□ **NEW REGISTRATION** □ **UPDATED** □

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX □ MALE □ FEMALE

HOME PHONE #	EMAIL	CELL PHONE #	MARITAL STATUS: □ MARRIED □ SINGLE □ WIDOWED □ DIVORCED □ OTHER

REFERRING PHYSICIAN NAME AND PHONE NUMBER	PCP NAME & PHONE#

HOW DID YOU HEAR ABOUT US: □ PROVIDER REFERRAL □ INTERNET □ WORD OF MOUTH □ PREVIOUS PATIENT □ CURRENT PATIENT
□ BROCHURE □ INSURANCE □ HOSPITAL □ CONCENTRA □ MAGAZINE □ RADIO □ OTHER

MANDATORY-PER NEW CMS GUIDELINES

LANGUAGE	**ETHNICITY**	**RACE**
□ ENGLISH □ SPANISH □ RUSSIAN □ CREOLE □ OTHER _____	□ LATINO/HISPANIC □ NON LATINO/NON HISPANIC	□ ASIAN □ NATIVE HAWAIIAN □ OTHER PACIFIC ISLANDER □ BLACK/AFRICAN AMERICAN □ AMERICAN INDIAN/ALASKA NATIVE □ WHITE □ REFUSE TO REPORT

RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME	FIRST NAME	MI	HOME PHONE

ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYER	OCCUPATION	WORK PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY □ SELF □ SPOUSE □ CHILD □ OTHER

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT INFO –	PHONE

PHARMACY

NAME AND LOCATION	PHONE

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	**SUBSCRIBER NAME AND SOCIAL SECURITY**			DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER			

ADDRESS	CITY	STATE	ZIP	PHONE

SECONDARY INSURANCE	**SUBSCRIBER NAME AND SOCIAL SECURITY**			DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER			

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS, FINANCIAL POLICY TERMS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I have read, agree to and signed the Financial Policy. I agree I will be responsible for any unpaid balances for any reasons.

I herby authorize direct payment to Keith Zacher, MD, of any medical benefits payable to me for the services provided by Keith Zacher, MD.

X_____
Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Keith Zacher, MD to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This aurthorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X_____
Patient Signature or Signature of Guardian or Parent Date

Keith Zacher, MD

Phone: 480-772-2453 **Fax: 602-774-3255**

Past Medical History

Name: _____ **Date of Birth:** _____

Allergies to Medications: _____

List all past operations and/or serious illnesses (i.e. heart problems, hypertension, diabetes):

Operation/Illness	Year	Outcome

List all medications you are currently taking:

Medicine	Dose/Frequency

Have your grandparents, parents, or children had any significant medical problems? Yes or No
Specify: _____

Review of systems: **Have you or do you:**

Recently lost or gained significant weight?	Y N	Any lung/breathing problems?	Y N
Had fever/chills/night sweats in the past month?	Y N	Had chest pain?	Y N
Had any rashes that lasted more than 1 week?	Y N	Being treated for high blood pressure or heart problems?	Y N
Had skin cancer?	Y N	Had phlebitis/blood clots in the veins of your legs?	Y N
Bruise easy?	Y N	Any joint problems (arthritis)?	Y N
Have any chronic ear/hearing problems?	Y N	Have hives/hay fever/asthma?	Y N
if yes, please specify: _____			
Had any nausea/vomiting in the past month?	Y N	Been treated for depression?	Y N
Have any stomach pain?	Y N	Had seizures?	Y N
Have pain when urinating?	Y N	Had any numbness or tingling?	Y N
Any kidney/bladder infections in the past month?	Y N	Had any paralysis?	Y N
Been told you have bleeding problems?	Y N	Been told you have problems with lymph glands	Y N

Comments: _____

Patient Signature _____ **Date:** _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND HEALTH INFORMATION NOTICE

Patient Name: _____ Date of Birth: _____

I acknowledge that I have been provided the Keith Zacher, MD ("Practice") Notice of Privacy Practices:

- It tells me how Practice will use my health information for the purposes of my treatment, payment for my treatment, and Practices health care operations.
- The notice explains in more detail how Practice may use and share my health information for other than treatment, payment, and health care operations.
- Practice will also use and share my health information as required/permitted by law.

I acknowledge that I have been provided the Keith Zacher, MD ("Practice") Notice of Health Information Practices ("Notice"):

- It tells me how Practice will electronically share health information with a Health Information Organization (HIO).
- The notice explains in more detail how I may Opt-out of sharing my health information with the HIO.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Address

_____ _____
Description of Personal Representative's Authority Telephone

Keith Zacher, MD
3501 N. Scottsdale Rd. Ste.140
Scottsdale, AZ 85251
Phone# 480-772-2453
Fax# 480-774-3255

Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

_____

Telephone: _____

I authorize Keith Zacher, MD or other person/entity _____ to disclose/release the following information:

_____ All medical records related to (specify condition, treatment, etc.): _____

_____ All billing records related to (specify condition, treatment, etc.): _____

_____ Specific records/information as follows: _____

_____

Purpose of disclosure: _____

I do not want the following information disclosed (as defined by applicable state and federal laws):

_____ Alcohol/Drug Abuse _____ HIV Test Results _____ Mental Health/Developmental Disabilities

Release information TO:

Address: _____

_____

Telephone: _____ **Fax:** _____

This Authorization is good until the following date: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Address

_____ _____
Description of Personal Representative's Authority Telephone