



## New Patient Letter

**Thank you for choosing Healthy Outlook Family Medicine, P.C.**  
1835 W Missouri Avenue  
Phoenix, AZ 85015  
602-230-0777  
602-230-0008 (Fax)

Your appointment is scheduled at \_\_\_\_\_ on \_\_\_\_\_  
with \_\_\_\_\_. Please arrive 15 minutes prior to your appointment.  
You will need to bring the enclosed paperwork with you on the day of your  
appointment. You must have your insurance card. If your card does not have  
one of our providers listed on it, please call your insurance company and have  
it corrected before your visit.

If you are scheduled for a complete physical and were told you need  
to fast, stop eating 12 hours before your scheduled appointment time. Do  
not drink anything other than plain tea, black coffee, or water. Continue  
taking all vitamins and medications as usual. If you are diabetic, you may call  
the office for fasting instructions.

If you can not make your appointment, call the office 24 hours prior  
to your appointment to cancel. There is a \$50 charge for missed  
appointments. Thank you.

**Remember: Co-pays are due at time of service.  
We accept cash, check, Visa and MasterCard as  
forms of payment.**

**Patient Information**

fill in **ALL** blanks

(use same or N/A if needed)

**\*\*If you were preregistered by phone, only fill in information you did not have available during preregistration.\*\***

P  
A  
T  
I  
E  
N  
T

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_ Jr./Sr. (if used) \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_ ext \_\_\_\_\_  
 Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Sex \_\_\_\_  Single  Married  Other  Employed  FT Student  PT Student  Other  
 Social Security Number \_\_\_\_\_ Email \_\_\_\_\_  
 Race  White  Hispanic  African American  Asian  American Indian  Pacific Island  Other  
 Ethnicity  Not Hispanic  Hispanic or Latino  
 Language Preference  English  Spanish  Other \_\_\_\_\_

If patient is a minor, fill in this section. If insurance is in another person's name, fill in this section.  
**If it's okay to mail your family's statements together, fill in this section.**

Who are statements sent to?  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Is this an established patient?  Y  N  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_ ext \_\_\_\_\_  
 Relationship \_\_\_\_\_ SSN \_\_\_\_\_

I  
N  
S  
U  
R  
A  
N  
C  
E

Primary Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Group \_\_\_\_\_  
 Relationship to Cardholder  Self  Spouse  Child  Other \_\_\_\_\_

If "self" was not selected above, fill in this section.  
 Is cardholder a patient at this office?  Y  N  
 Cardholder's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_ Jr./Sr. \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Sex \_\_\_\_

If insurance is through an employer, name of employer \_\_\_\_\_  
 Secondary Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Group \_\_\_\_\_  
 How did you find out about our office?  Family  Co-Worker  Friend  
 Another Doctor  Insurance  Other \_\_\_\_\_

C  
O  
N  
T  
A  
C  
T

State Law requires the following information for emergency contact.  
 If your mailing address listed above is a PO Box, you must provide your physical address.  
 Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Emergency Contact:  
 Spouse/Partner's Name \_\_\_\_\_ Emergency Phone \_\_\_\_\_  
 Closest relative living at a different address:  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_ ext \_\_\_\_\_

Patient or Authorized Signer \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_



## Health Database

Name \_\_\_\_\_

Today's Date \_\_\_ / \_\_\_ / \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Race \_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_

### Past Illnesses (Circle those you have experienced)

Heart Disease	TB/Emphysema	Kidney Disease	Sexually Transmitted Disease
Hypertension	Asthma	Bleeding Tendency/Transfusions	Depression/Anxiety/Bipolar
Heart Murmur	Diabetes	Ulcers	Neurologic Disorder/Seizures
Rheum. Fever	Thyroid	Arthritis	Digestive Problems
Stroke	Cancer _____	Eye Problems	Other _____

List All Surgeries/Hospitalizations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Social History

Relationship status \_\_\_\_\_ Occupation \_\_\_\_\_

Age(s) of children \_\_\_\_\_ Vaginal or Caesarian birth(s)? \_\_\_\_\_

If patient is a child, were there any complications during birth? \_\_\_\_\_

Do you have a living will/advanced directives? \_\_\_\_\_

Do you have a religious/spiritual preference? \_\_\_\_\_

Use of	Circle
Tobacco	Y N
Cigarettes	Y N
Alcohol	Y N
Illegal Drugs	Y N
Caffeine	Y N
Guns in home	Y N
Pool at home	Y N

### Medications

Medications you are using or have used in the past year (name, dose, frequency): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergic or sensitivity reactions to any medication, product, or food:  
 None \_\_\_ List \_\_\_\_\_

Adult immunizations (Circle those done in the past 10 years – children must have their immunization records):  
 Flu COVID Shingrix Pneumonia Tetanus Others: \_\_\_\_\_

### Family History

Family Member	Health Problems	Cause of Death
Father		
Mother		
Brothers		
Sisters		
Children		
Grandparents		

Is there any history of sudden unexplained death in your family? \_\_\_\_\_

Is there any history of breast cancer in your family? \_\_\_\_\_

Names of other family members seen in our office \_\_\_\_\_

## Financial Agreement

Please review carefully. Fees are subject to change.

Appointment Late Cancellation (24 hour notice required, excluding weekends) .....\$25.00  
Appointment Late Arrival (cannot be seen for appointment) .....\$25.00  
Appointment No Show .....\$50.00

Forms (complete all patient sections before submitting)

Disability / FMLA ..... \$25.00 - \$50.00

We do not complete forms for conditions being treated by a specialist. Allow  
5 business days for completion or rejection. Additional visits may be required.

Biometric Screening .....\$15.00 - \$25.00

Medical Necessity Letters .....\$50.00

Nursing School .....\$25.00

Additional visits may be required.

Mission Physicals .....\$50.00 - \$75.00

Miscellaneous Form Not Listed ..... \$varies

There may be a charge for your particular form not listed here.

Medical Records from Patient Portal.....free

Medical Records Provided by Office..... \$varies

Allow two weeks. Mailing fees apply.

Fees are payable when the forms are dropped off. Forms are completed at the provider's discretion.

If your form cannot be completed, the fee will be refunded or placed as a credit on your account.

After billing is complete (select one):

\*\* Does not apply to amounts due on date of visit \*\*

- Bill my insurance. When the amount due is determined, charge my CREDIT CARD automatically.
- Bill my insurance. When the amount due is determined, send me a bill. I will pay by CHECK within 15 days. I understand that \$20 late fees will be added each month.

\_\_\_\_\_  
Last Name— **print neatly**

\_\_\_\_\_  
First Name

\_\_\_/\_\_\_/\_\_\_\_\_  
Date of Birth

I authorize this provider and its assignees to communicate with me by telephone, e-mail, text message, fax, or other means. I authorize any provider to give treatment. I authorize the release of medical records or other information necessary to process claims. I authorize insurance to pay the provider directly for services rendered. Insurance is billed one time as a courtesy. However, **payment for all services is my responsibility.** Furthermore, **I agree to pay any amount denied or not covered by insurance.**

State law requires payment of medical claims within 30 days. **45 days after service has been rendered, insurance coverage is deemed waived and the patient is responsible for all billed charges without adjustment. \$20 monthly late fees and an interest rate of 16% annually apply to all unpaid amounts. There is a \$50 charge for missed appointments. Collection agency fees of 40% plus court costs and reasonable attorneys' fees are my responsibility.**

Patient or Authorized Signer \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_\_\_

# Healthy Outlook Family Medicine, P.C.

---

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Healthy Outlook Family Medicine, an Arizona Professional Corporation, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement.

## **ACKNOWLEDGEMENT OF RECEIPT OF STATEWIDE HEALTH INFORMATION EXCHANGE NOTICE**

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

## **ACKNOWLEDGEMENT OF HEALTH INFORMATION EXCHANGE**

I acknowledge that Healthy Outlook Family Medicine may use or may add new data exchange capabilities with other networks, exchanges, hospitals, physicians, or other medical providers or companies. I acknowledge that this form serves as notice for any current or future exchange capabilities. I may request copies of any relevant notice.

---

Date

---

Signature of Patient or Patient's Representative

---

Patient Name (Print)