ABAN CARE CLINIC LLC
GUILLERMO G. ZEGARRA, MD
2182 HWY 95
BULLHEAD CITY, AZ 86442
PHONE: 928-758-6420 / FAX: 928-758-6509

REGISTRATION FORM AND HEALTH HISTORY

Last Name _____First Name _____Middle Initial_____
Sex □ M □ F Birthdate___/___/___ Age ____Todays Date ___/__/____Race _____
Mailing Address_____City_____State_____Zip_____
Phone Number Home: _____Cell Phone: _____
EMAIL ADDRESS: _____Social Security # _____
Marital Status □ Single □ Married □ Divorced □ Separated □ Widowed □ Minor
Occupation: _____Employer: _____Phone: _____
Person to Contact in Case of Emergency _____Phone_____
If patient is a Child:
Father_____DOB_____Mother_____DOB_____

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE AND ID CARD TO THE RECEPTIONIST)

Primary Insurance_____ Policy #_____Group #_____
If Patient is not Primary Holder of Insurance
Primary Holders
Name_____DOB_____SSN_____
Relationship to Patient_____

Secondary Insurance _____Policy # _____Group#_____
If Patient is not Primary Holder of Insurance
Primary Holders
Name_____DOB_____SSN_____
Relationship to Patient_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE: _____ DATE:_____

LAST NAME:_____FIRST NAME:_____DOB_____

LIVING WILL

HAVE YOU COMPLETED A LIVING WILL AND/OR ADVANCED DIRECTIVE REGARDING MEDICAL TREATMENT ADMINISTERED TO YOU: YES_____ NO_____
IF SO, PLEASE PROVIDE OUR OFFICE A COPY OF SUCH DOCUMENT

Consent to Access of Protected Heath Information: The following are family members or representatives whom we can disclose your protected health information, such as, but not limited to, test results, appointment reminders, payment issues, benefit determination, and coverage of services. Indicate any restrictions on the type c disclosures to be made:
Name:_____Relationship:_____
Name: _____Relationship: _____
Do you give Aban Care Clinic consent to leave detailed messages on your phone regarding missed appointments, Appointments, referrals and billing? YES_____ NO_____ INITIALS_____ If Yes, is your responsibility to notify Our office of any changes to your contact information.

Acknowledgement of Receipt of Notice of Privacy Practices: I have received a copy of Aban Care Clinics Notice of Privacy Practices, which describes how Aban Care Clinic may use and disclose my protected health information, certain restrictions On the use and disclosure, and rights I may have regarding my protected health information. **Initials:_____**

Billing Insurance: I understand my insurance is billed as a courtesy, and I acknowledge that I am financially responsible for All charges whether or not they are covered by insurance. If it becomes necessary to effect collections on any amount owed this or subsequent visits, I agree to pay for all expenses, including reasonable Attorney fees. I authorize the release of information concerning my/child's health care, advice & treatment Provided for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of Medical benefits to Aban Care Clinic LLC. **Initials: _____**
CAN OUR OFFICE EMAIL YOU A COPY OF YOUR BILLING STATEMENT? YES_____NO_____

Missed Appointments: I understand that if I do not call and notify the staff of Aban Care Clinic of my cancelation 24 hrs **PRIOR** to my appointment. I will be subject to a **$25.00** no show fee. For AHCCCS patients your Insurance will be Notified and they can provide disciplinary measures. Please call as soon as possible to let us kn you will not be making your scheduled appointments. **Initials:_____**

Date of Last Exam: _____ Reason for Visit: _____

********ARE YOU ALLERGIC TO ANY MEDICATON? No □ Yes □ (If yes please specify)**

_____

List All Medications/Herbs/Vitamins/Supplements you are currently taking and Dosage(write "None" if none**) IF YOUR LIST OF MEDICATIONS IS MORE THAN 6 PLEASE PROVIDE US A SEPARATE LIST OF ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING**

1. _____2._____3._____
_____
4. _____ 5. _____
6._____

Pharmacy of Preference_____

FAMILY HISTORY

Mother □ Alive □ Deceased /Present Health? _____ Father □ Alive □ Deceased/Present Health?

_____
 # Of Brothers? _____Current Health_____# of Sisters ___ Current Health _____
Name of Spouse _____Health_____# of Children ____ Health _____

LAST NAME: _____NAME: _____ DOB: _____

CIRCLE ILLNESSES WHICH HAVE OCCURRED IN ANY BLOOD RELATIVES:
□ DIABETES □ CANCER□ BLEEDING TENDANCY □ KIDNEY DISEASE □ TB □ HEART DISEASE □ STROKE □ HIGH BLOOD PRESSSURE
□ ALLERGIES □ OTHER_____

MEDICAL HISTORY

PLEASE CIRCLE ALL THAT APPLY TO YOU ONLY

GENERAL	CARDIOVASCULAR	SKIN	GASTROINTESTINAL	PAIN
CHILLS	CHEST PAIN	BRUISE EASILY	POOR APPETITE	ARMS
DEPRESSION	HIGH BLOOD PRESS	HIVES	BLOATING	BACK
ANXIETY	LOW BLOOD PRESS	ITCHING/RASH	CONSTIPATION	LEGS
DIZZINESS	IRREGULAR HEART	MOLE CHNG	DIARRHEA	FEET
FAINTING	POOR CIRCULATION	SORES	EXCESS THIRST	NECK
FORGETFUL	SWELLING ANKLES	**URINARY**	GAS	SHOULDERS
HEADACHE	VARICOSE VEINS	BLOOD IN URINE	INDIGESTION	HANDS
SLEEP LOSS	MIGRAINES	FREQ URINATION	NAUSEA	
WEIGHT LOSS		BLADDER CONT	STOMACH PAIN	
NUMBNESS		PAIN URINATING	VOMITTING---W/BLOOD	

CONDITIONS YOU HAVE OR HAD IN PAST		EYE, EAR, NOSE, THROAT	MEN ONLY
AIDS	APPENDICITIS	BLEEDING GUMS	ERECTION PROBLEMS
ARTHRITIS	ASTHMA	BLURRED VISSION	LUMPS IN TESTICLES
BLEEDING DISORDER	BREAST LUMPS	CROSSED EYES	PENIS DISCHARGE
CANCER	CATARACTS	DIFF IN SWALLOWING	SORES IN PENIS
CHEMICAL DEP	CHICKEN POX	DOUBLE VISION	**WOMAN ONLY**
DIABETES	EMPHYSEMA	EARACHE OR DISCHARGE	ABNORMAL PAP
EPILEPSY	GLAUCOMA	HAY FEVER	ABNORMAL BLEEDING
HEART DISEASE	HEPATITIS ____	HOARSENESS	BREAST LUMPS
HERPES	HIGH CHOLESTEROL	HEARING LOSS	PAINFUL PERIODS
KIDNEY DISEASE	LIVER DISEASE	NOSE BLEEDING	HOT FLASHES
MEASLES	MIGRAINES	PERSISTANT COUGH	NIPPLE DISCHARGE
MULTIPLE SCLEROSIS	MUMPS	RINGING IN EARS	PAINFUL INTERCOURSE
PACEMAKER	PROSTATE PROBLEMS	SINUS PROBLEMS	VAGINAL DISCHARGE
PNEUMONIA	POLIO	VISION FLASHES	LAST PAP _____
RHEUMATIC FEVER	SCARLET FEVER		LAST MAMO_____
STROKE	THYROID PROBLEMS		LAST PERIOD_____
TB	ULCER		
VENERIAL DISEASE			

SURGICAL HISTORY: _____

SOCIAL HISTORY □ Mark here if none of this applies to you
Do you Smoke? _____If so how many per day? ____Do you Drink Alcohol? _____ If so how much per week? _____
Do you use Illegal Drugs? ____Do you regularly exercise? ____If so how much per week? _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT/GUARDIANSIGNATURE_____DATE_____

OFFICE STAFF SIGNATURE _____DATE_____

Aban Care Clinic LLC

2182 Highway 95
Bullhead City, AZ 86442
Phone: 928-758-6420
Fax: 877-712-4076

Patient Name: Date of Birth:

We at Abanc Care Clinic are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Health Plan Deductibles, Co-Payments and Coinsurance: If you have not met your health plan's deductible on the date of service, we will collect an estimated amount before you are seen towards your deductible. Please note you may receive a bill for additional charges for services rendered. You are responsible for any co-payments and co-insurance required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services.

Non-Covered Services: We will do our best to verify coverage before you are seen, but it is ultimately your responsibility to ensure payment of your bill. Any service performed by our providers that is not covered by your insurance is your responsibility. It is your responsibility to know your benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment.

Self-Pay: If you don't have health insurance, are on a plan we are not contracted with, or if we are unable to verify your coverage at the time of service, you will be charged as a self-pay patient. New Patient Visits are $150.00, and established patient visits are $75.00. You may be charged for any other services rendered at the time of visit, including but not limited to immunizations, other injections, in office tests, in office procedures, etc.

Returned Checks: We charge a $25.00 fee for any returned checks.

No Show Policy: If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before they are to be seen in our office. Failure to cancel an appointment in a timely manner may result in a No Show fee of $25.00. Multiple No Shows may result in the patient being discharged from Aban Care Clinic.

Minors: For all services rendered to minor patients, the parent, guardian or responsible party who brings the patient to the appointment is responsible for all payments due at the time of service.

Delinquent Accounts: Additional fees, including collection fees and finance charges may be added to unpaid delinquent accounts. Your account may be sent to a collection agency if the balance is 90 days old and partial or no payment has been made towards the balance.

I have read the above financial policies of IMS and agree to be bound by its terms. I also understand that IMS has the right to amend these policies at any time.

Signature of Patient or Responsible Party:_____ Date: _____
Printed Name of Patient:_____
Printed Name of Responsible Party: _____ Relation to Patient: _____
Contact Phone Number of Responsible Party: _____

PATIENT NAME: **DOB:**

2019 Annual Wellness Form – New Patient

The following information is being collected today as part of an Annual Wellness Visit. We understand that some of this information may have already been communicated to the doctor, but we would like to ensure that we keep your medical records up to date. If you have any questions, please let us know.

Patient Name	Date of Birth	Physician Name	Today's Date

MEDICAL AND SURGICAL HISTORY

ALLERGIES

MEDICATIONS

List all medications including OTCs, vitamins/minerals, and dietary supplements including dosage, frequency, and route of administration

FAMILY HISTORY

	Father	Mother	Children	Sibling	Grandparents
Hypertension	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐

GENERAL HEALTH & HEALTH MANAGEMENT

In general, would you say your health is:	☐Excellent ☐Very Good ☐Good ☐Fair/Poor
In general, would you say your hearing is:	☐Excellent ☐Very Good ☐Good ☐Fair/Poor
Please describe the current condition of your mouth and teeth (including false teeth or dentures)?	☐Excellent ☐Very Good ☐Good ☐Fair/Poor
In the past 7 days, how much pain have you felt?	☐ None ☐Some ☐A lot
How confident are you that you can control and manage most of your health problems?	☐I do not have any health problems ☐Confident ☐Somewhat confident ☐Not Very Confident
Current physical activity as compared to last year is?	☐More ☐ Less ☐Same

PATIENT NAME: **DOB:**

VACCINATION & IMMUNIZATIONS

Did you receive **last season's (Aug. 1, 2017-March 31, 2018)** Flu immunization?	☐ Yes ☐ No ☐ Declined ☐ Allergic _____ / ____ /_____ Month Day Year
Have you received **this season's (Aug. 1, 2018-March 31, 2019)** Flu immunization?	☐ Yes ☐ No ☐ Declined ☐ Allergic _____ / ___ /____ Month Day Year
When was your last Tetanus shot?	☐ Yes ☐ No ☐ Declined ☐ Allergic _____ / ____ /_____ Month Day Year
Have you ever had a Shingles Vaccination?	☐ Yes ☐ No ☐ Declined
Have you ever had a Pneumonia Vaccination?	☐ Prevnar 13 _____ / ____ /_____ ☐ Pneumovax 23 _____ / ____ /_____ ☐ Yes, but I'm not sure of the type _____ / ____ /_____ ☐ No

DIAGNOSTIC HISTORY

Please complete the following section with as much information as possible. Leave a section blank, if the section does not apply to you or if you do not remember the information.

Colonoscopy	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ No Polyps ☐ Positive for Polyps ☐ Other Results ☐ Not Applicable due to total Colectomy or colorectal cancer
Diabetic Eye Exam	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Eye Exam	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Echocardiogram	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Dental Exam	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Bone Density	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Hepatitis C	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Prostate Exam	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
FEMALES ONLY			
Last Mammogram	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results ☐ Not Applicable due to Bilateral mastectomy or 2 unilateral mastectomies
Pap Smear	_____ / ____ /_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results

PATIENT NAME: **DOB:**

ADULT DEPRESSION SCREENING TOOL- PHQ-9 (*If under the age of 18, please request an Adolescent screening tool)*

In the Past 2 weeks:	Not at All	1 – 3 Days	Half the Days	Everyday
I have little interest or pleasure in doing things	0	1	2	3
I'm feeling down, depressed, or hopeless	0	1	2	3
I'm having trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
I'm feeling tired or have little energy	0	1	2	3
I haven't had an appetite or am overeating	0	1	2	3
I'm feeling bad about myself, I feel I've let my family or myself down	0	1	2	3
I have trouble concentrating on things such as reading the paper or watching TV	0	1	2	3
People have noticed that my speech slowed down or is rushed like I am restless	0	1	2	3
I have thoughts I would be better off dead or have thought about hurting myself in someway	0	1	2	3
(OFFICE USE ONLY) **TOTALS**	=	+	+	+

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.	Not at All	Somewhat Difficult	Very Difficult	Extremely Difficult
	☐	☐	☐	☐

TOBACCO / ALCOHOL/ OTHER ASSESSMENT

Do you currently use any form of tobacco products?	☐ Yes ☐ No
If yes, how many years have you used tobacco products?	_____ years
What form of tobacco do you use?	☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe ☐E-Cig
If you do smoke, would you like to quit?	☐ Yes ☐ No
Do you drink alcoholic beverages?	☐ Yes ☐ No
How many per week?	☐ 10 or more ☐ 6-9 per week ☐ 2-5 per week ☐ I do not drink alcohol
Do you drink caffeine?	☐ Yes ☐ No # servings a day _____
Do you use sunscreen?	☐ Yes ☐ No
Do you use recreational drugs?	☐ Yes ☐ No

FALL RISK ASSESSMENT

During the last 12 months, have you fallen 2 or more times?	☐Yes ☐No
During the last 12 months, have you had a fall that resulted in an injury?	☐Yes ☐No
Do you think that you are at high risk for falling?	☐Yes ☐No
Do you use any assistive devices such as a walker, wheelchair or cane?	☐Yes ☐No
Are you having trouble with walking or balance?	☐Yes ☐No
Do you require assistance getting up from a sitting position?	☐Yes ☐No

DIABETES CONTROL

Do you have Type 1 or Type 2 Diabetes?		☐Yes ☐No
If yes, please report your most recent HbA1c level to your best knowledge:	_____ HbA1c level	_____ / _____ / _____ Date of screening

PATIENT NAME: **DOB:**

IVD AND STATIN

Are you taking ANY of the following medications Prasugrel (Effient), Aspirin, Clopidogrel (Plavix), Ticlopidine (Ticlid), Dipyridamole (Persantine), Ticagrelor (Brillinta)?	☐Yes ☐No
Are you taking a Statin?	☐Yes ☐No

ACTIVITIES OF DAILY LIVING

During the past 4 weeks, was someone available to help you if you needed and wanted help?	☐ No, Not at all ☐ Yes, Sometimes ☐ Yes, Always

In the past 4 weeks, have you had any trouble doing any of the following? If applicable, please list an individual who helped complete the task.

Take medications	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Getting around the home	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Bathing and Dressing	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Using the Telephone	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Traveling	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Grocery Shopping	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Preparing Meals	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Housework	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Managing Money	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Do you have a living will?	☐Yes ☐No
Do you have difficulty driving your car?	☐ No, difficulty ☐ Yes, sometimes ☐ No, I do not drive
Do you always fasten your seat belt when in a vehicle?	☐ Yes ☐ No
During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?	☐Heavy ☐Moderate ☐Light ☐Very Light
Do you exercise for 20 minutes, 3 or more days a week?	☐Yes, most of the time ☐Yes, some of the time ☐No, I do not exercise
Have you been given information to help you with the following: • Hazards in the home which may hurt you? • Keeping track of your medications?	☐ Yes ☐ No ☐ Yes ☐ No

Please indicate any of the following Chronic Conditions that apply to you:

Chronic Condition	Date diagnosed	Managing Doctor	Date you last saw doctor	Today Physician Initials
Chronic Kidney Disease				
Cancer				
Coronary Artery Disease				
Depression/Anxiety				
Diabetes, (Type 1 or 2)				
DVT				
Genetic Disorder				
Heart Disease				
High Blood Pressure				
Liver Disease				
Osteoporosis				
Paraplegic/Quadriplegic				
Neurological Disorder				
Stroke				
Rheumatoid Arthritis				

PATIENT NAME: **DOB:**

LIST OF PHYSICIANS
Optometrist
OB/GYN
Ophthalmologist
Cardiologist
Gastroenterologist
Nephrologist
Oncologist
Orthopedist
Pulmonologist
Rheumatologist
Urologist
Neurologist
Psychiatrist
Home Health Company
CPAP Company
Diabetes Supply Company
Other Supply Companies
Other
Other