New Patient Form

Name: _____ Date of Birth: _____ Male ___ Female ___
Social Security #: _____ Height: _____ Weight: _____
Facility: _____ Level of Care: IL __ AL __ MC __ SNF __ Care Home __
Pharmacy: _____ Pharmacy Phone: _____
Address: _____ Phone: _____
Primary Contact: _____ Phone: _____ Email: _____
MPOA: _____ Phone: _____ Email: _____
Emergency Contact: _____ Phone: _____ Email: _____
Is Patient on Hospice? _____ Hospice Provider: _____
Marital Status: _____ Previous PCP: _____

Payment Information
Guarantor Name (person responsible for payment if not patient): _____
Bill to Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____

Insurance Information
Medicare ID# (Including alpha letter): _____ (Required for all patients)

Primary Insurance: _____ Member/Policy ID #: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip Code: _____ Group #: _____
Case Manager (If applicable): _____ Phone: _____

Additional/Secondary Insurance: _____ Member/Policy ID#: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip Code: _____ Group #: _____

Medical Information
Drug, Food or Chemical Allergies/Sensitivities: _____
Recent Changes in Condition: _____

Chronic Medical Problem List	Date	Past Surgical History	Date
		Hospitalizations	Date

Patient Name: DOB: Facility:

Health Information

Patient History

Y	N		Note/Date
☐	☐	Alzheimer's	
☐	☐	Memory Loss	
☐	☐	COPD	
☐	☐	CHF/CAD	
☐	☐	Cancer	
☐	☐	Stroke	
☐	☐	Diabetes Type	
☐	☐	Skin Conditions	
☐	☐	Hearing Loss	
☐	☐	Glaucoma	
☐	☐	Macular Degen.	
☐	☐	HTN	
☐	☐	Anxiety	
☐	☐	Depression	
☐	☐	Thyroid	
☐	☐	Blood Transfusion	
☐	☐	Dialysis	
☐	☐	Difficulty Urinating	
☐	☐	Blood in Urine	
☐	☐	UTI	
☐	☐	Kidney Infection	
☐	☐	Gastrointestinal	
☐	☐	Bladder Incontinence	
☐	☐	Bowel Incontinence	
☐	☐	Sleep Disorder	
☐	☐	Frequent Falls	
☐	☐	Coumadin	

PT INR Schedule:

Patient Social History

☐ Married ☐ Single ☐ Divorced
☐ Separated ☐ Lives Alone
☐ Widow(er) Date: _____

Past Occupation: _____
Education: _____
Veteran: _____
Religious Preference: _____

Advance Directive? ☐ Yes ☐ No
If Yes, Date: _____
Code Status: DNR? ☐ Yes ☐ No
If Yes, Date: _____

☐ Alcohol Use _____
☐ Drug Use _____
☐ Tobacco/Smoker _____

Childhood Illnesses:
Mumps _ Measles _ Rubella _ Polio _
Chicken Pox ___ Rheumatic Fever ___

Immunizations: Influenza _____
Pneumonia _____ Hepatitis _____
Tetanus _ MMR _ Chicken Pox ___

Assistive Devices: (wheelchair, walker, hearing aide, etc…)

Family History of:

Y	N		Family Member
☐	☐	Alzheimer's	
☐	☐	Breast Ca	
☐	☐	CAD	
☐	☐	CHF	
☐	☐	Cervical Cancer	
☐	☐	Colon CA	
☐	☐	Depression	
☐	☐	DM	
☐	☐	Hearing Loss	
☐	☐	Glaucoma	
☐	☐	Macular Degen.	
☐	☐	HTN	
☐	☐	Ovarian CA	
☐	☐	Prostate CA	
☐	☐	Skin CA	
☐	☐	Thyroid	

Family Social History:
(Any past traumas or events)

Patient Signature: _____ Date: _____
or
Patient Representative Signature: _____ Date: _____

Ultimate Integrated Patient Care, PLLC
Phone: 480-510-0165 Fax: 866-703-1877 www.UIPCare.com UIPCare@gmail.com

ULTIMATE INTEGRATED PATIENT CARE PLLC

Authorization for Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize Ultimate Integrated Patient Care to disclose the protected health information described below to:

Name: _____

Address: _____

City, State, Zip: _____

Fax #: _____

This authorization for release of information covers the period of healthcare from:

☐ _____ to _____.
☐ ALL records

Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
☐ I authorize the release of my complete health record with the exception of the following information:
  ☐ Mental health records
  ☐ Communicable diseases (including HIV and AIDS)
  ☐ Alcohol/drug abuse treatment
  ☐ Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in the force and effect for one year or until _____ (date or event), at which time this authorization expires.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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

_____ _____
Signature of patient or personal representative Date

_____
Printed name of patient or personal representative and his or her relationship to patient

P.O.BOX 10214 GLENDALE, AZ 85318 * TELEPHONE 623-428-9885 * FAX 866-703-1877

ULTIMATE INTEGRATED PATIENT CARE PLLC

ASSIGNMENT OF BENEFITS:

I hereby authorize my insurance company to make direct payments to Ultimate Integrated Patient Care PLLC.

I understand that I am ultimately responsible for my bill.

I am aware that Medicare does not pay for preventative medicine, routing screening test, or routine physician examinations. I also understand that I will be responsible for the deductible and co-insurance amount.

Insured/policy holder Signature: _____ **Date:** _____

PATIENT PRIVACY:

May Ultimate Integrated Patient Care release medical information to specified person other than you?

Yes ____ No ____

Authorized Person	Relationship to You
_____	_____
_____	_____
_____	_____

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnoses and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to may other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises and on their website a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical record, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me on request.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

Patient Signature: _____ **Date:** _____

PLEASE FILL OUT COMPLETELY AND CLEARLY. ALL INFORMTION IS REQUIRED TO CONSIDER NEW PATIENT FOR SERVICE. THANK YOU

PLEASE FAX COPIES OF ALL INSURANCE CARDS AND POWER OF ATTORNEY

P.O.BOX 10214 GLENDALE, AZ 85318 * TELEPHONE 623-428-9885 * FAX 866-703-1877

ULTIMATE INTEGRATED PATIENT CARE, PLLC
MEDICAL INFORMATION RELEASE

Patient Name: _____ Admit Date: _____

MRN: _____ DATE OF BIRTH: _____

The above-named patient is seeking care with ULTIMATE INTEGRATED PATIENT CARE, PLLC. Please send us any and all information regarding prior treatment of this patient, which could be relevant to our providing appropriate medial and personal care as part of the palliative care plan. In addition, we specifically request the following:

- ☐ Current History and Physical
- ☐ Chemotherapy Summary
- ☐ Radiation Therapy Report
- ☐ Operative Report
- ☐ EKG Report
- ☐ Previous Hospice or Home Health Records
- ☐ Discharge Summary: From _____
- ☐ X-ray Report: Type _____ Date: _____
- ☐ Pathology Report: From _____
- ☐ Consultations Report: From: _____
- ☐ Other: _____

Date of Request	Request Sent To	Information Requested	2nd Request	Date Received
	Physician:			
	Hospital:			
	Hospice/HAA:			
	Insurance Company:			
	Other:			

Patient Authorization for Release of Information

Permission is granted for the release of the above requested medical information to ULTIMATE INTEGRATED PATIENT CARE, PLLC and any other records or information related to my illness that may assist in my care which may include Drug/alcohol, HIV, and mental or behavioral health related records.

_____ Date

Signature of Patient or Legal Representative

_____ Date

Legal Representative's Name (Please Print)

_____ Date

Signature of Witness

Please return this requested information via **fax** to ULTIMATE INTEGRATED PATIENT CARE, PLLC, to fax number below at the appropriate

P.O. BOX 10214
GLENDALE, AZ 85318
(623) 428-9885 phone
(866) 703-1877 fax