PATIENT INFORMATION /INFORMACION DEL PACIENTE

Last / Apellido Paterno	First / Primer Nombre	Middle / Segundo Nombre

Soc. Sec. No. / Número de Seguro Social	Birth Date / Fecha de Nacimiento	☐ Male/Masculino ☐ Female/Femenino	Apt. Number / Número de Apartamento

Address / Dirección	City / Cuidad	State/Zip / Estado y Codigo postal

Phone / Teléfono ( )	Marital Status / Estado civil ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single	Employer Name / Nombre de Epliador

Employer Address / La direccion de Epliador	City / Cuidad	State/Zip / Estado y Codigo postal	Work Phone / Teléfono de trabajo ( )

GUARANTOR INFORMATION / GARANTE DE INFORMACIÓN
(head of household to receive billing statements, if any) (cabeza de familia a recibir estados de cuentas, si lo hubiere)

Last / Apellido Paterno	First / Primer Nombre	Middle / Segundo Nombre

Soc. Sec. No. / Número de Seguro Social	Birth Date / Fecha de Nacimiento	☐ Male/Masculino ☐ Female/Femenino	Apt. Number / Número de Apartamento

Address / Dirección	City / Cuidad	State/Zip / Estado y Codigo postal

Phone / Teléfono ( )	Marital Status / Estado civil ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single	Employer Name / Nombre de Epliador

Employer Address / Dirección del empleador	City / Cuidad	State/Zip / Estado y Codigo postal	Work Phone / Teléfono de trabajo ( )

Patient's Relationship to Guarantor: / Relación con el paciente Garante: ☐ Self / Solo ☐ Spouse / Esposa ☐ Son / Hijo ☐ Daughter / Hija ☐ Other / Otro

INSURANCE INFO. (Provide copy of insurance card) Información del Seguro (Proporcione copia de la tarjeta de seguro)

PRIMARY INSURANCE INFORMATION / PRIMARIA DE INFORMACION DE SEGUROS

Subscriber (Policyholder):	Last / Apellido Paterno	First / Primer Nombre	Middle / Segundo Nombre

Insurance Company Name / Nombre de la empresa de seguros	Subscriber Employer Name / Nombre del empleador suscriptor

Policy Effective Date / Fecha de vigencia política	Subscriber ID Number / Número de Identificación del Suscriptor	Group Number / Número de grupo	Birth Date / Fecha de nacimiento

Insured (Patient) ID Number / Asegurado (paciente) Número de Identificación	Insured (Patient) PCP / Asegurado (paciente) PCP	Patient's Relationship to Subscriber: / Relación del paciente al suscriptor ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other

SECONDARY INSURANCE INFORMATION / INFORMACION SECUNDARIA DE SEGUROS

Subscriber (Policyholder):	Last / Apellido Paterno	First / Primer Nombre	Middle / Segundo Nombre

Insurance Company Name / Nombre de la empresa de seguros	Subscriber Employer Name / Nombre del empleador suscriptor

Policy Effective Date / Fecha de vigencia política	Subscriber ID Number / Número de Identificación del Suscriptor	Group Number / Número de grupo	Birth Date / Fecha de nacimiento

Insured (Patient) ID Number / Asegurado (paciente) Número de Identificación	Insured (Patient) PCP / Asegurado (paciente) PCP	Patient's Relationship to Subscriber: / Relación del paciente al suscriptor ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other

EMERGENCY CONTACT / OTHER INFORMATION / CONTACTO DE EMERGENCIA / OTRAS INFORMACIONES

Name / Nombre	Relationship / Relación

Address / Dirección	City / Cuidad	State/Zip / Estado y Codigo postal

Home Phone / Teléfono de la casa ( )	Work Phone / Teléfono de trabajo ( )

Other than to yourself, to whom may we release test results: / Distinto a usted, a quien le podemos liberar los resultados de la prueba:

Name / Nombre _____ Relationship / Relacion _____

I hereby authorize payment directly to Panda Medical Associates, LLC for surgical and/or medical benefits, if any, otherwise paid to me for unpaid services rendered and the release of any information necessary to process claims for said services and authorization to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan, via voice, electronic, mail or fax transmission. I also agree to pay all charges and/or co-payments at the time of service. In the event of default, I promise to pay all legal fees, collection costs, and/or interest as may be required to effect collection of this note. This will also serve as an authorization for release of emergency department, urgent care and/or medical records which may be necessary in my medical care.

Signed: / Firmado: _____ Date: / Fecha _____
(Patient or Responsible Party) (Paciente o Persona Responsable)

PANDA MEDICAL ASSOCIATES

FINANCIAL AGREEMENT

Payment is due at the time of your medical services unless other arrangements have been made with the Practice Administrator or Billing Department.

We have always filed and will continue to file claims for our patients, but the patient must share equal responsibility for obtaining and giving the doctor or insurance company the necessary information needed to get their claim processed and paid within a reasonable time.

While we realize that patients are not always given all the information required by their insurance company or agent, it is still the **patient's responsibility** to call and obtain this information before receiving treatment and before filing claims for treatment. We cannot emphasize enough how important this is, for you, the patient, to receive the proper benefits you are entitled to under your insurance plan or contract.

We are, therefore, requesting your cooperation so that we may better serve you and give you the proper health care you deserve without having to spend an exorbitant amount of time dealing with the pros and cons of your insurance company. **You should have and know all the information required by your individual plans of insurance to avoid any confusion on your behalf of what is being provided for you.** _____initials

All patient portions are due upon services rendered. In the case where we are billing your insurance, we may send you a statement for the remaining patient portion which is due upon receipt. _____initials

Because we contract differently under each insurance company, the staff at Panda Medical Associates does their best to make sure if you require a Referral or Prior Authorization from your insurance company that we notify you. ***However, as the patient, it is your responsibility to provide a current (check for the expiration date) Referral or Prior Authorization to our office at the time of service to prevent from being billed for the services. Your Primary Care Physician can assist you in getting the correct Referral and Prior Authorization to us.*** _____initials

We reserve time for each patient. There will be a fee of $50.00 added to your account if you fail to cancel your appointment within 24 hours. _____initials

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that PMA has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and any collection fees assessed by an outside collection agency. _____initials

AHCCCS PATIENTS

We reserve the right to discharge you from the practice after three (3) "No Show" appointments. _____initials

If your AHCCCS coverage is **terminated** and you are seen by a provider, you will receive a bill for the balance due. Panda Medical Associates will not be responsible for rebilling your charges to your AHCCCS plan (if you reinstate your coverage) unless you call us and request us to do so. You will be held responsible for any charges incurred due to untimely filing of said charges. _____initials

MEDICAL RECORDS

We do not charge for medical records to be copied and **mailed/faxed/hand carried to another physician,** but we do charge $30 for your medical records to be copied for you for: (life or medical insurance, disability coverage, personal, etc.), which is due before we start the copying process. _____initials

Methods of payment available: ☐ Cash ☐ Debit ☐ VISA/MC ☐ American Express

_____ _____

Patient or Guardian Date

Thank you for letting us take care of your medical needs.

CONTACT/RELEASE INFORMATION AND NOTICE OF PRIVACY PRACTICES

Patient Name _____ **Date** _____

Age _____ **Date of Birth** _____

Yes _____ **No** _____ You *may/may not* discuss or release my medical results or any medical issues (i.e. labs, x-rays, medications, consults, etc.) with

_____.

Yes _____ **No** _____ You ***may/may not*** leave a message on my voice mail regarding (i.e. lab results, x-ray results, medication, consults, appointment confirmation, etc).

Phone number to contact with results _____ AM _____ PM _____

Okay to call work? **Yes** _____ **No** _____
Okay to leave a message on work voice mail? **Yes** _____ **No** _____

Work Phone _____ Extension _____

Patient Privacy: *Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this Notice. However, we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.*

I have read and understand all of the above.

Patient Signature _____ **Date** _____

Witness
Signature _____ **Title** _____ **Date** _____

Consent for Use or Disclosure of Information for Purposes Requested by Physician's Office

I hereby permit Panda Medical Associates to use my health information, and/or to disclose my health information to any third party payor, or to any party involved in my health care.

I understand that there is a Notice of Privacy Practices posted in the practice reception area, available to me to read.

This consent shall be in force and effect as long as I am a patient at this practice.

I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my physician(s) at this practice.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I also understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- I refuse to sign this consent.

_____

Signature of patient, guardian, or personal representative

_____

Date

_____

Name of patient, guardian, or personal representative

_____

Description of personal representative's authority

PANDA MEDICAL ASSOCIATES, LLC
CHIOMA IWEHA, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received
(Name of Patient)

a copy of PANDA MEDICAL ASSOCIATES, LLC's **'Notice of Privacy Practices'.** This Notice describes how PANDA MEDICAL ASSOCIATES, LLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
(Signature of Patient, or Personal Representative) (Date)

_____
(Relationship to Patient)

Panda Medical Associates, LLC

PATIENT HISTORY QUESTIONNAIRE

Name _____ Age _____ Birth date _____ Today's Date _____

Address _____ Phone _____

Occupation _____ Previous Occupation _____

List other Doctors treating you _____

_____ Who referred you to this office? _____

Please list all medicines that you are currently taking:

Medicine	Dose	Frequency	For What Illness?

Are you allergic to any medicines or foods? ☐ Yes ☐ No If so, list: _____

List all past operations and serious illnesses:

Operation or Illness	Month and Year	City, State	Outcome

Have you ever been advised to have any surgical operation which has not been done? ☐ Yes ☐ No If yes, explain: _____

Do you have a Living Will (Advanced Medical Directives)? ☐ Yes ☐ No If no, would you like information regarding Living Wills? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes ☐ No How much? _____ When did you stop? _____
How much before stopping? _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____ When did you stop? _____
How much before stopping? _____

Have you ever used any street drugs or illicit drugs? _____

How physically active are you? _____

FAMILY HISTORY:

	Age	State of Health	Age at Death	Cause of Death
Father:				
Mother:				
Brother/Sister: (state which)				

Has any blood relative ever had:

Cancer	☐ Yes ☐ No	Relative:	_____
Tuberculosis	☐ Yes ☐ No	Relative:	_____
Diabetes	☐ Yes ☐ No	Relative:	_____
Heart Trouble	☐ Yes ☐ No	Relative:	_____
High Blood Pressure	☐ Yes ☐ No	Relative:	_____
Stroke	☐ Yes ☐ No	Relative:	_____
Epilepsy	☐ Yes ☐ No	Relative:	_____

HAVE YOU EVER HAD:

Heart Attack ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Leaky Heart ☐ Yes ☐ No
Enlarged Heart ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Valley Fever ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Blood Clots ☐ Yes ☐ No
Gonorrhea or Syphillis ☐ Yes ☐ No
Nephritis ☐ Yes ☐ No
Jaundice - Hepatitis ☐ Yes ☐ No
Gall Bladder Disease ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Childhood Diseases ☐ Yes ☐ No
Scarlet Fever ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Any Others Not Listed _____

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST TWO (2) YEARS:

Chest Pain ☐ Yes ☐ No
Pain in arms or throat ☐ Yes ☐ No
Wake up due to chest pain ☐ Yes ☐ No
How many pillows do you sleep on?_____
Wake up due to shortness of breath ☐ Yes ☐ No
Palpitations or very rapid heart rate ☐ Yes ☐ No
Skipped heart beats ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Leg cramps when walking ☐ Yes ☐ No
Leg cramps when lying down ☐ Yes ☐ No
Varicose veins ☐ Yes ☐ No
Swelling of ankles ☐ Yes ☐ No
Heartburn ☐ Yes ☐ No
Recurrent nosebleeds ☐ Yes ☐ No
Fainting spells ☐ Yes ☐ No
Light-headedness on standing up ☐ Yes ☐ No
Double vision ☐ Yes ☐ No
Severe headaches ☐ Yes ☐ No
Coughed up phlegm ☐ Yes ☐ No
Coughed up blood ☐ Yes ☐ No
Persistent hoarseness ☐ Yes ☐ No
Recurrent skin rashes ☐ Yes ☐ No
Numbness or tingling of hands or feet ☐ Yes ☐ No
Change in hair texture ☐ Yes ☐ No
Change in weight ☐ Yes ☐ No
Nausea or vomiting ☐ Yes ☐ No
Vomited blood or "coffee ground material" ☐ Yes ☐ No
Black bowel movements ☐ Yes ☐ No
Blood in bowel movements ☐ Yes ☐ No
Clay-colored bowel movements ☐ Yes ☐ No
Abdominal cramping ☐ Yes ☐ No
Colitis ☐ Yes ☐ No
Pain while urinating ☐ Yes ☐ No
How often do you get up at night to urinate?
Number of times _____
Difficulty in starting urination ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
Lose urine when coughing or sneezing ☐ Yes ☐ No
Discharge from penis ☐ Yes ☐ No
Swelling of any joints ☐ Yes ☐ No
Have you had any X-rays of stomach or colon in past 10 years? ☐ Yes ☐ No
Have you had any X-rays of gallbladder in past 10 years? ☐ Yes ☐ No
Discoloration of fingers when exposed to cold ☐ Yes ☐ No

FOR WOMEN ONLY:

Date of last Pap: _____
Age at onset of menstruation: _____
Onset date of last period: _____
Number of days between periods: _____
Number of days of flow? _____ Heavy? ☐ Yes ☐ No
Method of Birth Control: _____
Age at onset of intercourse: _____
Age at menopause: _____
Abnormal Paps? _____
PREGNANCIES: _____
Total number of pregnancies: _____
Number of live births: _____
Number of prematures: _____
Number of miscarriages: _____ Stillbirths: _____
Number of abortions: _____
Number of living children: _____
Any complications? ☐ No ☐ Yes If yes, what? _____

Check which of the following you have had:

1. Breast Biopsy ☐ Yes ☐ No Year Done _____
2. Breast Implants ☐ Yes ☐ No Year Done _____
3. Mammogram ☐ Yes ☐ No Year Done _____
4. Breast Surgery ☐ Yes ☐ No Year Done _____
5. Colposcopy ☐ Yes ☐ No Year Done _____
6. Cone Biopsy ☐ Yes ☐ No Year Done _____

Has a blood relative had breast cancer? ☐ Yes ☐ No

Relationship: _____

Date of last mammogram: _____

Do you perform breast self exam? ☐ Yes ☐ No

Other important information: _____