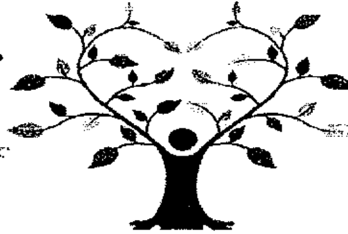
RUTH ELAINE FOWLER, DNP,FNP-BC
JILLIAN MUSICK, FNP-C
MAURICE DALE PARRY DO

VALORI CABLE, DNP, FNP-BC
MARLIE LUCAS, FNP-BC

Sycamore Ave.
Medical Center
Family Practice

Ruth Elaine Fowler DNP, FNP-BC
Phone: 928-692-1900
Fax: 928-681-1922



PATIENT INFORMATION

Name(Last, First, MI)________________________________ SSN:____________________

D.O.B____________________ Sex: Male/Female Marital Status: Single/Married/Widow

Address:____

City:____________________________ State:______________ Zip Code:___________

Home Phone:____________________ Cell Phone:_____________________________

Pharmacy:_______________________ Email address:__________________________

What is your ethnicity?_________________ What is your race?_________________________

Employer?____

May we call you at work?_______________ Work phone number?______________________

Prior medical provider?________________________ Provider phone number?________________

EMERGENCY CONTACT INFORMATION

Guardian/Emergency Contact Name:____

Relationship to the patient:__________________ **Pediatric only: Name of parent**_____________

Address:____

City:____________________________ State:________________ Zip Code:______________

Home Phone:___________________________ Cell Phone:______________________________

INSURANCE INFORMATION

Primary Insurance Company:____________________ Insured Party/Holder:_________________

Policy Number:___________________________ Group Number:__________________________

Secondary Insurance Company:__________________ Insured Party/Holder:_________________

Policy Number:___________________________ Group Number:__________________________

Name:_________________________________ D.O.B:____________________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: __________________________________
(PRINT NAME PLEASE)

Signature: ____ Date: ____________

Witness: ____ Date: ____________

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information:
Name ________________________________ DOB ________________ Phone ____________________
Person Requesting Information:

Sycamore Avenue Medical Center, PLLC. Provider ____________________________
975 Sycamore Avenue, Kingman, AZ 86409 Phone: 928-692-1900
Fax: 928-681-1922

Requesting Info From:
Name/Doctor ________________________________ Fax Number ____________________________
Address ____ Zip ________________________

__ Continuing Care __ Insurance Claim/Application __ Legal __ Other(Specify)

Only the records marked need to be released:
___ Pertinent medical records for the past 2 years
___ History/Physical ___ Labs ___ EKGS ___Progress Notes ___ ___Consults ___Surgery
___Pathology ___Xray Reports ___Xray Films ___Medication Info ___Complete Records

* * * * * * * * * * * * * *

I authorize the release of photocopies of the specified medical records and/or xray films, including those which may contain information regarding alcohol or drug abuse, or psychiatric diagnosis/treatment, or HIV/AIDS treatment, or confidential communicable disease, unless indicated here in writing.

- The information be used by the specified person or organization. It maybe further released without the additional written consent of the patient or guardian.
- I understand that there is no charge when records are mailed directly to a medical provider for continuing care. I also understand that there is a charge when records are mailed to any other party other than a medical provider, including when given to me personally.

________________________________ ________________________________
Patient/Guardian Signature Date

If a patient is unable to sign consent by reason of age or some other factor, please state reason:
____.

Signature of legally authorized representative: ______________________________
Relationship to patient: ____

Name: ______________________ DOB: __________

Patient Health History

Do you smoke? (circle) No Yes How much?________When did you quit?______ How many years_________

Do you drink alcohol? No Yes How much?__________________

Do you drink caffeine? (coffee/soda/energy drinks) No Yes How much?______________________

Do you use illicit/recreational drugs? No Yes

Do you exercise routinely? No Yes How many days per week?______________________

Do you have any of the following conditions? (Check box by all that apply)

Cataracts		Heart Disease		Reflux/ Ulcers		Anemia		Prostate Enlargement	
Glaucoma		Heart Murmur		Leg or foot Ulcers		Blood Clots		Abnormal Pap Smears	
Asthma		High Blood Pressure		Digestive Disorders		Bleeding disorder Bruise Easily		Alzheimers Dementia	
Allergies		Pneumonia		Hemorrhoid		Cancer		Alcoholism	
Stroke		Bronchitis (Chronic)		Kidney Disease		High Cholesterol		Insomnia	
Seizures/ Epilepsy		COPD Emphysema		Kidney Stones		Depression/ Anxiety		Head Injuries	
Heart Attack		Tuberculosis		Diabetes		Chicken Pox		Broken Bones	
Angina/ Chest pain		Liver Disease or Jaundice		Thyroid Problems		STD's/ HIV		Arthritis	

If yes to any of the above please explain:______________________________________

____

Operations: (Please list any surgery and the approximate year)

1. ____
2. ____
3. ____
4. ____

Name________________________________ **D.O.B.**________________

Hospitalizations: (Please list any hospitalizations other than with operations, I.E. Pneumonia)

1. ____
2. ____
3. ____
4. ____
5. ____

Immunizations: (Check if you have received and indicate last year received)

Type	Received	Year	Type	Received	Year	Type	Received	Year
Influenza			Pneumonia			MMR		
Tetanus			Hepatitis A or B			Shingles		

* Note if this is a pediatric patient a copy of vaccination records is needed.

Transfusions: Have you ever had a blood transfusion? Circle No Yes

Weight: What is your weight now?__________ One year ago? __________

Females only: Are you pregnant, planning a pregnancy, or nursing a child? No Yes

Date of last menstrual period?__________ Date of last pap smear?__________

Have you ever been told that you had an abnormal pap? No Yes When?__________

Have you had a mammogram?__________ Date of last mammogram?__________

Have you had a colonoscopy?__________ Date of last colonoscopy__________

Current Medication List

Please list all current medications including prescribed, vitamins, and over the counter medications that you take.

Medication	MG	Times taken per day

Name____ **D.O.B.**______________

Please list any allergies to **medications, food, an any environmental** allergies and the reaction to those allergies:

1. ____
2. ____
3. ____
4. ____
5. ____

Family History

Family Member	Age	Significant Illnesses	Age at Death	Cause of Death if applicable	Comments
Mother					
Father					
Brother					
Sister					
Maternal Grandparents					
Paternal Grandparents					

Has any blood relative ever had any of the following? Check if yes and indicate relationship.

Illness		Relationship	Illness		Relationship	Illness		Relationship
Alzheimer's			Heart Attack			Alcoholism		
Tuberculosis			High Cholesterol			Mental Disorder		
Diabetes			Depression/ Anxiety			Allergies		
High Blood Pressure			Stroke			Asthma		
Heart Disease			Seizures			Cancer		

Do you have an Advanced Directive?	Yes	No
Are you interested in an Advanced Directive?	Yes	No
May we text you on your cell phone?	Yes	No
May we call you to remind you of your appointment?	Yes	No
May we download your prior medication history?	Yes	No
May we share your medical information with your emergency contact?	Yes	No
May we obtain prior immunization history?	Yes	No

SYCAMORE AVENUE MEDICAL CENTER
FAMILY PRACTICE
975 Sycamore Avenue, Kingman, AZ 86409

Dr. Maurice Dale Parry DO

ATTENTION*

PATIENTS OF SYCAMORE AVENUE MEDICAL CENTER
UNDER THE CARE OF DR MAURICE DALE PARRY DO

THIS PROVIDER DOES NOT PRESCRIBE
ANY LONG TERM PAIN MANAGEMENT
NARCOTICS OR LONG TERM BENZODIAZEPINES.

THANK YOU FOR YOUR COOPERATION!

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

______________________________ ______________________________
Patient's Name Date