

PATIENT INTAKE FORM

DEDINSKY FAMILY MEDICINE

367 E. Virginia Ave Phoenix, AZ 85004

Main: 602-256-6303

Fax: 602-256-6302



PERSONAL INFORMATION

Full Name:	Date of Birth:	Sex: M or F
Full Address: (please include zip code)		
Phone:	Email:	
Is it okay to leave a message about results?	Communication preferences:	<input type="checkbox"/> Call <input type="checkbox"/> Text <input type="checkbox"/> Email
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married, number of dependent(s)		

PREFERRED PHARMACY

Pharmacy Name:	Phone Number:
Pharmacy Address:	

EMPLOYMENT

Employer's name:	Occupation:
Employer phone:	

EMERGENCY CONTACT

Full Name:	Relationship
Full Address: (please include zip code)	
Phone:	Work phone:

INSURANCE INFORMATION

Insurance company:	Policy #:
Group#:	Address:
Phone:	Medicare #:

*****If insurance is in the name of someone other than patient -- Complete below*****

Insured's Name:	Insured's Social:
Address:	
Relationship to patient:	Insured's employer:
Insured's Employer Address:	Insured employer phone number:

How did you find out about our office? _____

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

SIGNATURE: X _____ **DATE:** _____

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✉ dedinskyfamily@yahoo.com 🌐 dedinskymedicine.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Protection.
Print name here

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)

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 DISORDER _____
OTHER: _____

SURGERIES (AND DATES)

MEDICATIONS

NAME	DOSE	TIMES PER DAY	NAME	DOSE	TIMES PER DAY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ALLERGIES TO MEDICATIONS

ALLERGIES TO FOOD: _____

SOCIAL HISTORY

SMOKING _____ PACKS PER DAY _____ HOW MANY YEARS _____
ALCOHOL: TYPE _____ AMOUNT: _____
ILLICIT DRUGS: _____ CAFFEINE: _____
OCCUPATION: _____ MARITAL STATUS: _____
DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVE? Y / N IS IT ON FILE? Y / N

IMMUNIZATIONS

TETANUS _____ INFLUENZA _____ PNEUMONIA _____
DATE DATE 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: _____	Y N	_____	_____	_____

WOMEN ONLY

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