ADVANCED
HAND&WRIST
SPECIALISTS

Paul M. Guidera, M.D. Nicole M. Atallah, PA-C

Date _____

Patient Name _____ Age_____ Date of Birth _____
Last First M.I.

Home Address_____ City_____ State_____ Zip_____

Married ____ Single ____ Widowed ____ Divorced ____ Separated ____ Gender _____

Home Phone _____ Date of injury: _____

Mobile Phone _____

Work Phone _____ Social Security No. _____ Are you Right____ or Left____ handed?

Patient Occupation _____ How long? _____ Employer_____ How long?_____

Business Address _____
Street City State Zip

Is this a work-related injury? _____ Do you have an attorney? _____
Name and Phone Number

Name of Spouse or Next of Kin_____

Occupation _____ Employer _____

Emergency Contact and Phone Number _____

Patient Referred By _____

INSURANCE INFORMATION

Insurance company #1 _____
Member Name _____
ID or Policy # _____
Group #_____
Address for claims_____
_____

Insurance company #2 _____
Member Name_____
ID or Policy #_____
Group #_____
Address for claims_____
_____

Person Financially Responsible: Patient ____ Spouse ____ Parent ____ Other _____

Insured Date of Birth _____

IF THIS IS A WORK RELATED INJURY, WE NEED EMPLOYER'S INSURANCE COMPANY:

_____
Name Address Claim #

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the doctor to release any information required in the course of my examination or treatment.

Signed (patient or parent if minor) **X**_____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the doctor for the surgical and/or medical benefits. I understand that I am financially responsible for the charges not covered by this authorization. In the event this account is referred to collections, a 35% collection fee will be added to the account.

Signed (Insured person) **X**_____

IF PATIENT IS A MINOR PLEASE SIGN

I, _____, parent or guardian of the above named minor give my consent for medical and/or surgical treatment by doctors of Advanced Hand & Wrist Specialists.

1492 South Mill Avenue, Suite 214, Tempe, AZ 85281
4344 West Bell Road, Suite 103, Glendale, AZ 85308
Phone 602-812-7520 Fax 602-812-7534

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Patient History Form

Name_____ Age_____ Birthdate_____ Height_____ Weight_____

Consultation requested by: _____ ☐worker's compensation case ☐legal case

Are you: ☐right handed ☐left handed Occupation_____

Why are you here today? _____

When did the problem start? _____

How did it happen? _____

What makes it worse? _____

What makes it better?_____

For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT
- The pain is: DULL SHARP ACHY THROBBING BURNING OTHER _____
- On a 0 to 10 severity scale (worst =10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

Circle **ALL** that apply:

- Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NIGHT PAIN OTHER_____

Have you ever experienced any injury to or symptoms involving this body part in the past? ☐Yes ☐No

If so, please provide details: _____

Have you had any treatment for this problem? ☐NONE ☐medication ☐therapy ☐splinting ☐injection ☐surgery

_____

Medical History: Do you currently or have you ever had any of the following? ☐NONE

☐anemia	☐arthritis	☐asthma / COPD	☐bleeding disorder	☐blood clots
☐cancer	☐chronic pain syndrome	☐circulatory problems	☐depression	☐diabetes
☐drug / alcohol problem	☐gout	☐fibromyalgia	☐heart disease	☐hepatitis
☐high blood pressure	☐HIV / AIDS	☐kidney disease	☐osteoporosis	☐psychiatric illness
☐pregnancy (current)	☐reflux / heartburn	☐seizures	☐sleep apnea / CPAP	☐stomach ulcers
☐stroke	☐thyroid problems	☐other / details_____		

Medications: ☐NONE ☐additional sheet attached

Medications (including over the counter medicines and nutritional supplements)	Reasons Used	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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Medical Allergies (rash, swelling, or shortness of breath): ☐NONE ☐penicillin ☐sulfa ☐latex ☐metals ☐tape
☐iodine (IV contrast) ☐shellfish ☐poultry products ☐other _____

Medication Side Effects (heartburn, nausea, vomiting): ☐NONE ☐anti-inflammatories ☐codeine ☐Percocet
☐Vicodin / Lortab ☐other _____

Surgical History: ☐NONE **Circle all that apply**

☐Eyes/ENT	cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other _____
☐Heart	bypass, valve replacement, stent, other _____
☐Lung	resection, other_____
☐G I	appendix, gall bladder, hernia, other_____
☐Gynecologic	c-section, hysterectomy, tubal ligation, other_____
☐Urologic	prostate, bladder, vasectomy, other _____
☐Orthopedic	joint replacement, arthroscopy, fracture surgery, spine, other _____
☐Vascular	carotid, aneurysm, bypass, other _____
☐Neurosurgical	aneurysm, tumor, craniotomy, other _____
☐Cancer	skin, breast, other _____
☐Other	_____

Anesthesia Complications: ☐NONE. If yes, explain: _____

Other Current Symptoms: **Circle all that apply**

☐yes	☐no	Constitutional	unexpected weight loss, weight gain, fever, chills, night sweats, fatigue_____
☐yes	☐no	Eyes	blurred / double vision, eye pain, redness, watering _____
☐yes	☐no	ENT	headache, difficulty swallowing, nose bleeds, ringing in ears, earaches _____
☐yes	☐no	Cardiovascular	chest pain, palpitations, fainting, murmurs _____
☐yes	☐no	Respiratory	shortness of breath, wheezing, coughing, painful breathing, snoring _____
☐yes	☐no	Gastrointestinal	heartburn, nausea, constipation, incontinence, diarrhea, bloody / black stools _____
☐yes	☐no	Genitourinary	urinary frequency, urgency, difficulty, pain, bleeding, incontinence_____
☐yes	☐no	Musculoskeletal	other joint pains, swelling, instability, stiffness, redness, heat, muscle pain_____
☐yes	☐no	Skin	skin changes, poor healing, rash, itching, redness _____
☐yes	☐no	Neurological	numbness / tingling, unsteady gait, dizziness, tremors, seizures _____
☐yes	☐no	Psychological	nervousness, anxiety, depression, hallucinations _____
☐yes	☐no	Hematologic	easy bleeding, bruising _____
☐yes	☐no	Endocrine	excessive thirst or urination, heat / cold intolerance _____
☐yes	☐no	Allergic	reaction to foods or environment_____
☐yes	☐no	Other	_____

Family History (mother / father / siblings): ☐NONE

☐anesthesia complications_____ ☐bleeding disorder_____
☐cancer _____ ☐diabetes _____
☐gout _____ ☐heart disease_____
☐malignant hyperthermia_____ ☐arthritis _____
☐other _____

Social History:

Martial Status: ☐single ☐married ☐divorced ☐widowed ☐separated
Alcohol Use: ☐none ☐rare ☐daily
Tobacco Use: ☐none ☐previous When quit: _____ ☐current packs / day_____
Recreational Drug Use ☐none ☐previous ☐current drug_____ last used _____

Additional information that you would like for us to know:_____
_____

Patient or responsible party signature _____ Date _____

Physician review _____ Date _____

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NOTICE TO PATIENTS

State law, A.R.S. §32-1401 (24)(ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services that (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

Gateway Surgery Center

THESE SERVICES ARE AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. (I/We) will keep the signed original in your patient file; you will receive a copy upon request.

Signature _____

Date _____

Name of Patient _____

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Medical Information Authorization

Patient Name _____

Date of Birth _____

○ I **DO NOT** authorize the personnel of **Advanced Hand & Wrist Specialists** to release any medical information generated by the office.

○ I **DO** authorize the personnel of **Advanced Hand & Wrist Specialists** to release all medical information generated by the office to my family members and friends listed below.

I may revoke this authorization in writing at any time.

1. Name_____ Phone Number _____
Relationship to patient_____

□ Medical information

□ May change or updated any demographic or appointment information

2. Name_____ Phone Number _____
Relationship to patient_____

□ Medical information

□ May change or updated any demographic or appointment information

3. Name_____ Phone Number _____
Relationship to patient_____

□ Medical information

□ May change or updated any demographic or appointment information

_____ _____
Patient Signature Date

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Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____ _____
PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Advanced Hand & Wrist Specialists may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Advanced Hand & Wrist Specialists has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Advanced Hand & Wrist Specialists will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Advanced Hand & Wrist Specialists to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Advanced Hand & Wrist Specialists has taken action relying on this consent.

_____ _____
SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____
Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: (602) 812-7520.

FORM Us

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CODE OF CONDUCT

To provide a safe and healthy environment for staff, visitors, patients and their families, Advanced Hand & Wrist Specialists expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- If you have any questions about your care or are unhappy with the service you received in our office, please contact our practice manager before you leave our office.
- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give each patient the time and quality of care he/she deserves.
- Questions about your bill can be addressed by asking to speak with a representative from our billing department.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Adults are expected to supervise their children.

The following behaviors are prohibited:

- Intimidating or harassing staff or other patients
- Making verbal threats to harm another individual or destroy property
- Making threats of violence through phone calls, letters, voicemail, email or other forms of communication
- Physical assault or threatening to inflict bodily harm
- Damaging business equipment or property
- Making menacing or derogatory gestures
- Racial or cultural slurs or other derogatory comments

Violators are subject to removal from the facility and/or discharge from the practice.
Please sign below acknowledging that you understand this code of conduct.

_____ _____

Signature Date

If you are subjected to or witness any of these behaviors, please report to any staff member.

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Federal Health Care Privacy Law prohibits audio and/or video recording in a health care facility. You MUST have prior authorization from the facility to record.

Instructions from an attorney to record do not constitute authorization.

All violations are referred to the FBI for prosecution, including violations discovered after the fact.

A.R.S. 13-1204(A)(8)(e) It is a felony to physically or verbally abuse a health care worker in the line of duty.

I have read and understand the above.

Signature _____

Print Name _____

Date _____

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