Scottsdale Physicians Group
7975 North Hayden Road Suite D-354
Scottsdale, AZ 85258
Phone: 480.268.2670 - Fax: 480.268.2671
Email: Telemedicine@spg-md.com

New Patient Information

Patient Name (Last, First, Middle Initial): _____

DOB: _____ Gender: ☐ Male ☐ Female

Social Security #: _____ Medicare #: _____

RESIDENCE

Circle One: ☐ Private Home ☐ Group Home ☐ Assisted Living Community

Address: _____

City: _____ State: _____ Zip: _____

(If Applicable)

Group Home/ Assisted living Community Name: _____

Primary Contact: _____ Phone: _____

Fax: _____

Billing address (If not the same as above): _____

ADVANCE DIRECTIVES

We wish to follow your health directives. In order to do so, please provide copies of any legal documentation that will identify and provide guidance on your behalf.

- ☐ Power of Attorney (Durable Medical, Financial, Mental Health)
- ☐ Living Will
- ☐ Guardianship

Power of Attorney/Guardian Name: _____

Address: _____

Phone: _____

How were you referred to SPG Mobile? _____

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EMERGENCY CONTACTS

Contact #1: _____Phone: _____

Relationship to patient: _____

- ❑ Full access of patient medical file
- ❑ Limit access of patient medical file
- ❑ No access of patient medical file.

Contact #2: _____Phone: _____

Relationship to patient: _____

- ❑ Full access of patient medical file
- ❑ Limit access of patient medical file
- ❑ No access of patient medical file.

INSURANCE INFORMATION

PLEASE NOTE FOR "HMO" INSURANCE PLANS
We MUST be made the primary care physicians (PCP) on file with that insurance company. We will be unable to see patients who do not make this assignment.

In order to make this change, simply call your insurance company with the number found on the back of your insurance card and let them know that you will be changing your PCP.

Primary Insurance: _____ID#_____

Group #_____ Insured: _____

Address of Insurance: _____

Secondary Insurance: _____ID#_____

Group #_____ Insured: _____

Address of Insurance: _____

****PLEASE ATTACH IMAGE OF INSURANCE CARDS. FRONT AND BACK****

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PATIENT RELEASE AND CONSENT

- ❑ I hereby authorize Scottsdale Physicians Group to directly bill Medicare or Medicaid (AHCCCS), and for my insurance company to make direct payments to Scottsdale Physicians Group.
- ❑ Scottsdale Physicians Group may obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies ordered.
- ❑ I am aware the Medicare may not pay for preventative medicine, routine physical, or screening test
- ❑ I am aware that I am responsible for any deductible, co-payment or any amount that is not covered by my insurance company for my telemedicine visit. I understand all health plans are not the same, and they do not always cover the same services. In the event my health plan determines a service to be "not covered" I will be fully financially responsible for the complete charge(s).
- ❑ I hereby authorize Scottsdale Physicians Group to release any information necessary to insurance carriers regarding by illness and treatments.
- ❑ I hereby authorize a copy of my insurance card and any other identification to be used to process insurance claims for the period of my lifetime, this authorization will remain in effect until revoked by me in writing.
- ❑ I hereby authorize Scottsdale Physicians Group to obtain any and all medical records that pertain to my health care and/or any pertinent Protected Health Information.
- ❑ I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- ❑ I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.
- ❑ I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without effecting my right to future care or treatment.
- ❑ I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Initial: _____ *Please note: There will be a $25.00 fee for no-show visits.

*If a patient is absent or unavailable for their confirmed visit then a fee will be billed to the patient account unless the patient is hospitalized at the time of service.

Patient name: _____

Signature: _____

Relationship to patient (If other than patient): _____

Date: _____

Please note new patients must fill out all forms completely before our initial home visit.

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PHARMACY

Preferred Pharmacy: _____

Phone: _____ Fax: _____

MEDICATION				
MEDICATION NAME	DATE PRESCRIBED	STRENGTH	DOSE	PRESCRIBER

DRUG ALLERGIES	
MEDICATION	REACTION

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MEDICAL HISTORY

Which medical conditions do you have now or have had in the past? (Please check all that apply.)

Eye and Ear
- ❑ Glasses/Contact lens
- ❑ Macular Degeneration
- ❑ Cataracts
- ❑ Hearing Loss
- ❑ Hearing Aid
- ❑ Chronic Ear Infection
- ❑ Ringing in ears
- ❑ Other_____

Gastrointestinal Tract
- ❑ Nausea
- ❑ Heartburn/Reflux/GERD
- ❑ Ulcers
- ❑ Irritable Bowel
- ❑ Liver Disease/Cirrhosis
- ❑ Hepatitis
- ❑ Gallbladder Disease
- ❑ Colon Polyps
- ❑ Diverticulosis
- ❑ Bleeding Problems
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Other_____

Kidney and Urinary Tract
- ❑ Frequent Bladder Infections
- ❑ Kidney Disease
- ❑ Enlarged Prostate
- ❑ Urinary Incontinence
- ❑ Frequent Urination
- ❑ Painful Urination
- ❑ Kidney stones
- ❑ Other_____

Heart
- ❑ Heart attack - Year____
- ❑ Heart failure
- ❑ High Blood Pressure
- ❑ Aortic Stenosis
- ❑ Heart Valve Problems
- ❑ Angina
- ❑ High Cholesterol
- ❑ Pacemaker
- ❑ Atrial fibrillation
- ❑ Irregular Heartbeat
- ❑ Other_____

Lungs
- ❑ Asthma
- ❑ COPD/Emphysema
- ❑ Bronchitis
- ❑ Recurrent Pneumonias
- ❑ Other_____

Glands
- ❑ Thyroid Overactive
- ❑ Thyroid underactive
- ❑ Diabetes
- ❑ Other
- ❑

Nervous System
- ❑ Dementia - Type_____
- ❑ Stroke
- ❑ Epilepsy or Seizures
- ❑ Neuropathy/Nerve Damage

Cancer
- ❑ Location: _____

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MEDICAL HISTORY CONTINUED

Bones and Joints	**Surgical History**
❑ Gout ❑ Lower back pain ❑ Osteoporosis ❑ Arthritis _____ ❑ Fractured Bones_____	❑ Heart Bypass - Date_____ ❑ Heart Stent - Date_____ ❑ Heart Valve - Date_____ ❑ Pacemaker - Date_____ ❑ Defibrillator/ICD- Date_____ ❑ Hysterectomy- Date_____

Other past Surgeries and dates:

_____

_____

_____

Other Health Concerns:

_____

_____

_____

Have you recently been in the hospital or skilled nursing facility in the past 3 months?

YES or NO (Please Circle one)

Name of facility: _____ Discharge Date: _____

Are you currently on home health services? YES or NO (please circle one)

Name of Home Health Agency: _____

Name of person completing new patient intake packet: (Please print)

_____

Relationship to patient: _____

Signature of person completing forms: _____

Date: _____