Patient Name: _____
Patient DOB: _____/_____/_____

Please answer the following to the best of your ability. If you are unable to fill out these forms or need assistance, ask the front desk for additional help.

I authorize the following people to access my medical records and information:

Name (First and Last)	Date of Birth (MM/DD/YYYY)	Relationship
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____

What medical conditions have you been diagnosed with (Example: Diabetes, high blood pressure, etc.)

Condition	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What medical conditions are in your family history (Example: Diabetes, high blood pressure, etc.)

Condition	Family Member (Mother, Father, etc)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications or medical products? (If none write N/A) Please list these here:

Allergy:	Allergic Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any children? [ ] Yes [ ] No If yes, how many: _____

Do you currently smoke? [ ] Yes [ ] No If yes, how often: _____

Are you a former smoker? [ ] Yes [ ] No If yes, how many years: _____

Do you chew tobacco? [ ] Yes [ ] No

Do you drink alcohol? [ ] No, [ ] Socially, [ ] 1-2 per day, [ ] 3-4 per day, [ ] over 4 per day

Have you ever used illegal drugs? [ ] Yes [ ] No

If yes, list what kind(s): _____

Are you currently sexually active? [ ] Yes [ ] No

Have you ever had a sexually transmitted disease (STD)? [ ] Yes [ ] No

If yes, please list type: _____ Date: _____/_____/_____

What surgeries have you had done in the past? (If none write N/A)

Type of Surgery	Hospital/Facility	Year

Please list the medications that you take. (If you have a list, please turn it in with your packet, or have the front desk make a copy for your chart.) (If none write N/A)

Medication:	Milligrams or Dose:	How often:

Please list the information for the pharmacy you would like us to have on file for you.
Pharmacy Name: _____ Phone Number: (_____)_____-_____

Address or Cross Streets: _____

Do you prefer to use a mail order pharmacy? [ ] Yes [ ] No
Pharmacy Name: _____ Phone Number: _____

Please review the following checklist, and only check the medical conditions that apply to you. (If a condition applies to someone in your family, but you do not have it, do not check the box for that condition.)

Constitutional
- ☐ Recent appetite change
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fatigue
- ☐ Fever
- ☐ Chills

Skin
- ☐ Hives
- ☐ Itching
- ☐ Rash

Allergy/Immunologic
- ☐ Cancer (Type: _____)
- ☐ Seasonal Allergies

ENMT
- ☐ Hearing change
- ☐ Nosebleeds
- ☐ Tinnitus (Ringing in ears)

Eyes/Head
- ☐ Dizziness
- ☐ Headaches
- ☐ Changes to vision

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing

Cardiovascular
- ☐ Edema (Swelling)
- ☐ Chest pain/discomfort
- ☐ Syncope (Fainting)

Gastrointestinal
- ☐ Bloody stools
- ☐ Recent bowel changes
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Constipation

Genitourinary
- ☐ Weak urinary stream
- ☐ Painful urination
- ☐ FEMALES: Vaginal discharge
- ☐ MALES: Penile discharge

Endocrine
- ☐ Diabetes (Type 1 or 2: _____)

Musculoskeletal
- ☐ Bursitis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Muscle/joint stiffness
- ☐ Back pain/injuries
- ☐ Arthritis

Neurological
- ☐ Epilepsy
- ☐ Palsy
- ☐ Speech changes
- ☐ Stroke
- ☐ Tingling

Hematologic/Lymphatic
- ☐ Anemia (Low iron)
- ☐ Easy bruising

(Patients: This form allows our office to request medical records on your behalf from other physicians, hospitals, and care providers in order to better coordinate your care. Please fill this out to the best of your ability.)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Other Name: _____

Address: _____ DOB: _____/_____/_____

_____ Social Security Number: _____-____-_____

_____ Phone: (_____)_____-_____

I hereby authorize (Physician, hospital, or group): _____

_____

_____

To release information to:

Arizona State Urological Institute (ASUI)
2730 S. Val Vista Drive, Building 13, Suite 177
Gilbert, AZ 85295
Phone: (480) 394 - 0200 | Fax: (480) 394 – 0202

[ ] For the following purposes: _____

OR

[ ] All Records

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

[ ] **I DO** authorize the release of this type of information.

[ ] **I DO NOT** authorize the release of this type of information.

I understand that:

- I may revoke this authorization, except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization, unless the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization for my personal records.

_____ _____

(Signature of patient or responsible party) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arizona State Urological Institute (ASUI) and Arizona Oncology (AO) share the same commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our Practice, and outlines your rights with regard to your health information. Please sign this form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Arizona Oncology Associates, P.C.:

_____ _____/_____/_____

Signature of Patient or Personal Representative Date

_____

Printed name of Patient or Personal Representative

PATIENT CONTACT LIST

Please provide current information that our office can use to contact individuals on your behalf in case of disconnected number, difficulty with reaching you, or an emergency situation.

Emergency Contact: Indicate any person who should be notified in case you experience a medical emergency while at our office.

EMERGENCY CONTACT

Name: _____ Date of Birth: _____/_____/_____

Relationship: _____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

Non-Emergent Contact: Indicate persons who we may contact if we are having difficulty reaching you. Note: Unless you authorize the following individuals to access your protected health information (PHI), they may not receive test results or office visit information on your behalf.

NON-EMERGENT CONTACT #1

Name: _____ Date of Birth: _____/_____/_____

Relationship: _____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

NON-EMERGENT CONTACT #2

Name: _____ Date of Birth: _____/_____/_____

Relationship: _____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

NON-EMERGENT CONTACT #3

Name: _____ Date of Birth: _____/_____/_____

Relationship: _____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

_____ _____/_____/_____

Printed patient name Date

_____

Signature of patient or patient representative