Hernia Center of Arizona

cmirs

Center for Minimally Invasive and Robotic Surgery

CMIRS Intake

Brian Prebil DO
Rachel Alt MD
Jarvis Walters DO

Name: ______________________________ Date of Birth: ______________

Address: ____

City: ______________________________ State: ________ Zip code: ______________

Preferred Phone# ______________________ Social Security # ______________________

Primary email ____

Gender: Female ___ Male ___ Other Preferred _________ Marital Status: Married ___ Single ___ Widowed ___ Divorced ___

Employer: ______________________________ Work Phone: ______________

Emergency contact: Name______________________ Phone #: ______________Relationship:______________

May we discuss your medical care with this person? Yes_____ No_____

Who is your **Primary care physician** ______________________________________

Who may we thank for referring you to our practice?______________________Phone #______________

If you do not have a primary care physician, would you like a referral today? Yes_____ No _____

PRIMARY INSURANCE

Insurance Company: ______________________ Policy #: ______________ Group #: ______________

Policyholder Name: ______________________________ Date of Birth of Policyholder: ______________

SECONDARY INSURANCE

Insurance Company: ______________________ Policy #: ______________ Group #: ______________

Policyholder Name: ______________________________ Date of Birth of Policyholder: ______________

Relationship to policyholder: ______________________ SSN of policyholder: ______________________

AUTHORIZATION AND RELEASE

Authorization for treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents.

Release of records: I authorize CMIRS to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner for charges for this treatment and for quality management, utilization review, transfer and follow up purposes.

Signature: ______________________________________ Date: ______________

New Patient Intake form

Brian Prebil DO
Rachel Alt MD
Jarvis Walters DO

Rm 1 _____ Rm 2 _____

In order to provide you the best care possible, we need to know about your medical history. Please answer all the questions and add any information you feel necessary. If you need any help, please ask us. Thank you in advance.

Name: ____ Date of Birth: _________________________________

Who is your Primary care physician ____ Phone #______________________

Who may we thank for referring you to our practice?____

If you do not have a primary care physician, would you like a referral today? Yes_____ No _____

What is the primary reason for your visit today?____

How long have you had this problem? ____

Please describe your symptoms:____

Location of symptoms:____ Right _____ Left ______ N/A_______

Does anything make your symptoms better or worse? ____

How would you rate the severity of your symptoms? Lowest 1 2 3 4 5 6 7 8 9 10 Highest (Please circle)

Do you have any of the following symptoms? (Please circle)

Nausea	Vomiting	Fevers	Chills	Heartburn	Regurgitation	Shortness of breath
Diarrhea	Black stools	Cough	Hoarseness	Headaches	Wheezing	Chest pain
Anorexia	Constipation	Anxiety	Difficulty swallowing		Abdominal pain - Location______________	
Trouble urinating		Other?				

Medical history: do you now, or have you ever had any of these problems? (Please circle)

Thyroid (high/low)	Coronary artery disease	Hyperlipidemia	Congestive heart failure
Diabetes	Asthma	High blood pressure	Stroke
Kidney problems	COPD	Reflux/heart burn	Sleep apnea
Bleeding disorders	Heart attack	Ulcers	Pacemaker/defibrillator
Currently pregnant	Liver problems	Blood clots	Cancer (type?)
Other?			

Family history: has anyone in your immediate family ever had any of these problems? (Please circle)

Thyroid (high/low)	Coronary artery disease	Hyperlipidemia	Congestive heart failure
Diabetes	Asthma	High blood pressure	Stroke
Kidney problems	COPD	Reflux/heart burn	Sleep apnea
Bleeding disorders	Heart attack	Ulcers	Pacemaker/defibrillator
Cancer (type?)	Problems with Anesthesia		Other?

Surgical history: have you had any previous surgeries? Yes_____ No _____

Please list procedure and

dates:____

Are you allergic to any medications? Yes_____ No_____ If yes, what medication and what was your reaction?

____

Are you allergic to any thing else? (tape, latex, betadine) No_____Yes (please describe)_________________________________

Social History:

Do you smoke? Yes_____ No _____ If yes, what type how much and how many years?_________________________________

Have you ever smoked? Yes_____ No _____ If yes, when did you quit?____

Do you drink alcohol? Yes_____ No _____ If yes, how much and how often? ____

Do you take street drugs? Yes____ No _____ If yes, please list ____________________________________

Please list **all** prescribed medications, over the counter medications and supplements that you take with doses:

Preferred Pharmacy: ____ Phone number ________________________

Do you see any other physicians? (Cardiologist, pulmonologist, etc?) If yes, please list:

If you need surgery, what is your preferred hospital?

Banner Thunderbird _____ Abrazo Arrowhead _____ Dignity Westgate _____

Notice of Privacy

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 get 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:

-CMIRS 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:

-To public health authorities and health oversight agencies that are authorized by law to collect information.

-Lawsuits and similar proceedings in response to a court or administrative order.

-If required by a law enforcement official.

-When necessary to reduce or prevent a serious threat to your health and safety or the 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.

-If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

-To federal officials for intelligence and national security activities authorized by law.

-To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

-For workers Compensation and similar programs.

Your rights regarding your health information:

-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

-You can request a restriction of 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 when otherwise required by law, in emergencies, or when the information is necessary to treat you.

-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 records and billing records, but not including psychotherapy notes. You must submit your request in writing.

-You may ask 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.

-Right to copy 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.

-Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our front desk. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

-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.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy

Signature: ____ ***Date:*** __________________