# Complete Care Medicine
# Registration/Update Form

Today's Date: ______________

## Patient Information

Patient's Name: ______________ Last ______________ First ____ MI ______________ Date of Birth

Male ◯ Female ◯

____ Age ______________ Social Security Number

Race: American Indian ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Other ☐

Ethnicity: Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐

Home Address: ______________ Street ______________ City ______________ State ______________ Zip Code

______________ Home Phone ______________ Work Phone ______________ Mobile Phone ______________ E-mail Address

Preferred Method of Contact: Phone ☐ E-mail ☐ USPS ☐

Employment Information: ______________ Occupation ______________ Employer's Name

Employer Address: ______________ Street ______________ City ______________ State ______________ Zip Code

## Health Insurance Information

| PRIMARY INSURANCE | SECONDARY INSURANCE |
|---|---|
| Name of Insurance Plan ______________ | Name of Insurance Plan ______________ |
| Insurance Identification Number ______________ | Insurance Identification Number ______________ |
| Group No. or Name of Employer ______________ | Group No. or Name of Employer ______________ |
| Date Insurance Began ______________ | Date Insurance Began ______________ |
| HMO ☐ PPO ☐ Other ☐ | HMO ☐ PPO ☐ Other ☐ |
| Co-pay Amount ______________ | Co-pay Amount ______________ |
| Name of Person Who Carries Insurance ______________ | Name of Person Who Carries Insurance ______________ |
| ______________ Date of Birth ______________ Social Security Number | ______________ Date of Birth ______________ Social Security Number |

***Preferred Pharmacy:** Name ______________ Cross Streets ______________

**PLEASE COMPLETE FOR:** (SPOUSE IF MARRIED) OR (PARENT IF A DEPENDENT)

Name: ______________ Last ______________ First ____ MI ______________ Relationship to Patient ______________ Social Security Number

Home Address: ______________ Street ______________ City ______________ State ______________ Zip Code

______________ Date of Birth ______________ Home Phone ______________ Work Phone ______________ Mobile Phone

______________ Occupation ______________ Employer's Name

Employer Address: ______________ Street ______________ City ______________ State ______________ Zip Code

**IN CASE OF URGENT NEED, PLEASE CONTACT THE FOLLOWING PERSON**

Name ______________ Home Phone ______________ Relationship to Patient ______________

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# COMPLETE CARE MEDICINE
## Pediatric Medical History Form

**Name** ________________________________________ **DOB** ____________ **Age** _____________ **Date** _____________________

**Accompanied by (name and relation)** __________________________________ **Date of Last Physical** __________________ **Adopted** YES/NO

**BIRTH HISTORY**
Problems with pregnancy, labor or delivery? Yes/No
Premature? Yes/No
Cesarean section? Yes/No
Breathing problems at or after birth? Yes/No
Jaundice? Yes/No
Seizure? Yes/No
Other problems at birth or first week of life? Yes/No
Was discharge delayed for any reason? Yes/No
Birth weight of baby: __________

**Please list all Medical conditions (i.e. Chickenpox, Dental problems, Asthma, Mental illness, Discipline problems, Physical or sexual abuse, etc..)**

| | | |
|---|---|---|
| 1. | 2. | 3. |
| 4. | 5. | 6. |
| 7. | 8. | 9. |

**Please list <u>all</u> the medications, including any over the counter medications that patient is taking or has recently been taking**.

| Medication | Dose/Frequency | Discontinued | Medication | Dose/Frequency | Discontinued |
|---|---|---|---|---|---|
| 1. | | | 2. | | |
| 3. | | | 4. | | |

**Please list any allergies to food or medication:**
Allergy: ______________________________________________________What happens: ________________________________________________
Allergy: ______________________________________________________What happens: ________________________________________________

Are vaccines up to date? YES/NO If NO, what's needed? _____________________________________________

**Please list all Surgeries (Please include the approximate month/year)**

| | | |
|---|---|---|
| 1. | 2. | 3. |
| 4. | 5. | 6. |

**Social History:**
Child lives with (name/age/relationship): ________________________________________________________________________
Current grade in school: _______________
Do they smoke or use any tobacco products? **YES/NO**
Do they use alcohol products? **YES/NO**
Do they use recreational drugs? **YES/NO**
Are there smokers in the home? **YES/NO**
Are there guns in the home? **YES/NO**
Are there pets in the home? **YES/NO**
**If applicable:** Has your child started her period? **YES/NO**
**If yes,** at what age? _________

**Family History**
**Is there a history of:** (please circle disease below and check whom it applies to)

| | Mother | Father | Grandparents | Siblings | Other |
|---|---|---|---|---|---|
| **Neurological problems, Seizure, ADHD** | | | | | |
| **Diabetes, Thyroid problems, Endocrine Problem** | | | | | |
| **Hearing problem** | | | | | |
| **Heart Attack, Heart disease, High cholesterol** | | | | | |
| **Metabolic disorders** | | | | | |
| **Asthma/Emphysema, other Lung disease** | | | | | |
| **Psychiatric disorder, Depression, Alcohol or drug abuse** | | | | | |
| **Blood disorders, bleeding problems, sickle cell anemia** | | | | | |
| **Ulcerative colitis and other intestinal diseases** | | | | | |
| **Other Diseases** | | | | | |

Parent/Guardian Signature:_____________________________________________ Date:__________________________________________

**By signing this form, I acknowledge that I have read and understand Complete Care Medicine's office policies.**

Patient Name: ___________________________________ Date of Birth: ____________________

Print Name: _____________________________________ Date: ______________________

Relation to Patient (Circle): Self Mother Father Spouse Other: ____________________

Signature: ______________________________________

1489 S. Higley Road, Suite 101
Gilbert, AZ 85296
Tel (480) 457-8800
Fax (480) 457-8885
www.completecaremedicine.com

# Complete Care Medicine

## Privacy Practice Acknowledgement and Family Auth

Patient Information (Please Print):

Name:__________________________________________ Date of Birth: _____________

Phone:________________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under HIPAA requirements, we are not allowed to release this information without the patient's consent. If you would like us to release billing or medical information to family members you must sign this form. Only the family members listed below **CAN** have access to your records.

1.__________________________________________________ Relationship to Patient: __________________

2.__________________________________________________ Relationship to Patient: __________________

3.__________________________________________________ Relationship to Patient: __________________

Please list any family members that you **DO NOT** want CCM to discuss your medical or billing information with:

1.__________________________________________________

2.__________________________________________________

Complete Care Medicine is authorized to: (Please check appropriate boxes below. )

- ☐ Call my home phone number
- ☐ Call my cell phone number
- ☐ Call my work phone number
- ☐ Leave a message on my home phone number
- ☐ Leave a message on my cell phone number
- ☐ Leave a message on my work phone number

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By voluntarily signing this form I affirm that I am the above patient, parent or legal guardian and have read and fully understand all statements made in the Notice of Privacy Practices. I am aware that I may request a copy of the Notice of Privacy Practices for Complete Care Medicine and one will be provided to me. I understand that I have the right to revoke this authorization at any time by providing a written statement to Complete Care Medicine where the authorization was originally submitted, except to the extent that CCM has already completed action on it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. **I understand that this authorization will remain in effect indefinitely unless revoked in writing by the patient or legal representative.**

Patient's Signature ____________________ Date ________

Parent/Legal Representative Signature/Relationship To Pt ____________________ Date ________

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# Complete Care Medicine

## Authorization For Release of Medical Records

Patient Information (Please Print):

Name:________________________________________ Date of Birth: ____________

Social Security Number:__________________________

Address: ________________________________________________

City: _____________________ State: ______ Zip Code:_________

Phone:______________________

## Release Information **From**:

☐ Name_________________________________________________________________
Address:_______________________________________________________________
City:___________________ State: ______ Zip Code: ________
Phone: ___________________ Fax:______________________

## Release Information **To:**

☐ Name_________________________________________________________________
Address:_______________________________________________________________
City:___________________ State: ______ Zip Code: ________
Phone: ___________________ Fax:______________________

## Information to Be Released:

☐ Entire Medical Record, **including** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS

☐ Entire Medical Record, **excluding** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS

☐ Past _______Years

☐ Lab Results

☐ Imaging Results

☐ Other: (Please be as specific as possible, including any information you **DO NOT** want released) ____________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

## Reason for Release:

☐ Personal Copy

☐ Legal

☐ Continuation Of Care (Specialist)

☐ Changing Primary Care Doctors

By voluntarily signing this form I affirm that I am the above patient, parent or legal guardian and have read and fully understand all statements made in this document. I understand that this authorization is valid for 1 year unless otherwise specified and I have the right to revoke this authorization at any time by providing a written statement to Complete Care Medicine where the authorization was originally submitted, except to the extent that CCM has already completed action on it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

Patient's Signature ____________________ Date __________

Parent/Legal Representative Signature/Relationship To Pt ____________________ Date __________