Holland Center for Family Health
6760 W Thunderbird Rd., Suite E-100, Poria, AZ 85381
Phone: 602-978-8477 Fax: 602-978-0734

PATIENT INFORMATION SHEET

PATIENT'S NAME: LAST_____ FIRST_____ MIDDLE IN_____

SOCIAL SECURITY NO:_____ SEX: ___M ___F DATE OF BIRTH:_____ MARITAL STATUS: _____

RACE:_____ ETHNICITY: _____ LANGUAGE:_____

MAILING ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

EMAIL ADDRESS:_____ PHARMACY:_____

EMPLOYER'S NAME:_____ YOUR OCCUPATION:_____

EMPLOYER'S ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____

WHO REFRRED YOU TO THE PRACTICE?:_____

EMERGENCY CONTACT:_____ PHONE:_____ RELATIONSHIP TO PATIENT:_____

INSURANCE INFORMATION: (THIS IS REQUIRED TO FILE YOUR INSURANCE FOR YOU.)

INSURANCE COMPANY:_____ ID#_____ GROUP#_____

NAME OF POLICY HOLDER:_____POLICY HOLDER'S SSN:_____ POLICY HOLDER'S DOB:_____

PHONE NUMBER:_____

MAILING ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____

POLICY HOLDER'S EMPLOYER:_____ RELATIONSHIP TO PATIENT:_____

YOUR PERMISSION IS REQUIRED TO RELEASE ANY OF YOUR MEDICAL INFORMATION (lab results, appointments, etc.) TO ANOTHER PERSON. If you are 18 years of age or older, we must have your written consent to release any medical information to ANY person other than yourself. Please read and sign below if you would like to give your consent for us to speak to someone else (spouse, significant other, family members, etc.) concerning you. If you have diagnostic tests or procedure results, our office will attempt to reach you by phone two times. If we are unable to reach you, we will mail you the results. Our office will contact you within 10 to 14 days with any results. If you do not hear from us within the 10 to 14 days, please call our office. I, authorize Holland Center for Family Health to discuss anything pertaining to my medical care to the following persons:

Name:_____ Relationship to Patient:_____ Phone No:_____

Name:_____ Relationship to Patient:_____ Phone No:_____

May we leave results/information on your voice mail?: _____Yes _____No

I hereby authorize Joshua D. Holland, M.D. to release any medical information that may be necessary for either medical care or processing application for financial benefit. This information may be disclosed by fax, mail or oral communication. I understand that my records are protected and may not otherwise be disclosed without written consent. I also understand that this authorization will remain valid until revoked in writing.

acknowledge notification of the Privacy Practices, Policies and Procedures and may receive a copy at my request.

Patient Signature (or Parent of minor/Legal Guardian): X_____ **Date:**_____

FINANCIAL RESPONSIBILITY I hereby authorize direct payment of surgical and/or medical benefits to Joshua D. Holland, M.D. for any services rendered by him. I understand that I am financially responsible for any changes not covered by my insurance. In the event of default, I agree to pay any collection fees added to unpaid balances. I also agree to pay court costs, interest allowed by law and attorney fees incurred because of the default. I understand that charges for office service are payable at the time of service. I also understand that there is a **NO SHOW FEE** of $25 to $50 for any appointments not cancelled with 24-hour notice. I authorize the release of any information necessary to determine liability for payment or obtain reimbursement on any claim. This authorization will remain valid until revoked in writing.

Patient Signature (or Parent of minor/Legal Guardian): X_____ **Date:**_____

MEDICAL HISTORY

Name:_____ Date of Birth:_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____ Yes _____ No If yes, please list:_____

Current medication and dosage:_____

_____

List any surgeries and/or hospitalizations and when they occured:_____

_____

Have you ever had a blood transfusion? _____ Yes _____ No if yes, when:_____

Immunizations: Year of last Tetanus _____ MMR_____ Hep B_____ Pneumo vaccine _____

Have you ever been told you have any of the following:

	Yes	No		Yes	No		Yes	No
Migraines	___	___	Arthritis	___	___	Rheumatic fever	___	___
Allergies	___	___	Meninigitis	___	___	High blood pressure	___	___
Anemia	___	___	Valley fever	___	___	Thyroid disease	___	___
Asthma	___	___	Measles	___	___	Kidney disease	___	___
Diabetes	___	___	Tuberculosis	___	___	Heart disease	___	___
Mumps	___	___	Depression	___	___	Lung disease	___	___
Seizures	___	___	Ulcers	___	___	Birth defect	___	___
Lupus	___	___	Glaucoma	___	___	High cholesterol	___	___
Strokes	___	___	Gout	___	___			
Cancer	___	___	What type?_____					

Do you exercise? _____ What and how often?_____

Do you smoke or use tabacco?_____ How much per day?_____

Any other drugs?_____ What and how often?_____

Birth control method? _____

Have you prepared advance directives? (living will, power of attorney)_____

For women:

Age at start of menses _____years Length of period _____ days

Number of pregnancies _____ Number of living children _____ Number of miscarriages_____

Complications of pregrancies and/or deliveries:_____

Have you ever had an abnormal PAP smear? _____ If yes, what year?_____

NAME: _____

Insurance guidelines now request that we ask the following questions of ALL our patients EVERY YEAR. Failure to comply with these guidelines could result in oss of insurance contracts, which means we may no longer be able to care for you. Please answer all of the following questions to the best of your abillity, sign and date this form. We regret any inconvenience this causes you.

LAST TETANUS SHOT: _____ **MMR SHOT:** _____

LAST MAMMOGRAM: _____ **LAST PAP:** _____

DOCTOR: _____

Was it normal? ___**YES** ____**No**

FAMILY HISTORY OF:	**YES**	**NO**
High Blood Pressure:	_____	_____
Breast Cancer:	_____	_____
Ovarian Cancer:	_____	_____
Diabetes:	_____	_____

PREVENTATIVE ISSUES:

Do you regularly use or have any of the following:

	YES	NO
Seat Belts:	_____	_____
Sun Block:	_____	_____
Smoke Detectors:	_____	_____
Calcium Supplement:	_____	_____
Exercise:	_____	_____
Dental Visits:	_____	_____
Living Will:	_____	_____
Self Breast Exams:	_____	_____
Nicotine:	_____	_____

_____ _____

Date **Signature**

No-Show Policy

To ensure each patient is given the proper amount of time allotted for their appointment, it is very important to arrive on time to your scheduled visit. If it is necessary for you to reschedule your appointment, please call us immediately.

If you are unable to keep your appointment, please cancel at least **24 hours** prior to your scheduled appointment if possible. If the clinic is closed, please leave a voicemail for the receptionist.

A no-show fee of $25.00 for routine appointments and $50.00 for physicals will be charged for each missed appointment.

****All no show fees are the patient's responsibility and will not be covered by insurance. ****

X_____

Patient or Representative Signature and Da