**New Horizon Medical Center**
**3201 W Peoria Avenue, Suite D805**
**Phone: 602-715-1185 - FAX: 855-583-3686**

## NEW PATIENT PAPERWORK

First Name: _____ Last Name: _____

Date of Birth: _____ Phone number: _____

Primary Address: _____ City: _____

State: _____ Zip Code _____ Email: _____

Travel plans (Snowbird? Traveling for extended period of time in next couple of months. _____

How did you hear about us? (Circle One): Newspaper Ad, Facebook, Instagram, TV ad, mutual patient, other? Please specify. _____

What workup have you had? Primary care physician, Neurologist, Rheumatologist, Orthopedic specialist, Chiropractic, Podiatrist, or other? Please specify below.

Provider Name: _____ Specialty: _____

Phone Number: _____

Provider Name: _____ Specialty: _____

Phone Number: _____

Provider Name: _____ Specialty: _____

Phone Number: _____

What brings you in today? _____

**Diagnostic Tests:**

x-rays: _____Area:_____ CT scans: _____ Area: _____

MRI: ____area_____ EMG: Nerve conduction study? Area_____

**Motor Symptoms:**

| **Condition** | **Yes** | **No** | **Specific location** |
|---|---|---|---|
| Weakness: | _____ | _____ | _____ |
| Paralysis: | _____ | _____ | _____ |
| Foot drop: | _____ | _____ | _____ |
| Arm Swing: | _____ | _____ | _____ |
| Hand grip: | _____ | _____ | _____ |
| Contractures: | _____ | _____ | _____ |

| **Autonomic Symptoms:** | **Yes** | **No** | **Specific location** |
|---|---|---|---|
| Do you have any of the following? | | | |
| Orthostatic hypotension | _____ | _____ | _____ |
| Low blood pressure | _____ | _____ | _____ |
| Dizziness | _____ | _____ | _____ |
| Vertigo | _____ | _____ | _____ |
| GI (stomach) problems | _____ | _____ | _____ |

**For Neuropathy patients only:** Do you know the cause of your neuropathy? If so, please check Yes or No:

| **Condition** | **Yes** | **No** |
|---|---|---|
| Unknown (idiopathic) | _____ | _____ |
| Traumatic | _____ | _____ |
| Nutritional | _____ | _____ |
| Infectious | _____ | _____ |
| Toxic | _____ | _____ |
| Autoimmune | _____ | _____ |
| Entrapment syndrome | _____ | _____ |
| Surgical | _____ | _____ |
| Diabetes | _____ | _____ |

If Yes, DATE OF ONSET_____ LAST A1C Date: _____ Value: _____

| **Do you have any loss of the following functions** | **Yes** | **No** |
|---|---|---|
| Falls | _____ | _____ |
| Dropping items | _____ | _____ |
| Holding walls | _____ | _____ |
| Weakness | _____ | _____ |
| History of paralysis | _____ | _____ |

Do you have any bowel or bladder incontinence? Yes ___ No___ Which? _____

| **What treatments have you tried that did not work** | **Yes** | **No** |
|---|---|---|
| Gabapentin | _____ | _____ |
| Lyrica | _____ | _____ |
| Cymbalta | _____ | _____ |
| over the counter medications | _____ | _____ |
| injections | _____ | _____ |

What treatment have you tried in the past that worked the best for you? (Please specify): _____

_____

What makes your pain better? (Rest, sitting, ice/heat, over the counter medications such as Tylenol, Advil, Ibuprofen: please specify: _____

What makes your pain worse? (lifting, bending, standing, sitting in a chair, stairs, etc) please specify: _____

_____

Have you tried injection therapy in the past? Yes ____ No ___

On a scale of 1-10, 1= minimal and 10 = the worst), please rate the pain: Today: _____ At its worst: _____

If the following apply to you, please rate them on a scale of 1-10

Numbness: _____
Tingling: _____
Burning: _____
Tightness/Cramping: _____

| **Do you have any sleep issues?** | **Yes** | **No** |
|---|---|---|
| Insomnia | _____ | _____ |
| Restless leg syndrome | _____ | _____ |
| periodic limb movement syndrome | _____ | _____ |
| excessive daytime sleepiness | _____ | _____ |

Other: _____

**MEDICATIONS:**

| **Name** | **Dosage** | **How many times a day** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Past medical history ( see old form

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| High Blood Pressure | | | Migraines | | |
| High Cholesterol | | | Gastroesophageal Reflux Disease (GERD) | | |
| Congestive Heart Failure | | | Valley Fever | | |
| Chronic Kidney Disease/Failure | | | Tuberculosis | | |
| Liver Disease | | | Polio | | |
| Diabetes Type I | | | Lupus | | |
| Diabetes Type II | | | Osteoarthritis | | |
| Peripheral Neuropathy | | | Osteoporosis | | |
| Memory Issues/Dementia | | | Depression | | |
| Coronary Artery Disease | | | Anxiety | | |
| Myocardial Infraction (Heart Attack) | | | Anemia | | |
| Stroke | | | Blood Disorders, Specify: | | |
| TIA | | | Bipolar Disorder I | | |
| Hyperthyroidism | | | Bipolar Disorder II | | |

| Condition | Yes | No | Condition |
|---|---|---|---|
| Hypothyroidism | | | Other: |
| HIV | | | Other: |
| Herpes Simplex 1 | | | Other: |
| Herpes Simplex 2 | | | Other: |
| Shingles | | | Other: |
| COPD | | | Other: |
| Bronchitis | | | Other: |
| Glaucomea | | | Other: |
| Cancer (Specify) | | | Other: |
| DVT – Blood Clots (Please Circle) | | | Other: |
| Aneurysm | | | Other: |
| Atrial Fibrillation | | | Other: |
| Epilepsy | | | Other: |

Surgical History: _____ Date: _____

Surgical History: _____ Date: _____

Surgical History: _____ Date: _____

Allergies to medications: _____ Reaction: _____

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Allergies to medications: _____ Reaction: _____

Food allergies: _____ Reaction: _____

Food allergies: _____ Reaction: _____

Food allergies: _____ Reaction: _____

**Social History:**

Alcohol: Yes No If Yes, how many and what types of drinks do you consume per day/week? _____

Tabacco/nicotine use: Never Former Smoker Current Smoker

If former how many packs a day did you smoke and for how many years: _____

Approximate year you quit. _____

Illegal drug use? Yes No

If yes please specify: _____

## *Primary Insurance Information*

**Who is responsible for your bill? You and…. (Please, circle appropriate indicator)**
**Myself Only Spouse Worker's Comp Auto Insurance Medicare**
**Health Insurance Carrier: _____ ( PPO, HMO, EPO )**
**ID #_____ Group #_____**
**Holder's name:_____**
**Provider Service Phone # :_____**

## *Secondary/Supplemental Insurance Information*

**Who is responsible for your bill? You and…. (Please, circle appropriate indicator)**
**Myself Only Spouse Worker's Comp Auto Insurance Medicare**
**Health Insurance Carrier: _____ ( PPO, HMO, EPO )**
**ID #_____ Group #_____**
**Holder's name:_____**
**Provider Service Phone #:_____**

## *Workers Compensation Injury/ Auto/ Personal Injury*

**Have you filed and injury report with your employer? Yes/ No Date__/__/_____**
**Claim #_____**
**Carrier: _____ Policy #_____**
**Carrier's Phone # (___)____-____ Adjuster:_____**

## *Patient Billing/ Payment Understanding /Authorization of Care*

**I understand and agree that health /accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am directly responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. As the patient, I also agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my condition as he or she deems appropriate. I give authority for these procedures to be performed.**

**Patient Print Name: _____ Date: _____/_____/_____**

**Patient signature authorizing care: _____**

**Guardian or Spouse's signature authorizing care:_____**
**Relationship to patient: _____**

**New Horizon Medical Center**
**3201 W Peoria Ave, Ste D-805**
**Phoenix, AZ 85029**
**602/715-1185**

# HIPAA • Consent to Treat • Release of Information

## 1. Consent to Treatment

**I consent to evaluation and treatment by New Horizon Medical Center, including exams, procedures, and medication management. I understand I may ask questions at any time and may refuse treatment to the extent allowed by law.**

**Initial: _____**

## 2. HIPAA Privacy Practices Acknowledgment

**I acknowledge that I have received or been offered the Notice of Privacy Practices, which explains how my medical information may be used and shared for treatment, payment, and clinic operations.**

**Initial: _____**

## 3. Release of Medical Information to Family/Others

**I authorize New Horizon Medical Center to release or discuss my medical information with the individuals listed below.**

## Authorized Persons:

1. **Name: _____ Relationship: _____**

   **Phone: _____**

   **Information Allowed: ☐ All ☐ Appointments ☐ Billing ☐ Medications ☐ Other: _____**

2. **Name: _____ Relationship: _____**

   **Phone: _____**

   **Information Allowed: ☐ All ☐ Appointments ☐ Billing ☐ Medications ☐ Other: _____**

**I understand I may revoke this permission in writing at any time.**

**Initial: _____**

## Patient Information

**Patient Name: _____**

**Date of Birth: _____**

## Signatures

**Patient/Guardian Signature: _____Date: _____**

**Clinic Staff (optional): _____Date: _____**

# NOTICE OF PRIVACY PRACTICES

**This notice explains how your medical information may be used, shared, and your rights. Please read carefully.**

## How We Use Your Health Information

**We may use or share your information with:**

- **Treat you: With doctors, nurses, pharmacies, labs, and other providers.**
- **Bill for care: Insurance claims, benefits verification, payment collection.**
- **Run our clinic: Quality improvement, staff training, administrative purposes.**

## When We May Share Without Your Permission

- **Public health and safety**
- **Workers' compensation**
- **Legal or court requests**
- **Law enforcement and health oversight**
- **Preventing serious threats to health or safety**

## Your Privacy Rights

**You can:**

- **See or get a copy of your records**
- **Request corrections**
- **Ask for limits on use/disclosure**
- **Request confidential communication**
- **Receive a list of certain disclosures**
- **Get a paper copy of this Notice**

## Our Responsibilities

**We must:**

- **Protect your health information**
- **Follow the rules in this Notice**
- **Notify you of breaches affecting your information**
- **Provide the most current Notice upon request**

## Questions or Complaints

**Privacy Officer – New Horizon Medical Center**
**Phone: 602-715-1185**
**Address: 3201 W PEORIA AVE STE D805 PHOENIX AZ 85029**

***You may also file a complaint with the U.S. Department of Health & Human Services.***
***We will not retaliate against you for filing a complaint.***