Paper Cranes
HEALTHCARE

NEW PATIENT INFORMATION

Date: _____

Name: _____ Phone: (_____

Email: _____ Social Security: _____

Date of Birth: _____ Age: _____ Gender Identity: Male Female Other: _____

Ethnicity: _____ Marital Status: _____

Full Time Resident: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Other Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

Work Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Cross Streets: _____ City: _____

Emergency Contact:

Name: _____ Phone: (_____

How did you hear about us? _____

Chief Complaint/ Reason for Visit: _____

How long has this been a problem? _____

Prior Treatment: _____

Patient Name: _____ **Date:** _____

INSURANCE INFORMATION

Primary Insurance:
Name: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

ID#: _____ Employer: _____

SS#: _____ Relationship to Policy Holder: _____

Secondary Insurance:
Name: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

ID#: _____ Employer: _____

SS#: _____ Relationship to Policy Holder: _____

AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION (PHI)

Do we have permission to leave a message regarding test results, appointments, etc. on your answering machine? Yes ◯ No ◯

Please check one that applies

- ☐ I only want my medical information released to myself
- ☐ I give Paper Cranes Healthcare and staff authority to release my medical information regarding my care to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

AUTHORIZATION TO TREAT/RELEASE INFORMATION

I hereby give my permission to Paper Cranes Healthcare to administer treatment and to perform procedures that may be deemed necessary in the diagnosis and treatment of my health. I also hereby assign to the above-named practice all benefits provided by my insurance company policy or policies for medical care. **I understand that I am financially responsible for any balance due on my account.** I also authorize the above practice to release all of my information in the processing of my claims.

Patient Print Name _____

Patient Signature _____ Date _____

Parent/Guardian: _____

ACKNOWLEDGMENT OF RECEIVING PATIENT RIGHTS AND HIPPA POLICY

I acknowledge that I have reviewed a copy of my patient rights and HIPPA policy, as deemed by Paper Cranes Healthcare.

Patient Signature _____ Date _____

Parent/Guardian: _____

MEDICAL HISTORY

Do you have or have you ever had any of the following?

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Anesthesia Difficulties
- ☐ Blood Clots
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Chronic Pains
- ☐ Circulation Disorders
- ☐ Diabetes Type:_____
- ☐ Color Changes of Skin
- ☐ Depression
- ☐ Dialysis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Hearing Deficit
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type:____
- ☐ Hernia Type:_____
- ☐ History of Alcohol Dependency
- ☐ History of Drug Dependency
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Keloid (Scar Formations)
- ☐ Leg Pain (Cramps)
- ☐ Lung Pain
- ☐ Migraine Headaches
- ☐ Muscle Disease
- ☐ Neck Pain
- ☐ Pace Maker
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Prostate Disease
- ☐ Psoriasis
- ☐ PVD
- ☐ RSD
- ☐ Shortness of Breath
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Vision Problems
- ☐ Other: _____

PAST SURGICAL HISTORY AND HOSPITALIZATIONS

Operation/Serious Injury	Approximate date	Physician	Hospital

SOCIAL HISTORY

Do you smoke? _____ How many packs per day? _____

Do you drink? _____ Number of drinks per day/week/month? _____

GYNECOLOGICAL HISTORY

How many pregnancies have you had? _____ How many children do you have? _____

Date of last menstrual period: _____ Date of last pap: _____

Have you ever had an abnormal pap? _____

Date of last mammogram? _____ Abnormal or Normal? _____

FAMILY HISTORY

Has any blood relative had the following?	Who? (father, mother, sister, brother etc.)
Anesthesia Complications	
Asthma	
Bleeding Problems	
Cancer Type:	
Diabetes Type:	
Epilepsy	
High/Low Blood Pressure	
Heart Disease	
Kidney Disease	
Stroke	
Other:	

VITALS

Do you have metal in your eyes/body? YES/NO If yes, where? _____

Do you have stents? If yes, where? _____

Height: _____ Weight: _____

Do you have any known drug allergies? _____

MEDICATIONS

NONE

Medication	Dosage	How Often?

TESTING HISTORY

Type of Test	Date	Results
Abdominal Aortic Aneurysm Screening		
EKG		
Endoscopy/Colonoscopy		
Cardiac Stress Test		
Bone Density Scan		
STD Testing		

VACCINATION HISTORY

DATE OF:

Last Shingles vaccine? _____

Last Pneumonia vaccine? _____

Last Flu shot? _____

Last HPV vaccine? _____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service.

We will accept Visa, MasterCard, Discover, cash or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the practice. In other words, you agree to have your insurance company pay the practice directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services, however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

For most services provided in the facility, we will bill your health plan. Any balance due is your responsibility.

There are certain elective procedures that require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due on the day of the procedure.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fee, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

There may be an additional fee for continued or repeated missed appointments. This fee is subject to the practice's discretion.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Paper Cranes

HEALTHCARE

PH:(480)704-3474
FAX: (888)221-2541

I, _____ (Full Name) authorize the offices listed below to release my medical records to Paper Cranes Healthcare. If there is any information I do not want released, I have listed it below.

Physician or group name we are requesting information from:

Please send the following medical records for the patient listed below:

- ☐ Medical records from the past year
- ☐ Lab results from the past year
- ☐ Imaging from the past year
- ☐ Hospital information
- ☐ Other: _____

Please do not include the following records: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Guardian Name: _____ Guardian Signature: _____

Please send all records to Paper Cranes Healthcare. Our fax number is (888)221-2541.

Paper Cranes
HEALTHCARE

Well-Exam Visits

If you are having a "**well-exam visit**" or "**physical**" today, this visit, by definition, may include the following:

- Interim medical history since last visit
- Updates regarding allergies, family health or social situation changes
- Full physical exam
- Review of immunizations and administration if indicated

If you have an acute/urgent illness, significant chronic illness, or if you wish to discuss behavioral and mental health issues, your insurance may be billed for a problem visit along with being billed for your well-exam.

If your insurance denies payment or applies the balance to your deductible for one of these visits, you are responsible for the remaining balance.

You may choose to reschedule your well-visit to another day if you desire.

Signature _____ Date _____