Buckeye Medical Center
213 E. Monroe Ave, Buckeye, AZ, 85326
T: 623-386-9111 F: 623-386-6555

REGISTRATION FORM

(Please Print)

Today's Date:	PCP: Dr. Malhotra /Ronald Fergison PA-C

PATIENT INFORMATION

Last Name:	First Name:	Middle:

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

Is this your legal name? ☐ Yes ☐ No	Preferred Pharmacy :	Pharmacy Phone#:	Birth date:	Age:	Sex: ☐ M ☐ F

Home Address:

P.O. Box:	City:	State:	ZIP Code:

Social Security#:	Home Phone#:	Alternative Phone#:

Occupation:	Employer:	Employer Phone#:

How did you hear about us?
☐ Family ☐ Friend ☐ Close to home/work ☐ Insurance plan ☐ Hospital ☐ Internet ☐ Other

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Home phone#:	Alternative Phone#:
Name:	Relationship to Patient:	Home phone#:	Alternative Phone#:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Buckeye Medical Center or the insurance company to release any information required to process my claims.

Patient/Guardian Signature	**Today's Date**

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Health History Questionnaire

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	Date of Birth:	Today's Date:
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Previous or Referring Doctor:		Date of Last Physical Exam:	

PERSONAL HEALTH HISTORY					
Childhood Illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio				
Immunizations and Dates:	☐ Tetanus		☐ Pneumonia		
	☐ Influenza		☐ Chickenpox		
	☐ MMR *Measles, Mumps, Rubella*		☐ Hepatitis		

List any medical problems that other doctors have diagnosed

Surgeries (Please Print)		
Year	Reason	Hospital

Other Hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Drug Name	Strength	Frequency Taken
Allergies to Medications (Please Print)		
Drug Name	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					

	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY							
Relationship	Age		Significant Health Problems	Relationship	Age		Significant Health Problems
Father				**Mother**			
Grandmother *Paternal*				**Grandmother** *Maternal*			
Grandfather *Paternal*				**Grandfather** *Maternal*			
Siblings	☐M ☐ F			**Children**	☐M ☐ F		
	☐M ☐ F				☐M ☐ F		
	☐M ☐ F				☐M ☐ F		
	☐M ☐ F				☐M ☐ F		
	☐M ☐ F				☐M ☐ F		
	☐M ☐ F				☐M ☐ F		

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	☐ Extremities ie.legs/arms

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Financial Policy

Thank you for choosing Buckeye Medical Center as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with our billing coordinator. We accept cash, check or credit cards (Visa, MasterCard & American Express). Absolutely no post-dated checks will be accepted.

Self-pay/Uninsured Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which our office does not participate, or patients without an insurance card on file with us. Self-pay patients will be required to make payment in full at the time services are rendered. Please keep in mind new patient appointments can range anywhere between $120-$198 and $65-$160 for established patients. This amount does not include any lab work or specialty testing that may be required. If you require any specialty testing please see our billing coordinator for our cash pay prices. Payment must be made prior to your appointment unless prior arrangements have been made.

It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Missed Appointments

BMC requires 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled will be charged a fee of $40.00 for regular office visits and $75.00 for specialist appointments, which include Echoes, Stress Test, Ultrasounds and DXA (Bone density testing). This fee is not covered by your insurance plan and is your responsibility.

AHCCCS Members

We are now required by new AHCCCS guidelines that all missed appointments must be reported to your health plan, along with any missed mandatory co-pays.

Returned Checks

The charge for a returned check is $35.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Workers' Compensation and Automobile Accidents

In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Information Regarding Your Insurance Coverage

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding re-existing conditions etc.) It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to

promptly provide assistance and information to our billing office (internal and or external) and if your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services.

Non-Participating Provider or Non-Covered Benefits

If we do not participate with your health insurance carrier, or if the services provided are not covered under your participating health insurance plan, then you are responsible for paying for all services at the time of your service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes. (Please note: In certain rare circumstances-and in our sole discretion-we may directly bill your insurance carrier as out of network provider in lieu of accepting payment directly from you and if we do so, you agree to assign your payment rights to our office and forward us any checks you receive relative to the services we have provided to you).

Outstanding Balances

All outstanding balances shall be due within 30 days; unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances in full prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorney's office. If your account is referred to a collections agency, you will be responsible for paying a collection charge equal to 35% of your outstanding balance, which is an addition to your outstanding balance and any applicable interest.

Release of Medical Records

Medical records recreated by our office shall be released pursuant to your express written authorization in accordance with HIPPA. Patients requesting copies of medical records will be charged $1.00 per page. Attorneys and Insurance companies will be charged $1.00 per page plus shipping and handling. BMC will have up to 30 days to produce your records.

A special handling fee of $10.00 will be charged if records must be delivered within 48 hours of the request, in addition to the above mentioned fees. All recipients of med records must have patients' written consent from the patient prior to records being released.

Miscellaneous Fees

Certain services (e.g., family conferences, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. Prior to requesting any such services you should request a copy of our miscellaneous services fee schedule.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

By signing below, patient or responsible party acknowledges that he/she has read, understands and agrees to its terms.

X_____

Signature of Patient or Responsible Party ***Date***

X_____

Print Name of Patient or Responsible Party ***Date***

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Authorization for Release & Disclosure of Health Information

Patient Name:_____ Date:_____

Phone #:_____

1. I authorize the release, use, or disclosure of the above named patient's health information as described below.

2. The following organization is authorized to obtain medical records and make the disclosure:

   Name: Buckeye Medical Center: Dr. Rohit Malhotra & Ron Fergison, P.A.
   Address: 213 E. Monroe Ave, Buckeye, AZ, 85326

3. The type of information to be requested, used, or disclosed is as follows:

   _____ Consultation Reports _____ Diagnostic Films
   _____ Dosimetry Records _____ Laboratory Results
   _____ Physician Dictation _____ Portal Films/Simulation Films
   _____ Radiology Reports _____ Surgery/Pathology

   Other _____

   I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and be used by the following individual or organization:

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Name: _____

Relationship to Patient: _____

Address: _____

Purpose of: _____

_____ _____
Patient Signature or Legal Representative Date