TAHIR
Surgical Clinic of Arizona

New Patient Form

Patient Information

_____ _____ _____
Last Name First Name Middle Name

_____ - _____ - _____ _____ / _____ / _____ ❑ Male ❑Female
Social Security Number Birth Date

_____ _____ _____ _____ _____
Address 1 Apt# City State Zip

_____ _____ _____ _____ _____
Address 2 Apt# City State Zip

Marital Status ❑Married ❑Single ❑Divorced ❑Separated ❑Widowed

Race ❑American Indian or Alaska Native ❑African American / Black ❑Asian ❑Hispanic or Latino
❑Native Hawaiian or other Pacific Islander ❑White / Caucasian ❑Other ❑ Patient Declined

Ethnicity ❑ Hispanic/Latino Origin ❑ Not Hispanic/Latino Origin ❑ Patient Declined

Primary Language Spoken ❑ English ❑ Spanish ❑ Other: _____

(_____)_____-_____ (_____)_____-_____ _____
Home Phone Cell Phone Email

_____ _____ (_____)_____-_____
Employer Occupation Work Phone

_____ _____
Primary Care Physician Phone

_____ _____ _____ _____
Address City State Zip

_____ (_____)_____-_____ _____
Emergency Contact Full Name **Emergency Contact Phone** **Relationship**

Insurance Information

_____ _____ _____
Primary Insurance Company Name ID/Policy Number Group Number

_____ _____ _____
Secondary Insurance Company Name ID/Policy Number Group Number

Guarantor Information

_____ _____ _____
Guarantor Last Name Guarantor First Name Middle Name

_____ - _____ - _____ _____ / _____ / _____ ❑ Male ❑Female
Social Security Number Birth Date **Gender**

_____ _____ _____ _____ _____
Address Apt# City State Zip

_____ (_____)_____-_____ (_____)_____-_____
Guarantor Relationship Home Phone Cell Phone

_____ _____ _____
Patient Signature (If Minor Parent or Legal Guardian Signature**)** **Printed Name** **Date**

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Thank you for choosing Tahir Surgical Clinic for your surgical needs.

Pharmacy Authorization

I authorize Tahir Surgical Clinic to request pharmacy and medication history to assist with the management of my care.

_____	_____	_____
Patient Signature (If Minor Parent or Legal Guardian Signature**)**	**Printed Name**	**Date**

Insurance Authorization / Financial Agreement

I authorize and request that payments under my medical insurance program(s) be made directly to Tahir Surgical Clinic for any services furnished to me. I also authorize the Clinic to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

I understand I am responsible for any deductibles or co-pays, to be paid at the time of service. I understand that Tahir Surgical Clinic does not bill for laboratory services, but they are billed by the lab itself, and I am responsible for the balance after any insurance have paid their portion. Tahir Surgical is not responsible for these charges.

You agree, in order for us to service your account or to collect any amounts you may owe, we and our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you.

We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I acknowledge full responsibility for all charges incurred including any additional charges incurred in the collection of this account. I understand that my insurance will be billed according to the information I provide & I am ultimately responsible for all charges.

I/We have read this disclosure and agree that the practice may contact me/us as described above.

_____	_____	_____
Patient Signature (If Minor Parent or Legal Guardian Signature**)**	**Printed Name**	**Date**

Release Information to Relative / Friend

Protecting Your Privacy
I give my consent and authorization to the staff of Tahir Surgical Clinic to relay medical information to the following persons. This information may include but is not limited to schedule appointments and/or surgeries, lab results, radiological results and medications. Please check and list below anyone we may speak to regarding your protected health information. Without this information completed, we cannot speak to anyone about you.

List Names & Dates of Birth Below:

_____	_____	❑Spouse ❑Child ❑ Friend/Other
Name	**Date of Birth**	
_____	_____	❑Spouse ❑Child ❑ Friend/Other
Name	**Date of Birth**	
_____	_____	❑Spouse ❑Child ❑ Friend/Other
Name	**Date of Birth**	

Notice of Privacy Practices
I acknowledge that I have been presented with a copy of the Notice of Privacy Practices from Tahir Surgical Clinic and authorize the above persons listed to receive my protected health information: (You may obtain a copy of this notice upon request from Tahir Surgical Clinic)

_____	_____	_____
Patient Signature (If Minor Parent or Legal Guardian Signature**)**	**Printed Name**	**Date**

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Pharmacy

Pharmacy Name: _____ **Phone:** _____

Crossroads & City: _____

Allergies

❑**No Allergies** ***** Please specify allergy and reaction *****

Drug	Reaction

❑**No Allergies** **Other Allergies (Latex, Dyes, etc.)**

❑**No Medications** **Prescription Medications**

Name	Strength	How often

❑**None** **Over the Counter Medications (include ALL Herbs and Vitamins)**

❑**No Surgeries** **Surgical History**

Year	Surgery	Reason

Women's Health History: Could you now be pregnant? ❑ Yes ❑ No Date of Last Period: _____

Number of: pregnancies_____ deliveries_____ abortions_____ miscarriages_____

Family History

Any family history of cancer? ❑ Yes ❑ No

Type? _____ Family member?_____ Living? ❑ Yes ❑ No

Any Family history of Diseases or Disorders? (ex: Diabetes, High Blood Pressure Etc.) ❑ Yes ❑ No

Diseases or Disorders? _____ Family member?_____ Living? ❑ Yes ❑ No

Diseases or Disorders? _____ Family member?_____ Living? ❑ Yes ❑ No

Social History

Tobacco ❑Yes ❑Never If Yes, ❑Cigarettes ❑Chew ❑Cigars ❑Pipe How long? _____ ❑years
Quit smoking? ❑yes ❑no Date ____/____/____
Alcohol ❑None ❑Occasional ❑Social ❑Light ❑Heavy What kind? ❑Beer ❑Wine ❑Hard liquor

How much? _____ ❑Daily ❑Weekly ❑Monthly

Illegal Drugs/substances (including marijuana) ❑Yes ❑No If yes, What _____ How often _____

Print Name _____ **Age** _____ **Date** _____

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PAST AND PRESENT MEDICAL HISTORY: Please check all that apply.

Constitutional	**Year**	**Meds?**		**Year**	**Meds?**
❑Chills			❑Fatigue		
❑Fever			❑Weight Gain		
❑Weight Loss			❑Other: _____		

Head					
❑Dizziness			❑Head Injury		
❑Headaches			❑Other: _____		

Eyes					
❑Cataracts			❑Blurry Vision		
❑Glaucoma			❑Other: _____		

ENT					
❑Ear Problems			❑Neck Lump		
❑Hearing Impairment			❑Neck Tenderness		
❑Other: _____					

Respiratory					
❑Asthma			❑Abnormal Chest X-ray		
❑Bronchitis			❑Recurrent Pneumonia		
❑Emphysema			❑Sleep Apnea		
❑TB			❑Other: _____		

Cardiovascular					
❑Heart Attack			❑Mitral Valve Prolapse		
❑Angina/Chest Pain			❑Circulation Problems		
❑Abnormal EKG			❑Heart Failure / CHF		
❑Irregular Heartbeat			❑Rheumatic Fever		
❑Pacemaker			❑High Blood Pressure		
❑Murmur			❑Other: _____		

Gastrointestinal					
❑Heartburn			❑Peptic Ulcer Disease		
❑Hemorrhoids			❑Rectal Bleeding		
❑Hepatitis			❑Rectal Pain		
❑GERD			❑Nausea		
❑Cholelithiasis			❑Vomiting		
❑Pancreas Problems			❑Constipation		
❑Ulcerative Colitis			❑Diarrhea		
❑Liver Disease			❑Swallowing Difficulty		
❑Other: _____					

Musculoskeletal					
❑Muscle Weakness			❑Bone Disease		
❑Arthritis			❑Gout		
❑Rheumatoid Arthritis			❑Paralysis		
❑Joint Pain			❑Other: _____		

Print Name _____ **Age** _____ **Date** _____

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	Year	Meds?		Year	Meds?
Psychiatric					
❑Depression			❑Psychiatric Disorder		
❑Anxiety			❑List:_____		
❑Other: _____			_____		
Breast					
❑Discharge			❑Tenderness		
❑Lumps			❑Other: _____		
Skin					
❑Lumps			❑Mole increased in size		
❑Rash			❑Other: _____		
Neurological					
❑Headaches			❑Seizures/Epilepsy		
❑Stroke/TIA			❑Memory Loss		
❑Convulsions			❑Other: _____		
Endocrine					
❑Diabetes			❑Thyroid		
❑Other: _____					
Hematologic/Lymph					
❑Anemia			❑Blood Clotting Problem		
❑Blood Disorders			❑HIV/Aids		
❑Blood Thinners			❑Other: _____		
Allergic/Immunologic					
❑MRSA			❑Other: _____		
❑Recurrent Infections					
Genitourinary					
❑Urinary Tract Infections			❑Pain with Urination		
❑Kidney Stones			❑Prostrate Problem		
❑Other: _____					

Please add anything not listed above or anything Dr. Tahir should know: _____

_____

Please list any Specialist who follows you and their phone number (ie.: Cardiologist, Pulmonologist, Endocrinologist, etc.)

_____

I have answered truthfully and provided to Dr. Tahir all my medical, social history and all information about myself.

_____ _____ _____

Patient Signature (If Minor Parent or Legal Guardian Signature**)** **Printed Name** **Date**

Tahir Surgical Clinic has proudly represented the medical community by teaching medical students and allowing surgical residents to expand their medical knowledge and skills while working under the supervision of Dr. Tahir. Dr. Tahir will make sure you are well cared for, and maybe you can make a new doctor a better doctor. We appreciate your willingness to allow all medical staff to participate in your care.