FAMILY MEDICINE
367 E. VIRGINIA AVE
PHOENIX, AZ 85004
Phone: (602) 256 - 6303
Fax: (602) 256 - 6302

Brian Dedinsky, M.D. ☐

PATIENT INFORMATION

PLEASE PRINT

NAME _____ BIRTH DATE _____ SEX: M OR F

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # _____ BLOCKED? Y / N OK TO LEAVE MESSAGES ABOUT RESULTS? Y / N

SOCIAL SECURITY # _____ MARITAL STATUS _____ RELIGIOUS PREFERENCE _____

ETHNICITY _____

EMPLOYMENT

EMPLOYER'S NAME _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____

EMPLOYER'S PHONE # _____ ZIP _____

SPOUSE, PARENTS OR PERSON TO CALL IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____

PHONE # _____ BUSINESS PHONE # _____ ZIP _____

OCCUPATION _____ EMPLOYER _____

INSURANCE INFORMATION

INSURANCE COMPANY _____ POLICY # _____ GROUP # _____

ADDRESS _____ CITY _____ STATE _____

PHONE # _____ MEDICARE # _____ ZIP _____

IF INSURANCE IS IN THE NAME OF SOMEONE OTHER THAN PATIENT - COMPLETE BELOW

INSURED'S NAME _____ INSURED'S SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____ INSURED'S EMPLOYER _____

INSURED'S EMP. ADDRESS _____ INSURED'S EMP. PHONE # _____

INSURED'S EMP. ZIP _____ **REQUIRED:** INSURED'S D.O.B. _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICE WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I AUTHORIZE [redacted] DEDINSKY FAMILY MEDICINE [redacted] TO FURNISH TO INSURANCE CARRIERS OR OTHER FINANCIALLY RESPONSIBLE PARTIES CONCERNING MY ILLNESS AN TREATMENTS AND HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUN NOT COVERED BY MY INSURANCE. I AUTHORIZE [redacted] BRIAN DEDINSKY, M.D. [redacted] TO PROVIDE THE NECESSARY TREATMENT FOR MY CARE.

DATE _____ SIGNATURE: X _____

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HEALTH DATABASE

NAME _____ DATE _____

AGE _____ HEIGHT _____ WEIGHT _____

CURRENT & PAST ILLNESSES

ASTHMA_____	THYROID_____	DIABETES_____	HEART DISEASE_____	HYPERTENSION_____
PNEUMONIA_____	ALLERGIES_____	STROKE_____	KIDNEY DISEASE_____	HEPATITIS_____
MIGRAINE_____	SEIZURES_____	ARTHRITIS_____	ACID REFLUX_____	DEPRESSION_____
PSYCHIATRIC_____	OBESITY_____	ANEMIA_____	PROSTATE_____	OSTEOPOROSIS_____
CANCER_____		CHOLESTEROL_____	COLON_____	BLOOD DIS_____

OTHER _____

SURGERIES

MEDICATIONS

NAME	DOSE	TIMES PER DAY	NAME	DOSE	TIMES PER DAY

ALLERGIES TO MEDICATIONS

ALLERGIES TO FOOD _____

SOCIAL HISTORY

SMOKING: _____ PACKS DAILY FOR _____ YEARS
ILLICIT DRUGS: _____
OCCUPATION: _____

ALCOHOL: TYPE _____ AMOUNT _____
CAFFEINE: _____
MARITAL STATUS: _____

IMMUNIZATIONS

TETANUS _____ (DATE) INFLUENZA _____ (DATE) PNEUMONIA _____ (DATE)

OTHERS _____

FAMILY HISTORY

FAMILY MEMBER	*ALIVE*	*PRESENT HEALTH*	*CAUSE OF DEATH*	*AGE(S)*
FATHER	Y N			
MOTHER	Y N			
BROTHERS	Y N			
SISTERS	Y N			
CHILDREN	Y N			
OTHERS _____				

WOMEN ONLY:

LAST MENSTRUAL PERIOD _____ BIRTH CONTROL? Y N TYPE/NAME _____
PERIODS REGULAR? Y N DAYS BETWEEN CYCLES _____ NUMBER OF PREGNANCIES _____
NUMBER OF CHILDREN _____

Dedinsky Family Medicine

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____