AZ Elite Surgeons, LLC

I am a patient of ___ Dr. Ghazanfari ___ Dr. Howard

Patient Demographic Information Sheet

NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY NUMBER
DATE OF BIRTH	AGE	SEX __ M __ F	LANGUAGE __ English __ Spanish __ Other: _____	

PATIENT

RACE AND ETHNICITY ___ Asian ___ Black or African American ___ American Indian or Alaskan Native ___ Native Hawaiian or Other Pacific Islander ___ White ____Hispanic or Latino ___ Other: _____ ___ Decline to specify			
ADDRESS	CITY, STATE	ZIP CODE	
TELEPHONE	CELL PHONE	OTHER PHONE	OCCUPATION
EMAIL ADDRESS			
EMERGENCY CONTACTS	NAME AND RELATION TO PATIENT	PHONE	
	NAME AND RELATION TO PATIENT	PHONE	
PRIMARY/FAMILY PHYSICIAN	PHONE	REFERRING PHYSICIAN	PHONE
PHARMACY	PHARMACY PHONE	PHARMACY ADDRESS	

PRIMARY INSURANCE		SECONDARY INSURANCE	
INS. CO. NAME		INS. CO. NAME	
MEMBER ID #	GROUP #	MEMBER ID #	GROUP #
RELATIONSHIP TO PATIENT		RELATIONSHIP TO PATIENT	
INSURED'S NAME		INSURED'S NAME	
INSURED'S SS#	DOB	INSURED'S SS#	DOB

I GIVE MY PERMISSION FOR THESE INDIVIDUALS TO OBTAIN MY PROTECTED HEALTH INFORMATION

NAME	DATE OF BIRTH	RELATION TO PATIENT	PHONE

****May we leave messages regarding appointments on your answering machine? ___ Yes ___ No**

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

SIGNATURE _____ **DATE** _____

AZ ELITE SURGEONS, LLC ___ Dr. Ghazanfari ___ Dr. Howard

Medical History Form

NAME: _____ **Ht**: ____'____" **Wt**: _____ **lbs.**

What is the reason for today's visit? _____
Please describe details of condition: _____
Where are you affected? _____
How long, how often? _____
How severe, causes? _____
Contributing factors? _____

MAJOR MEDICAL EVENTS /PAST SURGERIES	Where/When	Doctor

Ongoing Medical Conditions for which you see a doctor or take medication.		
__ Bleeding Disorders	__ High Blood Pressure	__Cancer (Type) -
__ Arthritis/Gout	__ Heart Disease	__ Thyroid
__ Acute infections	__ Atrial Fibulation	__ Asthma
__ Diabetes	__ DVT	__ Pacemaker/defibrillator
__ Reflux/GERD	__ Stroke	__ Stents (specify)-
__ Seizures	__ COPD	__ Other (specify) -

CURRENT MEDICATIONS	
Medication	**Dose**

ALLERGIES		
Medication	**Reaction**	**Severity**
		__Mild __Mod __Severe
		__Mild __Mod __Severe
		__Mild __Mod __Severe
		__Mild __Mod __Severe
		__Mild __Mod __Severe
		__Mild __Mod __Severe

Social History

Marital Status: __ Single __ Married __ Divorced/Legally Separated __ Widowed __ Life partner
Use of alcohol: __ Never __ Rarely __ Moderate __ Daily
Use of cigarettes: __ Never __ Previously, but quit __ Yes - Current packs per day ____
Use of drugs: __ Never __ Type/Frequency _____

Family Medical History- List ONLY if they had or have significant diseases or conditions			
Disease	**Deceased**	**Disease**	**Deceased**
Father:	__Y __N	Siblings:	__Y __N
Mother:	__Y __N	Children:	__Y __N

SIGNATURE_____ **DATE:** _____

AZ ELITE SURGEONS, LLC ___ Dr. Ghazanfari ___ Dr. Howard

Systems Review

Name: _____ Date: _____

Please circle if you have or have had any of the following:

General
Recent weight change
Fevers/chills
Fatigue
Night sweats

Skin and Hair
Rashes/sores
Skin cancers/melanomas
Hair loss
Unusual lumps under skin

Endocrine
Diabetes
Thyroid disease
High blood pressure

Ear, Nose & Throat
Glasses/contacts
Double vision
Hearing loss
Persistent ringing in ears
Difficulty swallowing
Pain or stiffness in neck
Fullness in the neck or throat
Hoarseness or voice change

Lungs
Shortness of breath
Emphysema or chronic bronchitis
Asthma or wheezing
Congestive heart failure
Persistent cough
Pneumonia

Blood
Anemia
Blood transfusions
If yes: when, how much, and why
_____

Heart and Blood Vessels
Heart attacks
Chest pain
Heart murmur
Heart surgery
Irregular heart beat (palpitations)
Swelling in the feet
Phlebitis or blood clots
High blood pressure

Gastrointestinal
Difficulty swallowing
Heartburn
Hiatal hernia
Ulcer disease
Hepatitis or other liver disease
Jaundice
Colitis
Irritable bowel disease
Crohns' disease
Constipation
Diarrhea
Hemorrhoids/rectal disorders
Blood in stool
Abdominal pain

Musculoskeletal
Arthritis
Joint pain, stiffness or swelling
Decreased muscle strength
Osteoporosis
Any broken bones
Back pain/back surgery

Neurological
Headaches
Dizziness/fainting
Weakness or tingling in arms/legs
History of any head trauma

Infectious
Any serious infection
Childhood illnesses: __ measles __ mumps __ chicken pox
Last tetanus _____ Last flu shot _____

For Women Only
Abnormal bleeding or discharge
Any gynecological surgery
Pain during intercourse
Kidney stones
Urinary tract infections
Sexually transmitted disease (gonorrhea, herpes, venereal warts, HIV, AIDS)
Age at time of first period _____
Number of pregnancies _____
Number of live births _____
Did you breast feed your children? _____
Average how long? _____
Last menstrual period _____

Breasts
Breast pain
Nipple discharge
Breast lumps
Previous breast surgery
Changes in breast size

For Men Only
Kidney stones
Prostate disease
Difficulty urinating
Urinary tract infections
Vasectomy
Sexually transmitted disease (gonorrhea, herpes, venereal warts, HIV, AIDS)

If you circled any of the above, please explain.

_____
_____
_____
_____
_____

Any other Issues or concerns:

_____
_____
_____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of AZ Elite Surgeons LLC; Travis L. Howard D.O. -General Surgery of Payson PLLC dba San Tan General surgery; Ali Ghazanfari M.D. PLLC is dedicated to protect your "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:
Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct.

We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:
We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:
To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:
Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Government Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities who need this information for claims processing have access to your Protected Healthcare Information.

**We participate in an organized helth care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiancy of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or the health care operations of this organized health care arrangement.

YOUR RIGHTS:
You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your record.

If you leave this practice, your Protected healthcare Information will continue to receive the protection outlined in this notice.

COMPLAINT/COMMENTS:
If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S. W. Room 509F, HHH Building, Washington D.C. 20201. You also may contact the Privacy Officer of this practice at (480)926-6653.

THIS PRACTICE reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

This notice is effective as of September 1st, 2006.

_____
Patient Name (Print)

_____ **Date:**_____
Patient Signature