Malin Medical PLLC
1780 N. State Route 89
Chino Valley, AZ 86323
Ph 928-460-5214
Fx 928-632-4973

Patient Name: _____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Gender: Male / Female

Phone Number: _____ Alternate Number: _____

Email: _____

Responsible Party if Patient is a MINOR: _____ Relationship: _____

Contact Information: _____

Emergency Contact: _____ Relationship: _____

Contact Information: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Effective Date: _____

ID#: _____ Group#: _____

SS#: _____ (ONLY required if Medicare/Tricare- Policy holders SS#)

Secondary Insurance: _____ Effective Date: _____

ID#: _____ Group#: _____

SS#: _____ (ONLY required if Medicare/Tricare- Policy holders SS#)

I hereby authorize Malin Medical PLLC to furnish the above insurance companies all medical information necessary to process any appropriate claims. I authorize payment of medical benefits to Malin Medical PLLC. I accept responsibility for all accrued charges including those charges which my insurance company does NOT cover.

Signature: _____ Date: _____

Current : please list All medications including over the counter and vitamins		
Name/Strength	Dose (# of times per day)	How long : Years/Months
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Please select all conditions you have now or previously have been diagnosed with		
Diabetes	Urinary Issues	Crohn's Disease/Colitis
High Blood Pressure	Migraines/Headaches	Arthritis
High Cholesterol	Pulmonary Embolism	Anemia
Hypo/Hyperthyroidism	Chronic Sinusitis	Jaundice/Liver Disease
Asthma	Emphysema/Copd	Chronic Neck Pain
Hepatitis	Heart Burn/Ulcers	Chronic Back Pain
Kidney Disease	Kidney Stones	Rheumatoid Arthritis
Tuberculosis	Epilepsy(Seizures)	Strokes
Hiv/Aids	Seasonal Allergies	Cataracts
Psoriasis/Eczema	Other Skin Conditions	Gallstones
Angina/Chest Pain	Heart Murmur	Vascular Issues
Heart conditions, Type:		
Cancer,Type,Status:		
Psychiatric: Anxiety,Depression,Bipolar		

List any other medical conditions you have been diagnosed with:

Surgeries / Date:

Hospital Admittance's / Date:

Patients name:

Physician initials:

Please fill out to best of your ability

Family History:

Family Member	Diabetes	Cancer	Heart Disease	Rheumatoid Arthritis		
Father					Dead	Alive
Mother					Dead	Alive
Siblings					Dead	Alive
Children					Dead	Alive
					Dead	Alive

Extended family pertinent health and psychiatric problems

Maternal (mothers side)	
Paternal (Fathers side)	

Where were you born				
Where were you raised				
Any problems with birth				
Highest level of education	High school	Some college	College graduate	Advanced degree
Marital status	Single	Married	Divorced	Widowed Life partner
Lives with:				
Where do you work			how many hours	
Retired	Yes No			
Disabled	Yes No			
Do you receive SSI	Yes No	For how long:		
Do you have any religious beliefs that could affect your healthcare?				

Social History :

Smoker	Yes No	How long and how many a day :
Former Smoker	Yes No	How long and how many a day :
Drink Alcohol	Yes No	How long and how many a day :
Drink Caffeine	Yes No	What type and how many a day :
Use Illicit Drugs	Yes No	What type and how many a day :

Allergies:

Drug / Reaction	
Food / Reaction	
Insect / Reaction	

Health Maintenance:

Every one		**women**			
Last Colonoscopy		Age of first period		Are periods regular?	
Last Bone Density:		If no If no why?			
Last Lab work		Menopause:		If yes what age?	
		Last Pap:			
Men		Last Mammogram:			
Last Prostate Exam		Pregnancies:	Miscarriages:	Abortions:	

Patient name:

Physician Initials:

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AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ DOB: _____

Many of our patient allow family members such as their spouse, parents or other to request medical or billing information. Under the requirements of HIPAA we are NOT allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to family members that are indicated below.

I authorize Malin Medical PLLC to release my medical and/ or billing information to the following individuals:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Patient Signature: _____ Date: _____

You have the right to, at any point in time, revoke this consent in writing.

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HIPAA PRIVACY NOTICE

This office is required by federal regulations known as HIPAA Privacy Rule to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices.

This office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and healthcare operations. Protected Health Information (PHI) is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and/ or computer record. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services. Malin Medical PLLC does not release this information without your written consent.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE-Please print and sign below.

_____ _____

Printed Name-Patient/ Legal Guardian Date

_____ _____

Signature of Patient/ Legal Guardian Relationship (if not signed by patient)

Medical Record Release / Transfer

Malin Medical

Patient name: _____

DOB: _____ Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Authorize: **Malin Medical**
1780 N Hwy 89
Chino Valley, AZ 86323
Ph#:928-460-5214 Fax: 928-632-4973

To RELEASE / RECEIVE the information as described below:

(circle one)

Provider Name/Hospital: _____

Address: _____

Phone: _____ Fax: _____ (Required)

Notice to recipient: This information has been disclosed to you from records that Federal Law protects. These records are not subject to redisclosure. Federal Regulations prohibit you from making further disclosure of Substance Abuse information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of mical or other information is not sufficient for this purpose.

Reports Requested:
- ☐ clinical visit notes
- ☐ Discharge Summary
- ☐ Test Results _____
- ☐ Lab Results, Dates: _____
- ☐ OTHER: _____

Date of Service (for records to be sent):
- ☐ Past 60 Days
- ☐ Past 90 Days
- ☐ Past 6 Months
- ☐ Past 12 Months
- ☐ Other: _____

Purpose for Request: _____

I understand that I do not have to sign this authorization in order to obtain health care benefits, only that by not signing, my records can not be transferred. I understand that I may revoke this authorization in writing at any point in time. However, once the office has disclosed health information to the intended party the person or organization that received it may re-disclose it as privacy laws may no longer apply to protect it.

_____ _____

Patient/ Guardian Signature Date