Thomas J. Schenk, MD **Registration Information**

New Pt _____ **Established Pt _____** **Referred By: _____**

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Male / Female Social Security: _____

Mailing Address: _____ City, State, Zip: _____

Permanent Address: _____ City, State, Zip: _____

Email Address: _____

Home #: ( )_____ Work # ( )_____ Cell # ( )_____

How may we contact you? ____Home ____Cell ____Email **May we leave a detailed message?** Yes / No

Marital Status (circle one) Married Single Divorced Widowed **Language:** _____

Race (circle one) Caucasian Hispanic African American Asian Native American Other _____

Ethnicity (check one) Hispanic or Latino _____ / Not Hispanic or Latino _____

PCP/ Family Doctor (First & Last Name) _____ Phone # _____

Insurance Information

Primary Insurance _____ **Secondary Insurance** _____

Insurance ID # _____ Insurance ID # _____

Policy Holder Name: _____ Policy Holder Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Employer: _____ Employer: _____

Policy Holder's Date of Birth: _____ Policy Holder's Date of Birth: _____

Policy Holder SSN: _____ Policy Holders SSN: _____

Workers Comp Insurance: _____ Date of Injury: _____

Claim #: _____ Case Manager Name _____

Phone #: _____ Fax #: _____

Address: _____ City, State, Zip: _____

Chief Complaint

Reason for today's visit: _____

Patient Signature: _____ **Date:** _____

2905 West Warner Road, # 19, Chandler, Arizona 85224 Fax: 480.471.6943 Phone: 480.471.6934

Past Medical History

Have you had problems with Anesthesia: No _____ Yes _____ Explain: _____

Surgeries/Hospitalizations (list year)

1. _____ 3. _____
2. _____ 4. _____

Medical Illnesses (Circle ALL that Apply)

Lungs:	Pneumonia	Asthma	COPD	Valley Fever	TB
Heart:	Arrhythmia	Heart Attack	Coronary Artery Disease	Hypertension	Pacemaker
Eyes:	Glaucoma	Cataracts	Contact Lenses	Other	
Renal:	Kidney/Bladder	Stones	Tumor		
Gastrointestinal:	Peptic Ulcer	Hepatitis A, B, C	Diverticulitis	Pancreatitis	GERD
Metabolic:	Gout	Diabetes	Thyroid	Osteoporosis	Other
CNS:	Stroke	Seizures	TIA	Migraines	Other
Hem/Onc:	Blood Clots	Bleeding Disorders	Pulmonary Embolus	Cancer/ Specify: _____	
Arthritis:	Rheumatoid	Lupus	Gouty	Osteoarthritis	
Infections:	MRSA				
Other:	None				

Medications

Name	**Dose**	**Frequency**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Drug Allergies

Drug Name	**Reaction**
1. _____	_____
2. _____	_____
3. _____	_____

Social History

1. Occupation? _____ 2. Right or left handed? _____
3. History of substance abuse? _____ If yes, what type? _____
4. Do you smoke? _____ If yes, how many packs per day? _____
5. Do you drink? _____ If yes, how often? _____

Family History

Mother	Alive	Deceased	Cause of Death _____
Father	Alive	Deceased	Cause of Death _____
Grandmother (Mom's side)	Alive	Deceased	Cause of Death _____
Grandfather (Mom's side)	Alive	Deceased	Cause of Death _____
Grandmother (Dad's side)	Alive	Deceased	Cause of Death _____
Grandfather (Dad's side)	Alive	Deceased	Cause of Death _____

Patient Signature:_____ **Date:** _____

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REVIEW OF SYMPTOMS

CIRCLE ONLY THE PROBLEMS YOU ARE CURRENTLY EXPERIENCING.
IF YES TO ANY QUESTIONS, PLEASE GIVE WRITTEN EXPLAINATION.

CONSTITUTIONAL:	FEVER	N Y	UNINTENDED WEIGHT LOSS	N Y
	WEIGHT GAIN	N Y		
EYES:	VISION CHANGES	N Y	DOUBLE VISION	N Y
ENT:	DIFFICULTY SWALLOWING	N Y	THROAT SORENESS	N Y
	NOSEBLEEDS	N Y		
CARDIAC:	PALPITATIONS	N Y	CHEST PAIN/ PRESSURE	N Y
VASCULAR:	LEG PAIN	N Y	SWELLING (EDEMA)	N Y
RESPIRATORY:	PERSISTENT COUGH	N Y	SHORTNESS OF BREATH	N Y
GASTROINTESTIANL:	NAUSEA	N Y	VOMITING	N Y
	BLACK STOOL	N Y		
SKIN/DERM:	RASH	N Y	ITCHING	N Y
	REDNESS	N Y		
HEMATOLOGIC:	BRUISING	N Y	BLEEDING	N Y
ENDOCRINE:	EXCESSIVE THIRST	N Y	EXCESSIVE URINATION	N Y
PSYCHIATRIC:	DEPRESSION	N Y	HALLUCINATIONS	N Y
MUSCULOSKELETAL:	JOINT PAIN	N Y	MUSCLE PAIN	N Y

ANY ADDITIONAL SYMPTOMS YOU ARE EXPERIENCING:_____

_____

_____

_____

Pharmacy Information

I give my consent to allow the office of Dr. Thomas J. Schenk to transmit Electronic information of prescriptions to the Pharmacy listed below:

Name of Pharmacy:_____

Address: _____ Phone #: _____

Patient Signature: _____ **Date:** _____

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Thomas J. Schenk, MD

MEDICAL RECORDS AUTHORIZATION

Patient Name: _____ DOB: _____ Phone #: _____

Address: _____

I authorize Thomas J. Schenk, M.D. to **RELEASE** information to/**RECEIVE** information from : (Please circle one)

_____

Name Phone # Fax #

_____

Address City State Zip Code

Please release the following information from my medical record:

_____ Completed Record _____Operative Report(s) _____ Radiology Report(s) _____ Lab Report(s) _____Other

Date(s) of Service: _____

The undersigned hereby authorizes the physician to provide the above names persons with any copy of any and all records, documents, reports, clinical abstracts, histories and charts of every kind and description relating to treatment of patient described above excepts as indicated below. It is understood that the copy of the records will be provided to the designated company or individual upon payment of a reasonable charge for reproduction of the records.

The undersigned further authorizes the physicians to provide the above named persons with a copy of the following records, to the extent those records relate to the described treatment:

1. Records of treatment for drug/alcohol abuse and/or psychiatric illness: _____ Yes _____ No
2. Records of testing and/or treatment for AIDS related disease: _____ Yes _____ No

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The purpose of this request is for: (please circle ALL that apply)

Further Medical Care Insurance Disability Workers Comp Relocation Other: _____

Legal (Name & Address of Attorney):_____

_____

This authorization shall be considered invalid after twelve (12) months from the date signing. I may revoke this authorization at any time by providing the physician written notice of revocation. However, I may not revoke authorization retroactively for information already released.

In furtherance of this authorization, I hereby waive all provisions of law and privilege relating to the disclosures hereby authorize.

_____

Patient Signature or Parent/Legally Authorized Representative **Date**

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Thomas J. Schenk, MD

SUMMARY OF OFFICE POLICIES

I request and consent for Thomas J. Schenk, M.D. to examine, diagnose, provide treatment, and give advice.

HEALTH INFORMATION, PROVACY, AND PORTABILITY ACT
I acknowledge that I have been presented with a copy of Thomas J. Schenk, M.D. Privacy Practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I authorize the release of any medical or other information necessary for payment of any health or disability claim.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS
I authorize payment of surgical and/or medical benefits for services rendered by physician Thomas J. Schenk, M.D.
I understand I am responsible for the charges not covered by the insurance company I have chosen.

FINANCIAL RESPONSIBILITIES
I understand that I will be expected to pay for services at the time of each visit. I agree to pay all finance charges, collection costs, attorney fees, and any other cost that may be incurred to enforce collection of outstanding medical debts incurred.

MEDICATION REFILLS
I understand that prescriptions will be refilled only during office hours, Monday through Thursday 8am to 5pm and Friday 8am to 12:00pm. No narcotic prescriptions will be refilled on the weekend.

MISSED APPOINTMENT POLICY
I understand that failure to cancel my appointments at least 24 hours prior to my appointment time will result in a Missed Appointment Fee of $25.00.

WHO MAY WE DISCUSS YOUR MEDICAL TREATMENT WITH?
(Please list name, phone number(s), and relation)

Name	Phone Number (s)	Relationship
Name	Phone Number (s)	Relationship
Name	Phone Number (s)	Relationship

Patient Name: _____ Date of Birth: _____

_____

Patient Signature (or personal representative) **Date**

_____

Personal Representative's Authority

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