# Tatum Highlands Medical Associates - New Patient Paperwork

| PATIENT DEMOGRAPHICS | |
|---|---|
| First Name | |
| Middle Name | |
| Last Name | |
| Gender (circle one) | Male or Female |
| Date of Birth | |
| Social Security Number | |
| Street Address | |
| Unit/Apartment Number | |
| Zip Code | |
| City | |
| State | |
| Home Phone | |
| Mobile Phone | |
| Email Address | |
| Phone Preference (circle one) | Home or Mobile |
| Race (circle one) | American Indian Asian Black/African American White Other Race ______________ |
| Ethnicity (circle one) | Hispanic/Latino Not Hispanic/Latino Other______________ |
| Marital Status | |
| How did you hear about us? (circle one) | Ad Former PCP Specialist Hospital Patient in Practice Insurance Company Other |
| **EMERGENCY CONTACT** | |
| Emergency Contact Name | |
| Emergency Contact Phone | |
| Contacts Relationship (circle one) | Spouse Parent Child Sibling Friend Cousin/Family Member Guardian Other |

## COMMUNICATION PREFERENCES

I authorize Tatum Highlands Medical Associates to relay communications regarding lab results, medical records, medication history, referrals, billing, insurance and other pertinent information with pharmacies, hospitals and healthcare professionals involved in my healthcare.

YES _______ No_______

Tatum Highlands Medical Associates (THMA) communicates with our patients via email, phone messages and text messages related to upcoming appointments, health reminders, account balances and general announcements. I authorize THMA to communicate via:

| | | |
|---|---|---|
| EMAIL | YES _______ | No_______ |
| PHONE MESSAGES | YES _______ | No_______ |
| TEXT MESSAGES | YES _______ | No_______ |

| I give Tatum Highlands Medical Associates permission to disclose medical and billing/account information to the following individual(s) on my behalf.<br>If left blank, we will only speak with the patient. | |
|---|---|
| Name | |
| Relationship to Patient | |
| Phone Number | |
| **PATIENT PORTAL AND PRIVACY PRACTICES** | |
| Our office uses a secure patient portal as another means of communication with our patients. Our portal is a secure communication link between you and our practice. You may utilize the portal to send messages to our staff, view health records and lab or diagnostic tests. In addition, you can view medication history and request refills on existing prescriptions.<br><br>However, please be advised that the patient portal is for routine matters and NOT for URGENT requests or questions. We do not diagnose or treat a patient via the portal or phone. Diagnosis and treatment of a condition require an office visit.<br><br>I had the opportunity to review and/or receive a copy of Tatum Highlands Medical Associates Privacy Practices, which is available and posted on their website at tatummedical.com If I wish to change my communication preferences at any time in the future, I must complete and sign a new release and communication form. | |
| PRINT Patient's Name | |
| Patient's Date of Birth | |
| SIGNATURE of Patient or Guardian | |
| Today's Date | |
| **PRIMARY INSURANCE INFORMATION** | |
| Insurance Guarantor's Name | |
| Relationship to Patient | |
| Guarantor's Date of Birth | |
| Insurance Company | |
| Insurance Address | |
| Insurance Phone Number | |
| Guarantor's Employer | |
| Group Number | |
| Member/Policy ID Number | |
| **SECONDARY INSURANCE INFORMATION** | |
| Insurance Guarantor's Name | |
| Relationship to Patient | |
| Guarantor's Date of Birth | |
| Insurance Company | |
| Insurance Address | |
| Insurance Phone Number | |
| Guarantor's Employer | |
| Group Number | |
| Member/Policy ID Number | |

**We require proof of current/valid insurance cards at the time of service, please bring your photo ID and insurance card(s) to all office visits at Tatum Highlands Medical Associates.

**Patient Name:** ______________________________ **DOB:** _________________________

## MEDICAL HISTORY

### Previous and Other Healthcare Providers

**Previous Primary Care Physician:** ______________________________ **Phone:** ___________________
**Street Address:** ________________________________ **City:** ____________________ **State:**________

**Care Team:** **Please provide name, specialty and conditions being addressed by another health provider.**

| Physician's Name | Specialty |
|---|---|
| | |
| | |
| | |

### Pharmacies and Medications

**Do you have any medication allergies? YES NO**
**If yes, which medications are you allergic to?** _______________________________________________

**Local Pharmacy:** _______________________________________ **Phone:** ____________________
**Pharmacy Address or Major Cross Streets:** ______________________________________________

**Mail Order Pharmacy:** __________________________________ **Phone:** ____________________
(If Applicable)

**Current Medications and/or Supplements**

| Medication/Dosage/Instructions | Medication/Dosage/Instructions | Medication/Dosage/Instructions |
|---|---|---|
| 1. | 5. | 9. |
| 2. | 6. | 10. |
| 3. | 7. | 11. |
| 4. | 8. | 12. |

### Family Medical History

| Do you have an immediate family member (parent, sibling, or child) with a history of the following conditions? (Check all that apply) | |
|---|---|
| ____ Cancer, if so type/when: ________________________ | Relationship to patient: |
| ____ Diabetes | Relationship to patient: |
| ____ Heart Disease | Relationship to patient: |
| ____ Kidney Disease | Relationship to patient: |
| ____ Obesity | Relationship to patient: |
| ____ Psychiatric Disorder | Relationship to patient: |

### Surgical History

| Surgery and Date | Surgery and Date | Surgery and Date |
|---|---|---|
| 1. | 3. | 5. |
| 2. | 4. | 6. |

**Patient Name: ______________________________ DOB: ________________________**

## MEDICAL HISTORY

**Do you have any of the following conditions in your past or present medical history?(Check all that apply)**

| | |
|---|---|
| ☐ ADD/ADHD | ☐ GOUT |
| ☐ AIDS/HIV | ☐ HEADACHES |
| ☐ ABUSE/DOMESTIC VIOLENCE | ☐ HEART DISEASE |
| ☐ ALLERGIES/HAYFEVER | ☐ HEART PROBLEMS |
| ☐ ANEMIA | ☐ HEPATITIS |
| ☐ ANESTHESIA COMPLICATIONS | ☐ HIGH CHOLESTEROL |
| ☐ ANXIETY DISORDER | ☐ HOSPITALIZATIONS |
| ☐ ARTHRITIS | ☐ HYPERTENSION |
| ☐ ASTHMA | ☐ HYPERTYROIDISM |
| ☐ AUTISM SPECTRUM DISORDER (ASD) | ☐ HYPOTYROIDISM |
| ☐ BEDWETTING | ☐ INFERTILITY |
| ☐ BIRTH DEFECTS/INHERTITED DISEASE | ☐ KIDNEY DISEASE |
| ☐ BLADDER OR KIDNEY PROBLEMS | ☐ KIDNEY STONES |
| ☐ BLOOD DISEASES | ☐ LIVER DISEASE |
| ☐ BLOOD TRANSFUSION | ☐ LUNG DISEASE |
| ☐ BREAST CANCER | ☐ MRSA EXPOSURE |
| ☐ BREAST PROBLEM | ☐ MENIERE'S DISEASE |
| ☐ COPD | ☐ MENTAL DISORDER |
| ☐ CANCER | ☐ MENTAL ILLNESS |
| ☐ CHICKEN POX | ☐ MUSCLE/JOINT/BONE PROBLEMS |
| ☐ CHRONIC EAR INFECTIONS | ☐ OBESITY |
| ☐ CONGESTIVE HEART FAILURE | ☐ OSTEOPOROSIS |
| ☐ CONSTIPATION | ☐ OTHER |
| ☐ CORONARY ARTERY DISEASE | ☐ OVARIAN CANCER |
| ☐ DEPRESSION | ☐ POLYPS |
| ☐ DEVELOPMENTAL/BEHAVIORAL | ☐ PRE-ECLAMPSIA |
| ☐ DIABETES | ☐ PULMONARY EMBOLISM |
| ☐ DIFFICULTY SWALLOWING | ☐ REFLUX/GURD |
| ☐ DIVERTICULITIS | ☐ SEIZURES/EPILEPSY |
| ☐ EAR/HEARING PROBLEMS | ☐ SKIN PROBLEMS |
| ☐ EATING DISORDER | ☐ STROKE |
| ☐ ECZEMA | ☐ THROMBOPHILIAS |
| ☐ ENDOMETRIOSIS | ☐ THYROID PROBLEMS |
| ☐ FIBROMYALGIA | ☐ TUBERCULOSIS |
| ☐ GI PROBLEMS | ☐ VARICOSITIES |
| | ☐ VISION OR EYE PROBLEMS |

If cancer was selected, please indicate type: _______________________________________________

Please list any other medical concerns or problems not listed above: _____________________________

**Patient Name:** ______________________________ **DOB:** _________________________

## MEDICAL HISTORY

### Social History

**What is your current relationship status?** Married Single Divorced Separated Widowed Domestic Partner

**Are you sexually active?** YES NO

**What contraceptive method are you currently using?** _______________________________________

**Do you have any children**? YES NO If yes, how many?_________________________________

**Do you or have you ever smoked tobacco?** YES NO If you quit, when did you quit?_____________

**Do you or have you ever used any other forms of tobacco or nicotine?** YES NO

**What is your level of alcohol consumption?** None Occasional Moderate Heavy

**Do you use any illicit or recreational drugs?** YES NO

## Patient Health Questionnaire (PHQ-9)

**Over the last 2 weeks, how often have you been bothered by any of the following?**

| | NOT AT ALL | SEVERAL DAYS | MORE THAN HALF THE DAYS | NEARLY EVERY DAY |
|---|---|---|---|---|
| **Little interest or pleasure in doing things.** | | | | |
| **Feeling down, depressed, or hopeless.** | | | | |
| **Trouble falling or staying asleep or sleeping too much.** | | | | |
| **Feeling tired or having little energy.** | | | | |
| **Poor appetite or overeating.** | | | | |
| **Feeling bad about yourself or that you are a failure or have let yourself or your family down.** | | | | |
| **Trouble concentrating on things, such as reading or watching TV.** | | | | |
| **Moving or speaking slowly that other people have noticed or being fidgety/restless.** | | | | |
| **Thoughts that you would be better off dead or of hurting yourself in some way.** | | | | |

*I consent to medical treatment and agree to pay all charges, deductibles, and/or copayments at the time of service. Tatum Highlands Medical Associates may release any necessary medical information to my insurance company to process claims. I authorize my health insurance company to make payments directly to Tatum Highlands Medical Associates for applicable medical benefits and costs associated with my care. I give Tatum Highlands Medical Associates authorization to receive and provide medical information from hospitals, urgent care facilities, and medical specialists who are involved in my medical care.*

_______________________________ _______________________________ _________________

Patient's Name Signature of Patient or Legal Guardian Date

**TATUM HIGHLANDS MEDICAL ASSOCIATES OFFICE POLICIES**

Thank you for choosing Tatum Highlands Medical Associates and for trusting us with your healthcare needs.

1. **FINANCIAL POLICY:** Please bring your photo ID and insurance card to each office visit. If your insurance changes, please verify our practice has a contract with your new plan. If your insurance plan requires a copayment for office visits or you have an unmet deductible, **payment is due at the time of service**. Your insurance company may not cover all your healthcare costs. Your policy is a contract between you and your insurance company. It is your responsibility to know your policy and benefits and that you understand you are required to pay out of pocket for non-covered or denied services. In addition, unpaid account balances may be given to our outside collection agency and a collection transfer fee of $45.00 will be added to your account balance.

2. **CANCELLATION POLICY:** We see our patients by appointment only and that time is set aside for you. Therefore, when you do not show for an appointment or cancel with less than 24-hour notice, it is a loss for our practice and more importantly it is an appointment we could have used for another patient. If you do not cancel an appointment with at least 24-hour notice or no show for any appointment, you will be charged $25.00.

3. **TREATMENT PLANS:** We do not diagnose or treat over the phone. You need to be a patient of record and have an office visit with our provider, so we can appropriately diagnose and treat your symptoms and condition. Your compliance with outlined treatment plans and being an advocate for yourself is an important part of your overall healthcare. If you have questions or concerns about your plan of care or have not received results from labs, imaging, and other diagnostic tests you should contact our office to ensure you get the care and/or obtain results of any pending labs, images, tests, medical orders, or referrals.

4. **MEDICATION REFILLS**: It is your responsibility to keep track of your medication supply. For refills on existing prescriptions, you can call your pharmacy directly, request via the patient portal or call our office during normal business hours. Messages left for our Medical Assistants will be addressed within 48 hours. Requests left after normal business hours, on weekends or on holidays will be addressed the next business day.

   ***Please note, some medications and all controlled substances require an appointment with your provider at least every 90 days and many others require an appointment every 180 days, so scheduling routine visits will be necessary if you are prescribed maintenance medications.***

5. **PATIENT PORTAL:** Our patient portal is available to access patient information, ask clinical questions, and request prescription refills. However, **the patient portal is for routine matters and NOT for URGENT or EMERGENT requests or questions**. We DO NOT diagnose or treat over the patient portal. Information left on the portal will be addressed within 48 hours. If a request is left after normal business hours, on weekends or on holidays the request will be addressed on the next business day.

6. **AFTER HOURS:** The provider on call is available for urgent and emergent problems only and is not available for routine matters such as discussing labs, x-rays, or refilling prescriptions. If you require urgent medical attention, please call 911 or go to your nearest Emergency Department or Urgent Care.

7. **TREATMENT OF MINORS:** Patients under 18 must be accompanied by their parent or legal guardian.

8. **MEDICAL RECORDS:** If you request copies of your medical records, we provide the first 5 pages free of charge. However, if your records exceed five pages you will be charged a $25.00 fee.

9. **FORMS:** Your provider is willing to complete medical forms you may need for FMLA, Short- or Long-Term Disability, and other medically necessary forms, however there will be a $25.00 fee for forms of this nature and will is payable when forms are dropped off. Completed forms will be available for pick up within 72 hours after they are received in our office.

**By signing below, I acknowledge that I have read and understand the Office Financial Policies outlined above.**

| ______________________ | ______________________ | ____________ |
|---|---|---|
| Patient's Name | Signature of Patient or Legal Guardian | Date |

# Civility Policy

To our valued patients,

At Tatum Highlands Medical Associates, we train our staff to be respectful and courteous to each other and to our patients. Our employees play an important role in your care and as an extension of our providers they too need to be treated with respect.

Our *Civility Policy* is intended to promote a culture based upon mutual respect and professional communication. As your healthcare team we understand the importance of our relationship with our patients. Our goal is to provide exceptional patient care for the overall health and well-being of our patients and to provide a safe and respectful work environment for our staff and patients.

Our *Civility Policy* has no tolerance for disrespect. Therefore, we expect all parties to speak and act in a respectful manner. This policy does not permit the use of disrespectful or condescending language to staff, providers, or patients. Minor issues will be addressed in the spirit of conflict resolution, but egregious violations may result in patients or staff being dismissed from our practice.

We recognize you have a choice in your healthcare provider, and we appreciate that you have chosen our practice. However, to continue our healthcare relationship we need our patients and staff to agree to our policy. If for some reason our *Civility Policy* is not agreeable for you, we will be happy to forward your records to a practice that is more suitable to your needs.

We look forward to working together and addressing the healthcare needs for you and your family.

Respectfully,

*Peter F. Levins, M.D.*

Peter F. Levins, M.D.
Medical Director
Tatum Highlands Medical Associates

**I acknowledge that I have read, understand, and agree to abide by Tatum Highlands Medical Associates' Civility Policy. Failure to abide by the policy as outlined above may result in dismissal from this practice.**

| ___________________________________ | ___________________________________ | ___________________ |
|---|---|---|
| **PRINT Patient's Name** | **SIGNATURE of Patient or Guardian** | **Date** |

## RELEASE OF MEDICAL RECORDS AUTHORIZATION

**Patient Name: ________________________________________ Date of Birth: _____________________**

**I authorize the facility listed below to release my records to Tatum Highlands Medical Associates. Please send the following:** (check all that apply):

_____Complete Medical Records _____Progress Notes

_____Lab/Pathology Reports _____Immunization Records

_____Cardiology/EKG Reports _____Imaging Reports

| **Practice/Facility** | |
|---|---|
| **Street Address** | |
| **City, State, Zip Code** | |
| **Phone Number** | |
| **Fax Number** | |

I understand that authorizing the release of medical records and personal health information is voluntary and therefore I release Tatum Highlands Medical Associates, their providers, and their employees from all liabilities, damages, and claims which may arise from the release of information. In addition, I understand that disclosure of this information may not be protected by federal confidentiality rules and my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, human immunodeficiency, behavioral or mental health services, and treatment for alcohol and drug abuse. This authorization may be revoked at any time, however the revocation must be submitted in writing to Tatum Highlands Medical Associates and does not apply to health information previously released.

**Patient Signature: _________________________________________ Date:________________________**

**Please send records via mail, fax, or secure email:**

**Option 1 MAIL**

Tatum Highlands Medical Associates
26224 N Tatum Blvd. Suite 15A
Phoenix, Arizona 85050

****PAPER COPIES ONLY****
We CANNOT process records sent on a CD.

**Option 2 EMAIL**

If you wish to send electronic records, please EMAIL attachments in **PDF FORMAT** to our secure email at:

**admin@secure.tatummedical.com**

**Option 3 FAX**

FAX 480-419-6782