

Dr. Adam J. Farber



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

Review of Systems:

| | | | | | |
|-------------------------------|-----------------------------|------------------------------------|--------------------------------|-----------------------------|------------------------------------|
| Night Sweats / Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Weight Loss or Gain | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Chills | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Indigestion/Heartburn/Reflux | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Recent Illness | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Abdominal Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Fatigue/ Malaise (discomfort) | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Diarrhea | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Visual Changes | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Difficulty Swallowing | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Trauma or Cancer of Head/Neck | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Vomiting Blood | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Hearing Loss | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Jaundice | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Ringing in Ears | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Painful or Frequent Urination | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Chest Pain/Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Blood in Urine | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Dyspnea (Shortness of Breath) | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Bone Fractures | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Edema | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Abnormal or Prolonged bleeding | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Congestion/Cough/Wheezing | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ | Altered Level of Consciousness | <input type="checkbox"/> No | <input type="checkbox"/> 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
60 E Rio Salado Parkway
Suite #505
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, Visa and Master Card. 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: ____/____/____