are required to ask for this information	**Race (check one)**	□ American Indian/Alaskan Native □ Asian □ White □ Black/ African American □ Native Hawaiian/ Other Pacific Island □ Declined or Unspecified
	Preferred Language	□ English □ Spanish □Declined or Unspecified

Guarantor (If Guarantor is the Patient, Check Here □ and Skip to Next Section)

Last Name: _____ First:_____ MI: ____ Date of Birth: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____ SS#_____

INSURANCE Please present insurance card(s) with this completed form

Primary Insurance: _____Policy Holder: _____

Relationship to Patient: □ Self □ Spouse □ Parent □Other Date of Birth: _____ SS#_____

Employer's Name: _____Policy #: _____ Group#: _____

If you are over 65 and Medicare is Secondary, Please list reason: _____

Secondary Insurance: _____ Policy holder: _____

Relationship to Patient: □ Self □ Spouse □ Parent □Other Date of Birth: _____SS#_____

Employer's Name: _____ Policy #: _____ Group#: _____

EMERGENCY CONTACT

Name: _____Phone:(_____) _____Relationship: _____

Name: _____Phone:(_____) _____Relationship: _____

PATIENT CONSENT & AUTHORIZATION

I hereby give consent to General Surgery to provide whatever treatment they may deem necessary to the patient above. Insured party must sign for all claims. Dependent patients must sign, if not a minor. I authorize insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to my claim. I certify that the information I provided to be true and correct. I know it is a crime to fill out this form with facts I know to be false or omit facts that are important. I assign payment directly to providers of General Surgery which may be due from Medicare or any other insurance company. I understand I am financially responsible to General Surgery for any non-covered insurance services.

_____ _____

Patient Name (Please Print) Date:

_____

Patient or Authorized Representative's Signature

MEDICAL HISTORY

Please check □ Yes or No, if you have now, or have ever had diseases or conditions of:

VASCULAR			OTHER SYSTEMIC			LUNGS		
High Cholesterol	□ Yes	□ No	Diabetes	□ Yes	□ No	Emphysema	□ Yes	□No
High Blood Pressure	□ Yes	□ No	Arthritis/Joint Deformity	□ Yes	□ No	Asthma	□ Yes	□No
Chest Pain	□ Yes	□ No	Thyroid	□ Yes	□ No			
Irregular Heart	□Yes	□ No	Kidney	□ Yes	□ No			
Pacemaker	□ **Yes**	□ **No**						

Family History:

(Please list names of parents- if deceased please list at what age and cause of death)

Mother (health status): _____

[ ] Deceased, Reason, and Age: _____

Father (health status): _____

[ ] Deceased, Reason, and Age: _____

PREVIOUS SURGERIES

_____Date_____ _____Date _____

_____Date_____ _____Date _____

_____Date_____ _____Date _____

_____Date_____ _____ Date _____

****IF APOINTMENT IS FOR A COLONOSCOPY****

LAST COLONOSCOPY PREFORMED (mm/yyyy) _____

Name of Doctor whom preformed colonoscopy: _____

ALCOHOL STATUS **(check one)**

□ Yes □ No □ Socially □ Occasional □ Daily

SMOKING STATUS **(check one)**

□ Never been a smoker □ Former smoker □ Current sometimes smoker □ Current every day smoker
If so: How many per Day? _____ What age did you start?_____ How many years? _____

Substance Abuse **(check one)**

Yes_____ No_____ Current _____Past _____ Never _____ Other _____

Type _____

(Circle one): Recreational or Rx

Pharmacy _____ **Address** _____

Medications

(Please list all prescription & over-the-counter medication you are currently taking, including herbs, vitamins & supplements – along with the dosage)

If you currently DO NOT TAKE ANY MEDICATIONS, check this box: [ ]

Medication Name	Medication Name	Medication Name

Medication Allergies/Reactions (please list medication and associated allergic reaction)

If you have NO KNOWN MEDICATION ALLERGIES, check this box: [ ]

Medication Allergies	Reaction or Side effects

(Office Use Only):

WT: _____ HT: _____ B/P: _____ P: _____T: _____ Oxy: _____ (Route)

EP: _____ Date of last Visit: _____ NP: _____

Reason for Visit:_____

Thank you for choosing us as your healthcare provider. We are here to provide you with excellence of care in a warm friendly environment. The following financial policy is to inform you on our systems regarding insurance billing and what is expected from you regarding payments.

CONSENT TO THE DISCLOSURE OF PERSONAL HEALTH INFORMATION

Do you authorize this office to discuss your care or treatment with any parties besides yourself? □Yes□ No

If YES, list name and relationship to you: _____ _____

_____ _____

RECEIPT/REVIEW OF HIPAA PRIVACY PRACTICES

I understand that as part of my health care, General Surgery originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have reviewed and understand that General Surgery's ***Notice of Privacy Practices*** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review General Surgery's Notice of Privacy Practices prior to signing this acknowledgement; that General Surgery reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to address I've provided if requested.

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

□ Individual refused to sign
□ Communication barrier prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (please specify) _____

_____ _____

Signature of Privacy Officer, General Surgery Date

Patient Name: _____ DOB:_____

FINANCIAL POLICY

We will file your insurance and obtain authorization if needed. We allow 60 days for your insurance company to make payment. Your prompt response to your insurance company's or our requests for information is expected. A prompt response would be within 7 days. If you do not respond to requests for more information the balance on the account will be due immediately. It is your responsibility to check with your insurance company to see if the doctor is contracted with them.

Our financial coordinator is dedicated to making your experience with our Financial Department a positive one. She will go over your Health Insurance Plan with you and your estimated portion due. Your estimated portion is expected prior to any anticipated service, unless other written arrangements have been made with the financial coordinator. This will be an estimate only until insurance has paid their portion. There may be a balance owing and we request you pay that balance in 30 days unless other written arrangements have been made with the financial coordinator. In the event a refund is due, we will send you a refund check within 30 days.

INSUFFICIENT FUND/RETURNED CHECK POLICY

If your check is returned there will be a $25.00 NSF fee charged to your account. You need to contact this office immediately when notified by your bank of non-sufficient funds. We use the Yavapai County Bad Check Program to assist in recovering funds. We understand mistakes happen, that is why we allow two weeks from the date the bank sends the check back to us before contacting the Yavapai County Bad Check Program. We will make multiple attempts to contact you during those two weeks.

PAYMENT IS DUE AT THE TIME OF SERVICE

I understand that office visit charges are payable on the day service is rendered. If your account becomes over 60 days old the account will be charged a finance charge of 18% annum. If your account is not paid according to the above terms, please understand that our office reports to an outside collection agency. In the event that your account is turned over for collection, you agree to pay all additional fees accessed in the collection of the debt. These fees include a 33% collection agency fees and attorney fees. Thank you for your cooperation and if you have any questions please ask. We are here to help!

I understand and agree to policies outlined above

_____ _____20_____

PATIENT/PATIENT REPRESENTATIVE SIGNATURE DATE

The financial policies of General Surgery as outlined above, were discussed with patient/patient representative.

_____ _____20 _____

FINANCIAL COORDINATOR/PRACTIVE REPRESENTATIVE SIGNATURE DATE

Alan S Walters, M.D. **Thomas H. Hirasa,MD** **Donald J. Huang, M.D.**

804 Ainsworth, Suite 103
Prescott, Arizona 86301
(928) 771-1011
(928) 771-1332

Patient Name:_____ DOB:_____