Grand Canyon Family Medicine, P.C.

3960 East Riggs Rd. Ste. 1
Chandler, AZ 85249
Phone: 480-786-4441
Fax: 480-786-4609

Patient Information: (if under 18, parent information is required for email and phone number.

Name:_____ Nickname: _____

Date of Birth:_____ Sex: M F SS#:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Email:_____if under 18, Primary Guardian name:_____

Home Phone #:_____ Cell Phone #:_____

Work Phone #: _____ Is it okay to call you at work? Y N

Race: (please check)

- ☐ American Indian
- ☐ African American
- ☐ Asian
- ☐ White
- ☐ Hawaiian or Other Pacific Islander

Ethnicity: (please check)

- ☐ Hispanic or Latino
- ☐ Not Hispanic/Latino
- ☐ Refused

Language: (please check)

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Is your current condition the result of an accident or injury? Y N

If yes, is it: Auto Related Work Related Slip/Fall

Primary Insurance Information:

Insurance Company:_____

ID #:_____ Group #:_____ Plan #:_____

Primary Person Insured:_____
(last name) (first name) (middle initial)

Relation to Patient:_____ Date of Birth:_____ SS#:_____

Secondary Insurance Information:

Insurance Company:_____

ID #:_____ Group #:_____ Plan #:_____

Primary Person Insured:_____
(last name) (first name) (middle initial)

Relation to Patient:_____ Date of Birth:_____ SS#:_____

Emergency Contact Information:

Name:_____

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Home Phone #:_____ Mobile Phone #:_____

Permission to Disclose Medical Information:

I authorize Grand Canyon Family Medicine to release or discuss medical information regarding treatment, payments or health operations to the following:

1. _____
2. _____

Signature of Patient/Guardian:_____ **Date:**_____

Phone Message Consent:

Your physician(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT:

- LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GUARDIAN.
- LEAVE INFORMATION ON AN ANSWERING MACHINE
- LEAVE INFORMATION ON A VOICE MAIL

Please read below and consider carefully whom you want to have access to your medical information.

I _____ give Grand Canyon Family Medicine permission to leave phone messages regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

My cell phone: (_____) _____ - _____ initials_____
My home answering machine/voice mail: (_____) _____- _____ initials_____
My office/work voice mail: (_____) _____-_____ initials_____

_____ _____

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Patient/Guardian Signature Date

Health History (confidential)

Patient Name:_____ Today's Date:_____

Age:_____ Date of Birth:_____ Date of last physical exam:_____

What is your reason for today's visit:_____

SYMPTOMS: (circle current symptoms)

General:
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of Sleep
Loss Of Weight
Nervousness
Numbness
Sweats

Muscle/Joint or Bone:
Pain, weakness, numbness in:
arms hips back legs feet neck hands shoulders

Genito-Urinary:
Blood in Urine
Frequent Urination
Lack of Bladder Control
Painful Urination

Gastrointestinal:
Poor Appetite
Bloating
Bowel Changes
Constipation
Diarrhea
Gas
Hemorrhoids
Nausea/Vomiting
Rectal Bleeding
Stomach Pain

Skin:
Bruise easily
Itching
Rash
Sore that won't heal
Change in Moles

Cardio Vascular:
Chest Pain
High Blood Pressure
Low Blood Pressure
Irregular Heart Beat
Poor Circulation
Swelling of Ankles
Varicose Veins

Eyes, Ears, Nose, Throat:
Bleeding Gums
Blurred Vision
Difficulty swallowing
Double Vision
Earache
Ear Discharge
Hay Fever
Hoarseness
Loss of Hearing
Nosebleeds
Persistent Cough
Ringing in ears
Sinus Problems
Vision-Flashes/Halos

Men Only:
Breast Lump
Erection Difficulties
Lump in Testicles
Penis Discharge
Sore on Penis
Date of last Colonoscopy:_____
OTHER:_____

Women Only:
Abnormal Pap Smear
Bleeding Between Periods
Breast Lump
Extreme Menstrual Pain
Hot Flashes
Nipple Discharge
Painful Intercourse
Vaginal Discharge
Date of Last Period:_____
Date of Last Pap:_____
Date of Last Mammo:_____
Pregnant: Yes No
# of Pregnancies: _____
Pregnancy Complications: _____ _____
# of Children: _____
Date of Last Colonoscopy:_____
OTHER:_____

CONDITIONS: (circle conditions you currently have or have had)

Acid Reflux	Chemical Dependency	High Cholesterol	Prostate Problem
AIDS	Chicken Pox	HIV	Psychiatric Care
Alcoholism	Diabetes	Hypertension	Scarlet Fever
Allergies	Emphysema/COPD	Kidney Disease	Shingles
Anemia	Epilepsy	Liver Disease	Sleep Disorder
Aneurysm	Glaucoma	Measles	Stroke
Anorexia	Goiter	Migraine Headaches	Suicide Attempt
Arthritis	Gonorrhea/Chlamydia	Mononucleosis	Thyroid Problems
Asthma	Gout	Mumps	Tuberculosis
Bleeding Disorders	Heart Disease	Multiple Sclerosis	Ulcers
Bulimia	Hepatitis A B C	Pacemaker	Vaginal Infections
Cancer	Hernia	Pneumonia	Venereal Disease/STD
Cataracts	Herpes	Polio	Other:_____

Pharmacy & Address:_____ _____ _____

Phone:_____ _____ _____

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Medications:	Drug Allergies/Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History: (Fill in health information about your family)

Relation	Age	Health Problems	Cause of Death	Check if your blood relative had any of the following: Disease : Relation to You
Father				Asthma, Hay Fever
Mother				Cancer (type)
Brothers				Chemical Dependency
				Diabetes (type)
				Heart Disease, Strokes
Sisters				Kidney Disease
				Tuberculosis
				Other:

Hospitalizations/Surgeries:

Year	Hospital	Reason for Hospitalization & Outcome

Have you ever had a blood transfusion? Yes No
If yes, please give approximate date _____

Health Habits: (check which substances you use & describe how much you use)

	Caffeine	
	Tobacco	
	Street Drugs	
	Alcohol	

Occupational: (check if your work exposes you to the following)

	Stress		Hazardous Substances
	Heavy Lifting		Other:_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

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_____ _____

Reviewed By Date

Welcome to Grand Canyon Family Medicine:

Grand Canyon Family Medicine, P.C. is a full service family practice. We treat patients of all ages and the full spectrum of medical problems. We provide high quality family health care with an emphasis on preventative care and wellness. We are committed to providing you with the highest quality care. We offer extended hours for your needs. Our hours are Monday through Friday 7:00am to noon and 1:00pm to 5:00pm and on Saturday 8:00am to 2:30pm.

Payment Policy:

All copays, deductibles and co-insurance will be collected at the time of service. This reduces the cost of delivering medical care to you. Visa, MasterCard, and Discover cards are accepted. If you anticipate a billing problem, please contact our office prior to your appointment so that satisfactory arrangements can be made. All outstanding balances must be paid in full before any additional services will be rendered. Financial arrangements are available but must be approved by management.

Note: A fee of $35.00 will be added to unpaid balances that require collection and/or legal services. A service charge of $25.00 will be applied on all returned checks.

Form Fees:

There will be a $35.00 charge for all forms completed without an appointment. This fee is due at the time the form is presented to the office. The form will not be completed until the form fee is paid. The majority of forms including Disability forms, FMLA forms, Leave of Absence Forms will normally require an appointment.

Referrals/Prior Authorizations

Referrals to specialists and for procedures that are not life threatening can take up to 10 to 14 days. These are the time frames instituted by the insurance plans themselves. Referrals that your doctor feels is MEDICALLY URGENT will be processed ahead of all others.

Prescriptions and Refill Requests:

Medication refill requests should come directly from your pharmacy. This is the quickest and easiest method for refills. If an Rx is needed, please anticipate your need and allow 3 days for that request to be completed for pick up. We do not do any refills after regular hours. No prescriptions for long term narcotics or sedatives will be written at this office.

Insurance Information Changes:

Please be aware that it is your responsibility to notify us of any name, address and insurance changes which may have occurred since your last visit here. If claims are denied as a result of

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incorrect insurance information given to us by the patient and are beyond the insurances timely filing limits, then charges would become the responsibility of the patient.

No Show / Same Day Cancellation Policy

No show and same day cancellations make it impossible for our office to provide care to another patient in need. We require a 24-hour notice for cancellations.

Our policy without notice is as follows:

- 1st No show or same day cancellation: $50.00 charge
- 2nd No show or same day cancellation: $50.00 charge
- 3rd No show or same day cancellation: $60.00 charge and/or **Patient is discharged from the practice.**

Thank you for your consideration in this matter

Courteous Care:

Grand Canyon Family Medicine, PC staff strives to give **quality and courteous care.**

We ask that you please remember sometimes emergencies do arise and your appointment may be delayed. Your patience is greatly appreciated. We will do all we can to meet your expectations. Patients who exhibit **abusive language, rude or inappropriate behavior** will be asked to seek care elsewhere.

We look forward to caring for you and thank you for choosing our practice. Your signature below acknowledges that you have read and understand our office policies.

Signature:_____ **Date:**_____

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Notice of Privacy Practice:

To Our Patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual in the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.
9.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree with your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request I writing to Grand Canyon Family Medicine,

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3960 E. Riggs Road, Suite 1, Chandler, Az. 85249.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request may be made in writing and submitted to Grand Canyon Family Medicine, 3960 E. Riggs Road, Suite 1, Chandler, Az. 85249. You must provide us a reason that supports your request for amendment.

5. Right to copy this notice. You are entitled to receive a copy of the Notice of Privacy Practices. You may ask us to give you a copy of the notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file A complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Robert Tognacci, Grand Canyon Family Medicine, 3960 E. Riggs Road, Suite 1, Chandler, Az. 85249. All complaints must be submitted in writing. You will not be penalized for submitting a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Dr. Robert Tognacci
Grand Canyon Family Medicine
(480)786-4441

I hereby acknowledge that I have been presented with a copy of the Grand Canyon Family Medicine Notice of Privacy Practices.

Name of Patient:_____

Signature:_____

Date:_____

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Patient Medical Record Release Form

Patient Name:_____ Date of Birth:_____
This authorizes you to provide a copy, summary, narrative of my medical records (as indicated by the check mark(s) below or otherwise release confidential information.)
_____ Complete Record

_____ Records of Care from the Following Date:_____ to _____

Please request my records be sent to Grand Canyon Family Medicine from:
Facility/Physician Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Fax #:_____

*The reasons/purposes for this release of information are:_____
_____

Please send my records to:
Facility/Physician Name: GRAND CANYON FAMILY MEDICINE

3960 E. RIGGS RD #1

CHANDLER, AZ 85249

Phone #:480-786-4441 Fax #:480-786-4609

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agents of AIDS with the rest of medical records.
Initial:_____ Date:_____

I understand that you will provide this information in 7 to 10 days from the receipt of request and that a fee for preparing and furnishing information may be charged according to rulings set forth by the Arizona State Board of Medical Examiners. I, Robert Tognacci, D.O., take custody of all files.

Patient Signature:_____ Date:_____