New Patient Registration Form

Patient Name: _____

Address: _____

_____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Birthday: ___/___/_____

Ethnicity: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is it okay to web enable you to our patient portal? ☐ Yes ☐ No

Type of Insurance: _____

Primary Care Provider:

Name: _____

Phone: _____

Pharmacy:

Name: _____

Address: _____

Phone: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone: _____

Patient Signature: _____

Date: ___/___/_____

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Patient Name: _____ Date of Birth: ___/___/_____

Patient Medical History

Please list your complete medical history: (ie. Type II DM, Hypothyroid, etc)

Please list any allergies to any medication(s) and the side effect: (ie. Humalog - Hives)

Please list your surgical history: (ie. Thyroid removal, L Knee, etc.)

Please list your current medication(s) below: (ie. Metformin 500mg once a day)

Name	Dose	Directions

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Patient Name: _____ Date of Birth: ___/___/_____

Family History:

Below please check off the following conditions your family member(s) have/had.

Condition	Father	Mother	Brother	Sister	Other
Diabetes					
Pituitary Disease					
Cancer					
Thyroid Disease					
Thyroid Cancer					
Hypertension					
Heart Disease					
Obesity					
Kidney Stones					
Osteoporosis					
Infertility Problems					
High blood calcium					
Adrenal Gland Disease					

Social History:

Current use of tobacco? ☐ Yes ☐ No If yes, how long? _____

Did you smoke in the past? ☐ Yes ☐ No If yes, how long? _____

Any history of drug use? ☐ Yes ☐ No If yes, how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____

Do you drink caffeine? ☐ Yes ☐ No If yes, how often? _____

Do you exercise? ☐ Yes ☐ No If yes, how often? _____

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Informed Consent for Scribe Services

Our microphone-equipped exam rooms allow Virtual Medical Scribe assistants to listen and transcribe your visit into our Electronic Medical Records charting system. This courtesy service provides you a more accurate record quickly and helps your doctor focus on your well-being.

Your physicians could make an audio recording of your for quality-control purposes and accurate data entry into your permanent medical record – though only with your consent. Any recording would be temporary and deleted after entry into the permanent medical record.

I/We understand that my (or my family's) visit will be typed into the computer by a virtual medical assistant.

Patient or Patient Representative Name: _____

Signature of Patient: _____
(or person authorized to sign for patient)

Date: ___/___/_____

West Valley Endocrinology, Diabetes, Metabolism Center
3000 N. Litchfield Rd. Suite 120, Goodyear, AZ 85395
P: (623) 398 2222 F: (888) 880 1168

Medical Information (HIPAA) Release of Information Form

Patient Name: _____ Date of Birth: ___/___/_____

[ ] I authorize the release of information, including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Please call [ ] my home [ ] my work [ ] my cell Number _____ .

If unable to reach me: [ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____ .

Signed: _____ Date: ___/___/_____

Witness: _____ Date: ___/___/_____

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Informed Consent for Telemedicine Services

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to West Valley Endocrinology, Diabetes and Metabolism Center providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any Deductibles, copayments or coinsurance that apply to my telemedicine visit.

I acknowledge to pay $75 deposit on the first televisit and my deposit will be refunded upon payment from my Medical insurance.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting the office at 623-398-2222. As long as this consent is in force (has not been revoked) West Valley Endocrinology, Diabetes and Metabolism Center may provider health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient: _____
(or person authorized to sign for patient)

If authorized signer, relationship to patient: _____

I have been offered a copy of this consent form (patient's initials): _____

Date: ___/___/_____

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Medical Record Release Form

I authorize the release of any information including diagnosis, Pharmacy information, Labs, medical records, examination rendered to me and claims information.

[X] Medical records

[X] Labs

[X] Op reports

[X] Imaging reports or Disc

[X] All healthcare information

I release West Valley Endocrinology, Diabetes and Metabolism Center, its employees, agents, medical staff members and business associates from any legal responsibility for the disclosure of the information noted above to the extent indicated and authorized herein.

Patient Name: _____

Date of Birth: ___/___/_____

Signature: _____

Date: ___/___/_____

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Office Policies

Thank you for choosing West Valley Endocrinology Diabetes and Metabolism, please take a moment to read our office policies in its entirety. If you have any questions or would like better clarification on the policies below, give us a call at (623) 398-2222 and we will be happy to assist you.

Office Hours: We are open Monday through Friday from 8am to 5pm. We are closed from 12pm to 1pm each day for lunch.

Phones: Phones are answered Monday through Friday from 8am to 5pm. During lunch all calls are forwarded to our voicemail.

Emergencies: **For any life threatening emergencies, please call 911.**

Test Results: Any lab testing or diagnostic imaging ordered by our office, you will be notified about the results as soon as they become available. All results must be **reviewed** by Dr. Suzi Kochar first.

Prescriptions: All refills must be called into your pharmacy. Your pharmacy will then notify us. You should be calling at least a week prior to running out. If an appointment is required in order to get your medication, you will only receive a one-time refill to hold you up until your scheduled appointment.

No Show Policy: If you cancel your appointment the same day you are scheduled or no show, you will be charged a fee of $50. Please call our office 24 hours **prior** to your appointment to avoid any fees.

FMLA: For any form completion for short term disability or FMLA, there is a fee of $50.

Patient Name: _____

Date of Birth: ___/___/_____

Signature: _____

Date: ___/___/_____

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