

Durbin Family Internal Medicine

Dr. Drew A. Durbin, D.O.

*****PLEASE PRINT AND COMPLETE EVERYTHING*****

DATE: _____

Patient Name: _____
(First) (MI) (Last)

Address: _____

(City) (State) (Zip Code)

Preferred pharmacy: _____
((Name and address or cross streets))

E-mail address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Contact Preference: ☐ Home ☐ Work ☐ Cell

Date of Birth: _____ Social Security #: _____ Marital Status: S M Sep W D

Employer: _____ Occupation: _____

Spouse/Partner's Name: _____ Work Phone: _____

Emergency Contact: _____

Phone: _____ Relationship to Patient: _____

Do you have an: Advanced Directive, Living Will or Medical Power Of Attorney

Insurance information: CARDS ON FILE

Whom may we thank for referring you? Dr. _____, Friend/ Relative, Insurance Plan,
Yellow Pages, Hospital, Other: _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
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PERSONAL HEALTH HISTORY

Immunizations Dates/Year:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis A and B	<input type="checkbox"/> Shingles
	<input type="checkbox"/> Influenza	

Medical Problems:

Surgeries/Procedures

Colonoscopy	Date:
Mammogram	Date:
Bone Density	Date:
Surgery	
	Date:
	Reason

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

[illegible]

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND SOCIAL HISTORY**Marital Status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed**Employment Status:** ☐ Working, where? _____ ☐ Unemployed ☐ Disabled ☐ Retired**Do you have Children?** ☐ No ☐ Yes, How many? _____

Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How many drinks per day?				
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			

FAMILY HEALTH HISTORY

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Release of Information

Durbin Family Internal Medicine
16601 N 40TH Street Suite 119
Phoenix, AZ 85032
P: 480-779-4999
F: 480-779-4998

I _____,

Hereby grant the permission for _____,

(Family member or friend)

to obtain any and/or all medical information or results from my medical chart from Dr. Drew Durbin at the practice of Durbin Family Internal Medicine.

Chosen Persons Relationship to Patient: _____

Patient's Signature: _____ Date: _____

Patient's Printed Name: _____

FINANCIAL POLICY / RECEIPT OF PRIVACY PRACTICES / LEGAL ASSIGNMENT

All patients / legal representatives / guarantors are responsible for payment at the time of service. We accept cash, checks and most major credit cards.

If your insurance deductible is not met, we will collect a portion of it at the time of service until met. Thereafter, we will collect your co-payment only. Insurance co-payments are due at the time of service. We will bill for co-insurance payments. If you have no insurance, full payment is due at the time of service.

Supplements or medications prescribed, dispensed or suggested by our doctors must be paid for on receipt unless prior arrangements have been made. As a service to you we will bill your insurance for you, or print out a claim form for you to turn into your insurance for reimbursement.

If your account is placed in collection status, all future services must be paid in full at the time of service.

LEGAL ASSIGNMENT: I, the undersigned, have health insurance and/or employee healthcare benefits coverage and hereby assign and convey directly to Durbin Family Internal Medicine, PLLC all medical benefits and/or insurance reimbursement otherwise payable to me for services rendered to me by Durbin Family Internal Medicine, PLLC, its officers, directors and/or employees. Notwithstanding the above, I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Durbin Family Internal Medicine, PLLC to release any and all of my medical information as necessary to process my medical claims. Further, I agree to fully cooperate with Durbin Family Internal Medicine, PLLC in its attempts to pursue my medical claims against my insurers and/or health care benefit plan as necessary, including bringing suit against any such insurer and/or health care benefit plan. This assignment will remain in effect until revoked by me (or by patient's legal representative or guardian) in writing.

MISSED APPOINTMENT POLICY: If you are not able to keep your appointment, a 24 hour notice is requested. Appointments not cancelled within the 24 hour time period will be charged a fee. The first no show/non-cancelled visit results in a \$25 fee, the second and the third no show/non-cancelled visits are \$50 each. After the third no show/non-cancelled visit we will need to discharge a patient from the practice.

I have read and agree to abide by the above Financial Policy, Missed Appointment Policy and Legal Assignment. I have also received a copy of the Notice of Privacy Practices:

Patient Signature: _____ Date: _____

If a minor or incapacitated, name and signature of legal representative or guardian:

Signature: _____ Date: _____