



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.****

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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 _____

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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 _____

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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):
 Tetanus Influenza Pneumonia 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 agree that calls and text messages may be delivered to any phone number I provide. I authorize any provider at Healthy Outlook Family Medicine, P.C. to provide treatment. I authorize the release of all medical records or other information necessary to process claims. I authorize insurance to pay Healthy Outlook Family Medicine, P.C. 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 to be waived and the patient is responsible for all billed charges without adjustment. \$20 late fees and an interest rate of 10% 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)