PATIENT INFORMATION

Paradise Valley Medical Clinic
Douglas M. Lakin MD

9977 N 90th Street, Suite 180 **PLEASE COMPLETE ONLINE OR PRINT LEGIBLY** Date: _____
Scottsdale, AZ 85258 Phone: 480.614.5800 SSN: _____

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____ Spouse: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Phone (Home): _____ Work: _____ Mobile: _____

Current Employment Status: _____ Email Address: _____

Employer: _____ Address: _____ City: _____ ST: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Pharmacy Name: _____ Phone: _____

INSURANCE INFORMATION

We will need your current insurance card and driver's license. Please give to our receptionist to make copies

Are you on Medicare Insurance: Y ☐ N ☐ ****This office is committed to regular Medicare & supplementary insurances, not advantage or replacement Medicare plans.**

PRIMARY INSURANCE:

Name: _____ Billing Address: _____

Member ID#: _____ Group#: _____

Subscriber's Name: _____ Date of Birth: _____ Relationship: _____

SECONDARY INSURANCE:

Name: _____ Billing Address: _____

Member ID#: _____ Group#: _____

Subscriber's Name: _____ Date of Birth: _____ Relationship: _____

By signing this form, I authorize payment of medical benefits to Paradise Valley Medical Clinic for my healthcare charges. I also understand and agree I am responsible for the payment of all office fees and uncovered/denied medical charges incurred on behalf of a family member or myself.

Signature: _____ Relationship: _____

****Please bring completed form with you to your office visit with Dr Lakin. Thank you!**

MEDICAL HISTORY

PATIENT NAME: _____ **DOB:** _____

Social History:
(Please list all information about any smoking and/or drinking history and/or current use amounts, dates started, and date stopped)

Tobacco: _____

Alcohol: _____

Family History:
(Please list information about illnesses that run in your family. Include medical illnesses in individual family members. We are most interested in your parents, siblings, and children, but add anything else that you feel is pertinent.)

Father:_____
Mother:_____
Brother:_____
Sister:_____
Other:_____
_____

Advanced Care Planning Completed: Yes ☐ **No** ☐

Past Medical History:
(Please list any medical problems you may have such as high blood pressure, elevated cholesterol, ulcer problems, chronic pain, etc….)

_____
_____
_____
_____
_____

Past Surgical History:
(Please list any previous surgeries and hospitalizations you may have had.)

_____
_____
_____
_____

Date:_____

MEDICATION HISTORY

Patient Name:_____

**** ATTN NEW PATIENTS: Dr Lakin does not prescribe or manage chronic/long term pain medications. This practice refers to the recommended Pain Clinics on our website for prescribing and management.**

DRUG ALLERGIES

1._____ 3._____

2._____ 4._____

PRESCRIPTION MEDICATIONS: Please list all medicines or drugs being taken NOW that were **PRESCRIBED BY A DOCTOR** (include what you take for chronic conditions, birth control, etc).

MEDICINE NAME **DOSAGE** **HOW OFTEN TAKEN**

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

NON PRESCRIPTION MEDICATIONS: Please list medicines or drugs you sometimes take that were **BOUGHT WITHOUT A PRESCRIPTION** (such as aspirin, antacids, sleep medicine, allergy, cold medicine, vitamins).

MEDICINE NAME **DOSAGE** **HOW OFTEN TAKEN**

1._____

2._____

3._____

HIPAA Privacy Notice
Paradise Valley Medical Clinic, PC
Douglas M. Lakin MD

We are required by law to maintain the privacy of, and provide individuals with, a notice of our privacy practices with respect to protected health information. Our protected health information pamphlet is posted on our website, or available by asking our receptionist to furnish you a copy.
If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at 480-614-5800.

I give permission to the office of Dr. Douglas M. Lakin to release medical information on myself to the following persons:

_____ **Phone #:** _____

_____ **Phone #:** _____

_____ **Phone #:** _____

_____ **Phone #:** _____

_____ **Phone #:** _____

Your signature below is only acknowledgement that you give permission to release information to the persons referenced above:

_____ _____
Patient Signature **Date**

_____
Print Name

Authorization for Release of Protected Health Information/PVMC

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

Address: _____ **SSN:** _____

_____ **Telephone:** _____

Information Is To Be Release By:

_____
Physician or Facility

_____
Street Address

_____
City, State & Zip

_____
Telephone Number

Information Is To Be Sent To:

_____
Physician or Facility

_____
Street Address

_____
City, State & Zip

_____
Telephone Number

Information to Be Released – Covering the Periods of Health Care

From (Date): _____ **To (Date):** _____

Please check type of information to be released:

Complete Health Records	Pathology Report	Radiology Report
Laboratory Test Results	Complete Billing Record	EKG Report

Other (Specify): _____

Purpose of Request:

Treatment or Consultation	At Request of Patient	Billing or Claims Payment

Other (Specify): _____

Drug and/or Right to Revoke Authorization:

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse. Psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One: YES NO**

I understand if my medical or billing records contains information in reference to HIV/AIDS testing and/or treatment I agree to its release.
Check One: YES NO

Time Limit & Right To Revoke Authorization:

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to PVMC to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event _____, or 90 days from the date of signature, unless otherwise specified.

Re-release:

I understand the information released pursuant to this Authorization may be subject to re-release by the recipient and no longer protected by the health Insurance Portability and Accountability Act of 1998. The practice, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal representative Who May Request Disclosure:

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. By signing below, you authorize your provider; identified above, to release you protected health information specified above.

Signature: _____ Date: _____

Authority to Sign – if not patient: _____ Witness: _____

ID Verified by: _____

**** Please do NOT fax records over 50 pages. This practice prefers mail paper copies or CDs. Thank You!**