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TODAY'S DATE: _______________

DEMOGRAPHIC INFORMATION

Last Name	Legal First Name	MI	Nickname	SSN
Cell Phone #	Home and/or Work Phone#	Preferred phone (circle): Cell / Home / Work		Email address
DOB	Age	Gender: M F	Marital Status: M ☐ S ☐ D ☐W ☐	Student: Yes ☐ No ☐ Full Time / Part Time
Current *Mailing* Address	Apt./Space#	City, State, Zip code		
Current *Physical* Address (if different)	Apt./Space#	City, State, Zip code		

Race		Ethnicity	Employment Status	
☐African American	☐Hispanic	☐Hispanic/Latino	☐Employed	☐Part Time
☐Asian	☐Pacific Islander	☐Not Hispanic/Latino	☐Disabled	☐Student
☐Caucasian	☐ Other/Decline to say		☐Retired	☐Not employed

Family Physician	Referring Physician	Preferred Pharmacy/City it's located in
Parent/Guardian's Name (Please Print)	Relationship to Patient	Phone #

Emergency Contact Name. Please (☑) Whom we can verbally discuss your medical information with (HIPAA).

Name_________________________________Relationship___________________Phone__________________HIPAA?☐

Name_________________________________Relationship___________________Phone__________________HIPAA?☐

INSURANCE INFORMATION **Please bring your insurance card(s) & Picture ID**

Primary Insurance		Policy # / Group #	**Policy Holder's Name**
Policy Holder's SSN	**DOB**	*Relationship to patient* / Address if different from patient's	
Secondary Insurance		Policy # / Group #	**Policy Holder's Name**
Policy Holder's SSN	**DOB**	*Relationship to patient* / Address if different from patient's	
Policy Holder's Employer Name		Patient's Current Occupation/Employer/Phone#	
Is this visit related to an Auto Accident ☐Yes ☐ No		Is this visit related to Worker's Comp ☐ Yes ☐ No	

PATIENT MEDICAL INFORMATION

What are you being seen for today?	Previously treated here? ☐ Yes ☐ No	How did you hear about us?

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I hereby agree that you may contact me for whatever reason concerning my account on any and all phone numbers that I have provided you.

Signature: ___________________________________ **Date:** ____________________________

Print Name and Relationship (if not patient): ____

HEALTH HISTORY

(Please fill out to the best of your ability. Thank you.) Date: ____________

Patient Name:_________________________________ DOB:___________________ Height:_________Weight:_________

Reason for visit: ____

Were studies done? ☐ Yes ☐No If yes, study type, when and where? _________________________________

Tobacco Use: ☐Yes ☐No ☐Former **Do you consume alcohol? ☐Yes ☐No ☐Former**

Type of Tobacco	Packs/Day	For ? Years	Year Quit?
Cigarettes			
Other: (list type)			

Type of Alcohol	Frequency per week?	Amount each time?

Do you have a history of or currently have a problem with substance abuse? ☐Yes ☐No If yes, with what? _______________

PAST MEDICAL HISTORY

Have you ever had the following: (Please mark yes or no. Leave blank if uncertain.)

Condition	No	Yes	Condition	No	Yes	Condition	No	Yes	If Yes, please specify:
Headache/Migraines			Cholecystitis			Sleep Apnea			___________________
Seizures			Jaundice			Measles			___________________
Hearing Loss			Bladder Disorders			Mumps			___________________
Hypertension			Obesity			AIDS or HIV+			___________________
Edema			Thyroid Disorder			Smallpox			___________________
Heart Disease			Diabetes			Chickenpox			Any other diseases:
Pneumonia			Eczema			Venereal Disease			___________________
Asthma			Urticaria(Hives)			Tuberculosis			___________________
Esophageal Reflux			Arthritis			Hay Fever			___________________
Colitis			Bone Disorders			Cancer			___________________
Gallbladder Disease			Meningitis			Poisoning			___________________
Cholelithiasis			Poliomyelitis			Blood transfusion			___________________

PAST SURGICAL HISTORY

Surgery	Year	Surgery	Year	List other surgeries/hospitalizations:	Year
Adenoidectomy ☐Yes☐No		Neck/Thyroid Surg☐Yes☐No			
Tonsillectomy ☐Yes☐No		Sinus Surgery ☐Yes☐No			
Ear Tubes ☐Yes☐No		Appendectomy ☐Yes☐No			
Ear Surgery ☐Yes☐No		Cholecystectomy☐Yes☐No			
Nasal Surgery ☐Yes☐No		C-Section ☐Yes☐No			

FAMILY HISTORY OF:

	Who?		Who?		Who?
Migraines ☐		Diabetes ☐		Thyroid Disorder ☐	
Early Death ☐		Stroke (CVA) ☐		Osteoporosis ☐	
Hypertension ☐		Bleeding problems ☐		Blood Disorders ☐	
High Cholesterol ☐		Asthma ☐		Cancer (type): ☐	
Heart Disease ☐		Pulmonary Disease ☐			
Coronary Artery Disease ☐		Kidney Stones ☐			
Other Family History:					

Current Medications (include non-prescriptions): ____

____

____

Allergies to Medications:____

____

REVIEW OF SYSTEMS - PLEASE INDICATE THE PATIENT'S PERSONAL HISTORY BELOW:
(Being thorough helps us, help you! Please review carefully and mark all that apply.)

General Health Symptoms ☐ **None**	**Gastrointestinal (GI)** ☐ **None**
☐Fatigue	☐Decreased appetite
☐Fever	☐Anorexia
☐Chills	☐Heartburn
☐Sweating heavily at night	☐Nausea
☐Recent weight loss ☐Recent weight gain	☐Vomiting ☐with blood
Head Symptoms ☐ **None**	☐Abdominal pain ☐cramping
☐Headache	☐Jaundice
☐Sinus pain	☐ Diarrhea ☐ Constipation
Neck Symptoms ☐ **None**	**Genitourinary (GU)** ☐ **None**
☐Neck Pain	☐ Blood in the urine ☐ Odor to urine
Eye Symptoms ☐ **None**	☐Change in frequency of urination
☐Worsening vision	☐Frequent urination
☐Floaters	☐Waking at night to urinate
☐Double-vision (Diplopia)	☐ Urinary urgency ☐ Urinary incontinence
☐Blurry vision	**Endocrine** ☐ **None**
☐Halo/Flashes of light in vision (photopsia)	☐Excessive thirst
☐Pain with eye movement	☐ Heat intolerance ☐ Cold intolerance
☐Bright lights hurt your eyes (Photophobia)	☐Excessive sweating
☐Red eyes	☐Weakness
Ears ☐ **None**	**Musculoskeletal** ☐ **None**
☐Slowly progressive hearing loss ☐right ☐left ☐both	☐Back Pain
☐Sudden hearing loss ☐right ☐left ☐both	☐Muscle Aches
☐Ear pain ☐right ☐left ☐both	☐Joint pain
☐Ear drainage ☐right ☐left ☐both	☐Muscle cramps
☐Tinnitus (ringing or noises in the ears) ☐right ☐left ☐both	☐Localized joint swelling
Nose/Sinus/Mouth/Throat ☐ **None**	☐Joint stiffness
☐Nasal Discharge ☐Nose Bleeds (epistaxis)	**Neurological** ☐ **None**
☐Sneezing ☐Nasal itching	☐Dizziness
☐Hoarseness ☐Sore Throat	☐Vertigo
☐Bleeding Gums ☐Gum sores	☐Fainting
☐Mouth sores ☐Mouth dryness	☐Confusion
☐Trouble with swallowing (dysphagia)	☐Memory Loss
☐Altered sense of taste	☐Changes with speech
☐Enlarged lymph nodes	☐Limb weakness
☐Common cold	☐Paralysis
Cardiovascular ☐ **None**	☐Involuntary movements
☐Chest pain	☐Difficulty with balance
☐Palpitations	☐Tingling
☐Slow heart rate ☐Fast heart rate	☐Numbness
☐Hand joint swelling ☐Ankle joint swelling	**Psychological** ☐ **None**
☐Soft tissue swelling of foot	☐Depression
Pulmonary Symptoms ☐ **None**	**Integumentary (Skin)** ☐ **None**
☐Difficulty breathing	☐Dry skin ☐ Itchy skin ☐ Peeling skin
☐Shortness of breath ☐standing ☐laying down	☐Scaly skin ☐ Skin discoloration
☐Waking at night with shortness of breath	
☐Cough ☐dry cough ☐coughing up phlegm / ☐blood	
☐Wheezing	

To the best of my knowledge, the questions on these forms have been answered accurately. I understand that answering these questions as thoroughly as possible, assists my doctor with my treatment. It is my responsibility to inform the doctor's office of any changes to my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature: ________________________________ **Date:** __________________________

Print Name and Relationship (if not patient): ______________________________________

Jeffrey R. LeSueur, M.D., P.C.

FINANCIAL AND ADMINISTRATIVE POLICIES AGREEMENT

Thank you for choosing our office. It is important for you to understand your responsibilities as a patient when receiving care.

REFERRALS/AUTHORIZATIONS – If your insurance plan requires that you obtain a referral or authorization from your primary care physician for your visit, it is your responsibility to obtain this prior to your appointment. We often receive these from your family physician's office, but please confirm that it has been received. Failure to obtain a referral or auth for a visit will result in rescheduling your appointment or you may pay for your visit out-of-pocket. No exceptions.

CO-PAYMENTS – By law we are required to collect your co-pay at the time of your visit. Please be prepared to pay your co-pay **and** any outstanding balance at the time of your appointment (unless other arrangements have been made with us in advance).

INSURANCE – It is your responsibility to understand your insurance plan benefits, covered services and financial responsibility. We will gladly bill your insurance as a courtesy. In order to properly do this, we require that you provide ALL insurance information, as well as any changes prior to being seen. Failure to provide this information may result in the entire bill being your responsibility. Your insurance will make the final determination of your eligibility and benefits. Once the claim has been processed, you will be billed for any remaining liability. If we're not contracted with your insurance, we will file an insurance claim on your behalf. You agree to pay any portion of the charges not covered by insurance. It is your responsibility to find out in advance if we are contracted with your health plan by calling your insurance.

SELF-PAY PATIENTS – For patients without insurance coverage or who choose not to use their insurance, payment in full is expected at the time of your visit. The fee will vary depending on the length and complexity of your visit along with any procedures that are done that day.

MINOR PATIENTS – The custodial parent who brings a minor to our office for an appointment will be solely responsible to our office for payment of services rendered, *regardless of what post-divorce/separation dictates the courts have made.* We will not be involved in separation or divorce disputes. It is the custodial parent's responsibility to make arrangements necessary with the other parent for reimbursement of medical expenses. If a family member other than the parent brings the child, the parent must send a signed note, giving permission. All foster parents must bring documentation from the court, proving their guardianship. Minors (under age 18) will not be treated without an adult present.

UNPAID BALANCES – A statement will be sent 3 consecutive months in a row. If payment arrangements have not been made, your account will be turned over to a collection agency. Any dispute with regard to payment of an unpaid debt shall be subject to the laws of the State of Arizona. For accounts turned over to collections, the entire balance must be paid in full before you can be seen again. For balances written off due to bankruptcy or for a check returned for insufficient funds, future services will be on a cash only basis at the time of service.

RETURNED CHECKS – The amount of the check, plus a $30.00 fee will be due within 5 days of the check being returned.

MISSED APPOINTMENTS – As a courtesy, we will confirm your appointment the day prior to your scheduled date of service. Please call 24 hours before your appointment if you need to cancel or reschedule. New patients who miss their appointment without notifying the office will incur a $35.00 charge. Surgery patients who do not arrive for surgery and have not notified the office will incur a $250.00 charge. Thank you for helping us help you! We can see patients sooner when we can open time up on our schedule.

NOTICE OF PRIVACY PRACTICES – Our Notice of Privacy Practices is posted in our waiting room. It outlines how confidential patient information will be used, disclosed and protected and what your rights are concerning the information in your health information record. If you would like a copy of the Notice, please ask our front office. We would be happy to provide a copy for you.

PAYMENT METHODS ACCEPTED – We accept cash, check, cashier's check Visa, Mastercard, Discover and AMEX.

I authorize and direct my insurance company to send all checks or drafts relating to my healthcare services provided by Jeffrey R. LeSueur, M.D., P.C. to 5448 S. White Mountain Rd., Suite 140, Lakeside, AZ 85929. Any payments for services rendered by Jeffrey R. LeSueur, M.D., P.C., are to be applied toward the balance of my account. I authorize the release of any medical information necessary to process insurance claims or to obtain prior-authorization. I understand that failure to provide this office with current insurance information will result in my being responsible for payment in full. I acknowledge that I understand and am aware of the policies listed above.

X ____________________________________X______________________________ Date: _____________

Signature of Patient/Responsible Party **Printed Name**

Social Security Number of Responsible Party: ____________________________ DOB: _________________