□ **NEW REGISTRATION** □ **UPDATED** □

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX □ MALE □ FEMALE

HOME PHONE #	EMAIL	CELL PHONE #	MARITAL STATUS: □ MARRIED □ SINGLE □ WIDOWED □ DIVORCED □ OTHER

REFERRING PHYSICIAN NAME AND PHONE NUMBER	PCP NAME & PHONE#

HOW DID YOU HEAR ABOUT US: □ PROVIDER REFERRAL □ INTERNET □ WORD OF MOUTH □ PREVIOUS PATIENT □ CURRENT PATIENT
□ BROCHURE □ INSURANCE □ HOSPITAL □ CONCENTRA □ MAGAZINE □ RADIO □ OTHER

MANDATORY-PER NEW CMS GUIDELINES

LANGUAGE	**ETHNICITY**	**RACE**
□ ENGLISH □ SPANISH □ RUSSIAN □ CREOLE □ OTHER _____	□ LATINO/HISPANIC □ NON LATINO/NON HISPANIC	□ ASIAN □ NATIVE HAWAIIAN □ OTHER PACIFIC ISLANDER □ BLACK/AFRICAN AMERICAN □ AMERICAN INDIAN/ALASKA NATIVE □ WHITE □ REFUSE TO REPORT

RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME	FIRST NAME	MI	HOME PHONE

ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYER	OCCUPATION	WORK PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY □ SELF □ SPOUSE □ CHILD □ OTHER

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT INFO –	PHONE

PHARMACY

NAME AND LOCATION	PHONE

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	**SUBSCRIBER NAME AND SOCIAL SECURITY**	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

SECONDARY INSURANCE	**SUBSCRIBER NAME AND SOCIAL SECURITY**	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS, FINANCIAL POLICY TERMS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I have read, agree to and signed the Financial Policy. I agree I will be responsible for any unpaid balances for any reasons

I hereby authorize direct payment to David Johnson, MD of any medical benefits payable to me for the services provided by David Johnson, MD.

X_____
Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize David Johnson, MD to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X_____
Patient Signature or Signature of Guardian or Parent Date

David C. Johnson, MD

6242 E. Arbor Ave. Ste. 101
Mesa, AZ 85206
Phone# 480-219-0013
Fax# 480-219-0343

Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

_____

Telephone: _____

I authorize *David C. Johnson, MD* or other person/entity _____ to disclose/release the following information:

_____ All medical records related to (specify condition, treatment, etc.): _____

_____ All billing records related to (specify condition, treatment, etc.): _____

_____ Specific records/information as follows: _____

_____

Purpose of disclosure: _____

I do not want the following information disclosed (as defined by applicable state and federal laws):

_____ Alcohol/Drug Abuse _____ HIV Test Results _____ Mental Health/Developmental Disabilities

Release information TO:

Address: _____

_____

Telephone: _____ **Fax:** _____

This Authorization is good until the following date: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Address

_____ _____
Description of Personal Representative's Authority Telephone

REVIEW OF SYSTEMS: *Please tell us about current symptoms you are experiencing.*

◊ General

Recent Weight Change	Yes No
If Yes,	
Circle: Gain or Loss	
Specify,	
Weight change: _____ pounds	
Time interval: _____ wks or months	

◊ Skin

Skin Lesions	Yes No

◊ Head & Neck (HEENT)

Ear/Hearing Problems	Yes No
Eye/Vision Problems	Yes No
Nose Bleed	Yes No

◊ Respiratory

Asthma	Yes No
Chronic Cough	Yes No
Difficulty Climbing 1 Flight of Stairs	Yes No
Nighttime Breathing Difficulty	Yes No
Shortness of Breath	Yes No
Wheezing	Yes No
Oxygen at Home	Yes No

◊ Breast (Female)

Breast Lump	Yes No
Breast Pain	Yes No
Inverted Nipple	Yes No
Nipple Discharge	Yes No

◊ Cardiovascular

Chest Pain	Yes No
Difficulty Breathing on Exertion	Yes No
Heart Disease	Yes No
High Blood Pressure	Yes No
Irregular Heartbeat	Yes No
Poor Circulation	Yes No
Swelling of Extremities	Yes No
Previous Heart Attack	Yes No

◊ Gastrointestinal

Abdominal Mass	Yes No
Abdominal Pain	Yes No
Black, Tarry Stool	Yes No
Bloody Stool	Yes No
Change in Bowel Habits	Yes No
Constipation	Yes No
Difficulty Swallowing	Yes No
Food Intolerance	Yes No
Heartburn	Yes No
Indigestion	Yes No
Nausea	Yes No
Vomiting	Yes No

◊ Musculoskeletal

Arthritis	Yes No

◊ Neurological

Fainting/Dizziness	Yes No
Headaches	Yes No
Seizures	Yes No
Previous Stroke	Yes No

◊ Psychiatric

Anxiety	Yes No
Depression	Yes No
Difficulty Sleeping	Yes No
Insomnia	Yes No

◊ Endocrine

Appetite Changes	Yes No
Diabetes	Yes No
Hormone Problems	Yes No
Thyroid Problems	Yes No

◊ Hematology

Abnormal Bleeding	Yes No
Anemia	Yes No
Bleeding Problems	Yes No
Blood Clots	Yes No
Embolism	Yes No
Enlarged Lymph Nodes	Yes No
History of Blood Transfusion	Yes No

◊ Female Genitourinary

Dark Urine	Yes No
Difficulty Emptying Bladder	Yes No
Frequency	Yes No
Kidney Problems	Yes No
Menstrual Irregularities	Yes No
Painful Urination	Yes No
Kidney Stones	Yes No
Recent Kidney/Bladder Infection	Yes No
Excessive Urination at Night	Yes No

◊ Male Genitourinary

Blood in Urine	Yes No
Dark Urine	Yes No
Difficulty Urinating	Yes No
Frequency	Yes No
Hernia	Yes No
Kidney Problems	Yes No
Kidney Stones	Yes No
Nighttime Urination	Yes No
Painful Urination	Yes No
Recent Kidney/Bladder Infection	Yes No

Any additional information you feel we should know about?

MEDICATIONS: *Please list any medications including aspirin, vitamins, over-the-counter, or herbal medication.*

Medication Name	*Dose*	*Frequency (How Often Taken)*
Hormones or Birth Control Pills ☐ Yes ☐ Previously ☐ Never		
Herbal Supplements ☐ Y ☐ N Type:		
Vitamin E, Fish Oil or Omega 3's ☐ Y ☐ N		
Aspirin (81mg or more) ☐ Y ☐ N		
Blood Thinners ☐ Y ☐ N Type:		

PAST SURGICAL HISTORY:

Year	*Procedure*	*Surgeon*

Recent Imaging and Diagnostic Studies:

Year	*Procedure*	*Surgeon*
	Colonoscopy	
	Mammogram	
	Pap smear	
	DEXA (Scan, Wheelchair, Walker)	

SOCIAL HISTORY:

Years in Arizona: _____ Where were you born? _____

Tobacco Use: ☐ Never ☐ Former Smoker – When did you stop? _____ ☐ Smoker – Packs per day? _____

Alcohol Use: ☐ Never ☐ Occasionally ☐ Moderate ☐ Daily Type & drinks/weeks _____

Recreational Drug/Non-prescribed narcotics: ☐ Never ☐ Type & Frequency: _____

Caffeine: ☐ Never ☐ Coffee, # cups: _____ ☐ Tea, # cups: _____ ☐ Soda, # cups: _____ ☐ Chocolate

Marital Status ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Widow(er)

Occupation: Are you currently working? ☐ Yes ☐ No Disability? ☐ Yes ☐ No

How many children? _____

BREAST PATIENTS ONLY:

Date of last menstrual period? _____ Age of 1st menstrual period? _____ Age at menopause? _____

Of Pregnancies? _____ # of Deliveries? _____ Age at 1st Delivery? _____

Did you breast feed? ❑Yes ❑No If YES, for how long did you breast feed? _____

Are you currently on Estrogen replacement? ❑Yes ❑No

Do you have Ashkenazi Jewish ancestry? ❑Yes ❑No

Have you had a previous breast biopsy? ❑Yes ❑No # of breast biopsies? _____

Please list ALL known relatives who have been diagnosed with BREAST CANCER or OVARIAN CANCER.

	Relative's Relation to You	*Relative's Age at Diagnosis*		*Relative's Relation to You*	*Relative's Age at Diagnosis*
1.			5.		
2.			6.		
3.			7.		
4.			8.		

	Home Oxygen Therapy	☐ Y ☐ N			
	High Blood Pressure	☐ Y ☐ N			
	Joint Disorder	☐ Y ☐ N			
	Liver Disorder	☐ Y ☐ N			
	Lung Disorder	☐ Y ☐ N			
	Mental Illness	☐ Y ☐ N			
	Muscle Disorder	☐ Y ☐ N			
	Nerve Disorder	☐ Y ☐ N			
	Neurologic Disorder	☐ Y ☐ N			
	Osteoporosis	☐ Y ☐ N			
	Pacemaker	☐ Y ☐ N			
	Thyroid Disease	☐ Y ☐ N			
	Sleep Apnea	☐ Y ☐ N			
	Vascular Disease	☐ Y ☐ N			
	Other:				
	Other:				

Allergies: *List allergens and associated reactions (e.g. Hives, Rash, Nausea, ...)*

☐ No Known Drug Allergies ☐ No Known Food Allergies

Aspirin	☐ Y ☐ N			Latex	☐ Y ☐ N	
Codeine	☐ Y ☐ N			Adhesive tape	☐ Y ☐ N	
Morphine	☐ Y ☐ N			*Other drug, food, environmental allergens:*		
Penicillin	☐ Y ☐ N					
Sulfa	☐ Y ☐ N					
Coumadin/Warfarin	☐ Y ☐ N					

FAMILY HISTORY: *Please list any medical problems in your relatives.*

❑ Family Medical History Unknown

	Not Present	***Mother***	***Father***	***Sister(s)***	***Brother(s)***	***Other Blood Relative***
Diabetes *Type:*_____						
Gallbladder Disease						
Heart Disease						
Hypertension						
Liver Disease						
Obesity						
Stroke						
Thyroid Disease						
Cancer *Type:*_____						
Other Conditions:						

BARIATRIC PATIENTS ONLY: (Bariatric History)

Personal Goal Wt: _____ lbs Wt in High School: _____ lbs Highest Wt: _____ lbs Date: _____

Have you previously had bariatric surgery? ☐ Y ☐ N If Yes, Wt at time of surgery: _____ lbs Date: _____

Type of surgery: *(Circle)* Band Bypass Sleeve other: _____ If Band, Last fill date: _____

Diet History:

	Dates		*Dates*
Current:		Medifast	
Slimfast		Optifast	
Adkins		Other:	
Grapefruit			
HGH			

Exercise:

Type	Times a week	Minutes

How long at current weight (10 - 15lb range): _____ years

PAST MEDICAL HISTORY: *Have you ever been DIAGNOSED with any of the following problems?*

		Yes No	Date of Onset		Comments
	Anxiety	☐ Y ☐ N			
	Arthritis	☐ Y ☐ N			
	Asthma	☐ Y ☐ N			
	Autoimmune Disease	☐ Y ☐ N			
	Bladder Disease	☐ Y ☐ N			
	Bladder Infection	☐ Y ☐ N			
	Bone Disorder	☐ Y ☐ N			
	Cancer	☐ Y ☐ N			
	Please indicate type(s)				
	Clotting Disease	☐ Y ☐ N			
	COPD	☐ Y ☐ N			
	Colitis	☐ Y ☐ N			
	Chrons Disease	☐ Y ☐ N			
	Diabetes				
	Insulin Dependent (Type I)	☐ Y ☐ N			
	Non-Insulin Dependent (Type II)	☐ Y ☐ N			
	Emphysema	☐ Y ☐ N			
	Gallbladder	☐ Y ☐ N			
	Heart Disease	☐ Y ☐ N			
	Hernia	☐ Y ☐ N			

Patient History Questionnaire

Please help us be as efficient as possible with your first visit to our program. This health history questionnaire **must** be completed prior to your appointment. Should you need assistance with answers to any of the questions asked, feel free to contact our office and we will be happy to help you. You may fax the completed form to our office prior to your appointment. Health history questionnaires that are incomplete or forgotten at the time of your appointment and/or arriving late for your appointment may result in rescheduling a portion of or your entire appointment.

How are you recognized by your insurance?

Last Name: _____ First Name: _____ Middle Init: _____

Date of Birth (MM/DD/YYYY) _____ Gender: _____

Please note preferred if different: from above: _____

Please list all doctors you are currently seeing as a patient

	Doctor's Name	***Type of Doctor***	***Condition Being Treated***
Referring Physician:			
Primary Care Provider:			

Local Pharmacy:		**Mail Order Pharmacy:**	
Name:		Name:	
Address:		Address:	
Phone:	Fax:	Phone:	Fax:

REASON FOR VISIT: *What is the main reason you are seeing the doctor today?* If you are a Bariatric patient, you may ignore this section.

_____

How long have you had these symptoms? _____

How long does it last? _____

Grade your pain:

0	2	4	6	8	10
No Pain	Little Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Pain

What is the type of pain? *(Burning, cramping, dull,...)* _____

When do the symptoms occur? _____

What triggers your symptoms? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Describe other things that happen when the symptoms occur: _____