CHOLLA MEDICAL GROUP, INC.

New Patient Registration – Medical Information

Patient Name: First_____Middle_____Last_____

Date of Birth: _____/_____/_____

Who are your current medical providers?	
Provider name	Specialty, or condition for which they treat you

Preventive Care					
	Date		Date		Date
Annual physical		Prostate screen		Cholesterol test	
Colonoscopy		Pap screen		Diabetes screen	
Bone density		Mammogram		Eye exam	
Dental exam					

Immunizations					
	Date		Date		Date
Tetanus (Td or Tdap)		HPV (Gardasil)		Influenza (flu)	
Hepatitis A		Hepatitis B		Meningitis	
Pneumonia		Shingles		Other (please write below)	

Allergies or intolerances to medications?	
Name	Reaction

Please list all medications, supplements, over the counter drugs, creams and inhalers.		
Name	Dose/Strength	Frequency taken

Patient Name: First_____ Middle _____Last_____ Date of Birth: ____/____/_____

Please circle all current or past medical problems or conditions.		
Heart Failure	High Blood Pressure	ADD/ADHD
Chronic Lung Disease	Hyperthyroidism	Seasonal Allergies
Heart Artery Disease	Hypothyroidism	Anemia
Depression	Kidney Disease	Anxiety
Diabetes Type 1	Migraines	Arthritis
Diabetes Type 2	Heart Attack	Asthma
Emphysema	Stomach/Intestine Ulcers	Bipolar Disorder
Heartburn	Seizures	Blood Clots
Glaucoma	Sexually Transmitted Infection	Blood Transfusion
Heart Murmur	Stroke	Cancer
HIV/AIDS	Substance Abuse	Cataracts
High Cholesterol	Valley Fever	

Please circle all major operations or surgeries.		
None	Colon	Joint Replacement
Appendectomy	Coronary Artery Stent	Spine
Breast Augmentation	Cosmetic Surgery	Thyroid Surgery
Breast Surgery	Eye	Tonsillectomy
Cesarean Section	Fracture Repair	Tubes Tied
Heart Bypass	Hernia repair	Heart Valve surgery
Gallbladder	Hysterectomy	Ovaries

Family Medical History – Please check the appropriate box if a condition is/was present.

	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	High Cholesterol	High Blood Press	Kidney Disease	Mental Illness	Miscarriages	Stroke	Vision Loss	Alzheimer's	Other
Father																				
Mother																				
Siblings																				
Children																				
Other																				

Patient Name: First_____ Middle _____Last_____ Date of Birth: ____/____/_____

Social History											
Alcohol Use – Please circle your response.											
Glasses of wine per week	0	1	2	3	4	5	6	7	8	9	10+
Cans of beer per week	0	1	2	3	4	5	6	7	8	9	10+
Shots of liquor per week	0	1	2	3	4	5	6	7	8	9	10+
Mixed drinks with 0.5 ounces alcohol per week	0	1	2	3	4	5	6	7	8	9	10+

Sexual Activity – Please check your response.

Sexually active? ☐ Currently ☐ Never ☐ Not Currently

Sexual Partners? ☐ Men ☐ Women ☐ Both

Birth control used? ☐ Pulling out ☐ Condom ☐ Diaphragm ☐ Implant ☐ Inserts ☐ IUD
☐ The Pill ☐ Patch ☐ Rhythm ☐ Spermicide
☐ Sponge ☐ Surgical ☐ Not applicable

Drug Use – Please check your response.

☐ None ☐ Amphetamines ☐ Benzodiazepines ☐ "Crack" Cocaine ☐ Cocaine
☐ Heroin ☐ Marijuana ☐ Methamphetamines ☐ PCP ☐ Huff Gasses

Tobacco Use – Please check your response.

☐ Smoke every day ☐ Smoke some days ☐ Former smoker ☐ Heavy smoker
☐ Light smoker ☐ Never smoked ☐ Second-hand exposure

If ever smoked, how many packs/day average?
☐ ½ ☐ 1 ☐ 1½ ☐ 2 ☐ 3 or more
How many years smoked?

You ever chewed? ☐ Yes ☐ No

If you currently use any tobacco product, are you ready to quit? ☐ Yes ☐ No

Hospitalizations		
Reason	Year	Comments

Major Injuries		
Type	Year	Comments

Advance Directives (Living will and medical power of attorney)		
Do you have an advance directive?	☐ Yes	☐ No
Would you like information or a copy of advance directive forms?	☐ Yes	☐ No

CHOLLA MEDICAL GROUP, INC.

New Patient Registration – Demographics and Insurance

Patient: Name/First _____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Patient street address: _____

Patient address additional: _____

City: _____ State: _____ ZIP: _____-_____

Primary Phone Number: (_____) _____-_____Mobile | Home | Work

Secondary Phone Number: (_____) _____-_____Mobile | Home | Work

Email address: _____

What is your primary language? _____ Interpreter Required? Yes | No

Marital Status: Divorced | Legally Separated | Married | Other | Sig. Other | Single | Widowed

Religious preference: _____ ☐ I prefer to not answer.

The U. S. government requires we ask the following two questions:

1. How do you identify your ethnicity?
   _____Hispanic or Latino _____ Not Hispanic or Latino
   _____ I prefer to not answer.

2. How do you identify your race?
   _____ American Indian or Alaska Native _____ Black or African American
   _____ Native Hawaiian _____ Other Pacific Islander
   _____ White or Caucasian _____ Asian
   _____ I prefer to not answer

Who is your primary care physician? _____

Name of the primary care practice: _____

Employment Status: Full-Time | Part-Time | Retired | Disabled | Student | Unemployed

Employer Name: _____

How many employees work at your company? ☐ 1-19 ☐ 20-99 ☐100+ ☐ Don't know

Patient Name: First_____ Middle_____ Last_____ Date of Birth: ____/_____/_____

Who would you like to list as an **emergency contact**?

Name: _____

Address: _____

_____

Relationship to you: _____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Who is the **guarantor** of your account? Who is financially responsible for any amount not paid by the insurance company? Please write "self" if you are financially responsible.

Guarantor: Name/ First_____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Address: _____

_____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Medical Insurance Company Name: _____

Member/Subscriber Identification #: _____ Group #: _____

Medical Insurance Company Address: _____

Relationship of the insurance subscriber to the patient: Self | Parent | Spouse | Other: _____

Subscriber: Name/ First_____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Address: _____

_____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Do you have any additional insurance? Yes | No
Please present all insurance cards.

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

LIVING WILL (End of Life Care)
Instructions and Form

GENERAL INSTRUCTIONS: Use this Living Will form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. It is your written directions to your health care representative if you have one, your family, your physician, and any other person who might be in a position to make medical care decisions for you. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you complete and sign this Living Will.

If you decide this is the form you want to use, complete the form. **Do not sign the Living Will until** your witness or a Notary Public is present to watch you sign it. There are further instructions for you about signing on page 2.

IMPORTANT: If you have a Living Will and a Durable Health Care Power of Attorney, you must attach the Living Will to the Durable Health Care Power of Attorney.

1. **My information:** (the "Principal")
   Name:_____ Age:_____
   Address: _____ Date of birth: _____
   _____ Phone: _____

2. **My decisions about end of life care:**

NOTE: Here are some general statements about choices you have as to health care you want at the end of your life. They are listed in the order provided by Arizona law. You can initial any combination of paragraphs A, B, C, and D. **If you initial Paragraph E, do not initial any other paragraphs.** Read all of the statements carefully before initialing to indicate your choice. You can also write your own statement concerning life-sustaining treatments and other matters relating to your health care at Heading 3 of this form.

_____ **A. Comfort Care Only:** If I have a terminal condition I do not want my life to be prolonged, and I do not want life- sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death. (NOTE: "Comfort care" means treatment in an attempt to protect and enhance the quality of life without artificially prolonging life.)

_____ **B. Specific Limitations on Medical Treatments I Want:** (NOTE: Initial or mark one or more choices, talk to your doctor about your choices.) If I have a terminal condition, or am in an irreversible coma or a persistent vegetative state that my doctors reasonably believe to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but **I do not want the following:**

_____1.) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock, and artificial breathing.
_____ 2.) Artificially administered food and fluids.
_____ 3.) To be taken to a hospital if it is at all avoidable.

_____ **C. Pregnancy:** Regardless of any other directions I have given in this Living Will, if I am known to be pregnant I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ **D. Treatment Until My Medical Condition is Reasonably Known:** Regardless of the directions I have made in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable, or I am in a persistent vegetative state.

_____ **E. Direction to Prolong My Life:** I want my life to be prolonged to the greatest extent possible.

3. Other Statements Or Wishes I Want Followed For End of Life Care:

NOTE: You can attach additional provisions or limitations on medical care that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

___**A.** I have not attached additional special provisions or limitations about End of Life Care I want.
___**B.** I have attached additional special provisions or limitations about End of Life Care I want.

SIGNATURE VERIFICATION

A. I am signing this Living Will as follows:

Signature:_____ Date:_____

B. I am physically unable to sign this Living Will, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Living Will accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Living Will at this time. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Living Will expresses his/her wishes and that he/she intends to adopt the Living Will at this time.

Witness Name (printed): _____

Signature: _____ Date:_____

SIGNATURE OF WITNESS OR NOTARY PUBLIC

NOTE: At least one adult witness OR a Notary Public must witness you signing this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this document is signed.

A. Witness: I certify that I witnessed the signing of this document by the Principal. The person who signed this Living Will appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness. I confirm the following:

- I am not currently designated to make medical decisions for this person.
- I am not directly involved in administering health care to this person.
- I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
- I am not related to this person by blood, marriage, or adoption.

B. Notary Public: (NOTE: a Notary Public is only required if no witness signed above)

STATE OF ARIZONA) ss
COUNTY OF _____)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Living Will has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above, by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing care as a professional to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Living Will is physically unable to sign or mark this document, I verify that he/she directly indicated to me that the Living Will expresses his/her wishes and that he/she intends to adopt the Living Will at this time

WITNESS MY HAND AND SEAL this ____ day of _____, 20___

Notary Public: _____ My commission expires: _____