LifeScape

Patient Registration

Patient ________ Last Name ________ First Name ________ Middle Initial ________

Sex ☐ M ☐ F Age _____ Date of Birth MM / DD / YYYY Social Security No.________________

Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Sep. Spouse (or parent if a minor) ________ Last Name ________ First Name ________

Home Address ________ Street ________ City ________ State ________ Zip Code ________

Home Phone ________________ Work Phone ________________ Cell Phone ________________

Employer ________________________ How Long ________ Occupation ________________

Employer's Address ________ Street ________ City ________ State ________ Zip Code ________

Emergency Contact ________ Last Name ________ First Name ________ Relationship ________________

Address ________ Street ________ City ________ State ________ Zip Code ________ Phone ________________

IF PATIENT IS UNDER 18 PLEASE COMPLETE THIS SECTION

Responsible party's Name: ________________________ Relation to Patient ________________________

Phone Number (if different from above): Home ________________ Cell ________________ Work ________________

Address (if different from above): ____

INSURANCE INFORMATION & COPY OF INSURANCE CARD(S) (LIFESCAPE PREMIER DOES NOT BILL INSURANCE FOR ANYSERVICES RENDERED, BUT THIS INFORMATION IS REQUIRED TO FACILITATE COORDINATION OF REFERRALS TO EXTERNAL ENTITIES WHEN APPLICABLE)

Primary Insurance Company____

Policy Holder Last Name First Name Social Security No. ________________ Date of Birth MM / DD / YYYY

Identification No. ________________ Group No. ________________ Effective Date MM / DD / YYYY

Relationship to Patient________________________

Employer________________________

Secondary Insurance Company____

Policy Holder Last Name First Name Social Security No. ________________ Date of Birth MM / DD / YYYY

Identification No. ________________ Group No. ________________ Effective Date MM / DD / YYYY

Relationship to Patient________________________

Employer________________________

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Authorization to Disclose Protected Health Information to LifeScape Premier, L.L.C.

Susan Wilder, MD William Strohman, MD Laurie Pozun, DO Zoë McMillen, MD Valere Ziske, NP

Patient whose Protected Health Information is sought:

Patient ____Last Name ____ First Name ____ Middle Initial ____ Date of Birth _MM_ / _DD_ / _YYYY_

Home Address ____ Street ____ City ____ State ____ Zip Code ____

Home Phone ____________________ Work Phone ______________________ Cell Phone __________________

I hereby authorize LifeScape Premier to request my medical records from:

Name ____ Name of Doctor or Medical Office Entity ____

Address____ Street ____ City ____ State ____ Zip Code ____ Phone/Fax Number ____

Protected Health Information should be disclosed to:

LifeScape Premier
8757 East Bell Road
Scottsdale Arizona 85260
Tel. 480.860.5269
Fax. 480.860.5260

Attn: ______________________________

Description of Protected Health Information to be disclosed:

- ☐ Complete Medical Record
- ☐ History and Physical Exam
- ☐ Operative Reports
- ☐ X-Ray Reports
- ☐ Lab Tests
- ☐ Other ____ Specify ____

Purpose(s) of the disclosure:

- ☐ Supplemental Care
- ☐ Second Opinion
- ☐ Transfer of Care
- ☐ Personal Use
- ☐ Insurance Coverage or Payment of Care
- ☐ Workers' Compensation
- ☐ Legal
- ☐ Other ____ Specify ____

I hereby authorize Provider to release Protected Health Information ("Information") to LifeScape Premier, L.L.C. I understand that this authorization may cover Information relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eighty (180) days following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

____ ______________________
Signature of the Patient or the Patient's Legal Representative Date

____ ______________________________
Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.

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Approval to Transmit Protected Heath Information by Unsecured Electronic Communications

Upon a patient's request and approval, LifeScape Premier, LLC ("LifeScape") will communicate their provider's summary of test results by electronic communications ("ECs"). ECs may contain confidential and, in some instances, highly personal medical information including information relating to pregnancy, genetic markers, serious illness, AIDS, HIV, and other communicable diseases, and illicit drug use. **ECs are unsecured**. Among other things, they can be misdirected, intercepted in transmission, and viewed or heard by others including employers, household occupants, and those who share account or system access. **ECs can be blocked by spam, junk, and other electronic filters** resulting in delays or failures in communication and, consequentially, delays or failures in medical treatment. Questions regarding the content of ECs must be addressed by the provider or their assistant by telephone or office visit.

If you wish to receive ECs, please enter the desired mode(s) of communication by checking the relevant box(es), providing the requested contact information, and executing the statement below. We suggest that you use your personal email account and configure any spam/junk mail filter to accept transmissions from the "lifescapepremier.com" domanin.

Email **Email Address:** ____

Text Message **Tel. Number: (_____)** ________________________

Landline Tel. Message **Tel. Number: (_____)** ________________________

Mobile Tel. Message **Tel. Number: (_____)** ________________________

I, ____________________________, hereby authorize LifeScape to provide me with summaries of my test results and any other health information via the ECs selected above. I have been advised that such ECs may contain confidential and highly personal medical information. I have been further advised that such ECs can be misdirected, intercepted in transmission, and accessed by others. Finally, I have been advised that ECs can be blocked by spam, junk, and other electronic filters resulting in delays to or non-notification of such test results with potential adverse consequences to my medical treatment. By executing this document, I acknowledge and accept the risks associated with ECs and do hereby release LifeScape and its employees, officers, managers, members, and agents from any and all liability for fulfilling this authorization. I understand that I may revoke this authorization at any time provided I present written notice of such revocation to LifeScape. I understand that any ECs transmitted pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality.

____
Signature of the Patient or the Patient's Legal Representative

____
Date

____
Print Name

____
If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.

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Acknowledgement of Receipt of Notice Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of LifeScape Premier, LLC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgment.

____   ______________________
Signature of the Patient or the Patient's Legal Representative   Date

_______________________________________   ________________________________
Print Name   If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.

FOR OFFICIAL USE ONLY

I, ______________________________, made a good faith effort to obtain written acknowledgment of ______________________________'s receipt of the Notice of Privacy Practices of LifeScape Medical Associates, PC/LifeScape Premier, LLC. However, I could not obtain written acknowledgment because:

☐ Individual refused to sign this acknowledgment

☐ Communications barrier prohibited obtaining written acknowledgment

☐ An emergency situation prevented obtaining written acknowledgment

☐ Other (please specify)

____

____

____

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Patient Medical History

Name: ____Date of Birth:________________________

Marital Status: ☐ S ☐ M ☐W ☐ D ☐ Sep

Health Goals: ____

Foreign Travel Planned? ☐ Yes ☐ No ☐ Where? ____

Do you have a living will? ☐ Yes ☐ No

Personal Health Habits (check all that apply):

- ☐ Exercise at least 30 minutes most days
- ☐ Perform a variety of exercises including aerobic/cardio, strength, flexibility, and balance
- ☐ Eat at least 5 servings of fruits and vegetables per day
- ☐ Limit refined carbohydrates in diet (starches, sugars, sweet drinks)
- ☐ Avoid artificial sweeteners
- ☐ Eat fish at least twice a week or supplement omega-3 fats
- ☐ Eat at least 3 calcium-rich foods per day (dairy, dark green veggies, fortified foods)
- ☐ Keep portions small and avoid eating when distracted, bored, or not hungry
- ☐ Sleep on average at least 8 hours per night
- ☐ Take time daily for relaxation, meditation, prayer, gratitude or laughter
- ☐ Wear sun block to exposed skin daily
- ☐ Wear protective clothing, hats, and sunglasses when outdoors
- ☐ Have regular dental visits at least every 6 months
- ☐ Attend to good daily oral hygiene (brushing, flossing)
- ☐ Eyes examined within past year (date if known :______________________)
- ☐ Avoid loud noise exposure or use hearing protection when needed
- ☐ Monitor skin for changing moles or new lesions
- ☐ Have an annual skin check

Preventive Procedures

Procedure	Date (Mo/Yr)	Facility/Dr.	Outcome
Mammogram			
Colonoscopy			
Bone Density			
Stress Test			
Last Pap			
Prior abnormal Pap Smear			

Tobacco Use or Exposure

Ever Smoked? Y N	Age quit:	Type:	Smoke Smokeless	#/Packs/day:	#Years:
Lived with a Smoker? Y N			Age/#Years:		
Passive tobacco at Work? Y N			# Years		

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Preferred Pharmacy: Phone #:

Medications/Contraception/Vitamins/Supplements

Current Medications/Strength/Frequency	Vitamins and Supplements/Dosage/Frequency

Current Health Issues (established patients, update new issues)

Active Problem	When Onset/Resolved

Medication Allergies	Reaction

Surgical History (established patients, update procedures since last exam)

Procedure	Date (month/year)
Ever had Chicken Pox? Y N	Ever had Shingles? Y N

Preventative Health

Question	Answer
Do you drink alcohol?	Never rarely monthly weekly daily
# of drinks in an average week?	
Types of alcohol you typically drink?	Beer Wine Mixed Drinks Hard Liquor
Caffeine? Y N Type?	# per day?

Immunizations	Date (month/year)
Influenza Vaccine	
Tetanus Booster	
Pneumonia Vaccine	
Hepatitis A Vaccine Series	
Hepatitis B vaccine Series	
TB Test/Any TB exposures	
Chicken Pox? Y N Shingles? Y N	

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Personal/Family History (for existing patients, update new history since last exam)

If possible, your family medical history should include at least three generations. Compile information about your grandparents, parents, uncles and aunts, siblings, cousins, children, nieces and nephews, and grandchildren. For deceased relatives, please provide age and cause of death.

Condition	Self	Description	Family Member	Description
Alcoholism or other Substance Abuse				
Arthritis				
Asthma				
Back Problems				
Birth Defects				
Blood in Stool				
Cancer				
Change in Bowels				
Chicken Pox/Shingles				
Colon Polyps				
Dental Problems				
Depression				
Diabetes, Type 1 or 2				
Emphysema				
Headaches				
Hearing Loss				
Heart Problems/Disease				
Hepatitis				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Learning Disabilities or				
Leg Swelling				
Liver Problems				
Lung Problems				
Measles				
Mental Illness (Anxiety, Depression, Bipolar Disorder or Manic Depression, Attempted Suicide, Suicide)				
Migraine				
Miscarriage(s) or Stillbirth(s)				
Mononucleosis (Mono)				
Mumps				
Panic Attacks				
Seizures				
Sexually Transmitted Disease(s)				
Skin Problems				
Stroke				
Thyroid Problems				
Vision Problems				
Other:				
Other:				
Other:				

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For Women
Please provide the following information:

Sexually Active? Y N	
Date of last period?	
Could you be pregnant now? Y N	
Number of Pregnancies?	Number of Live birth(s)?
Number Miscarriage(s)?	Number of Abortion(s)?
Method of Birth Control?	Age at first period or menopause?
Planning pregnancy in next year? Y N	History of HPV virus? Y N

For Men
Please provide the following information:

Sexually Active? Y N	
Last Prostate Exam/PSA?	
Urine flow problems? Y N	
Prostate problems? Y N	
Lump/pain in testicle(s)? Y N	
Erection issues? Y N	
Loss of height? Y N	If so, how many inches?
Lack of energy? Y N	

Risk Factors for Mood Issues

Symptom	How Frequently in Past 2 Weeks			
Feel sad, depressed, or hopeless	Never	Occasionally	Often	Daily
Little interest or pleasure in life	Never	Occasionally	Often	Daily
Unable to fall asleep or stay asleep	Never	Occasionally	Often	Daily
Low energy or fatigued	Never	Occasionally	Often	Daily
Poor appetite or excessive eating	Never	Occasionally	Often	Daily
Feeling badly about yourself/low self-worth	Never	Occasionally	Often	Daily
Trouble concentrating or focusing	Never	Occasionally	Often	Daily
Moving too slow or fidgety	Never	Occasionally	Often	Daily
Thoughts that life not worth living/suicidal thoughts	Never	Occasionally	Often	Daily
Feeling anxious or excessive worry	Never	Occasionally	Often	Daily
Feeling revved, excessive energy	Never	Occasionally	Often	Daily
Trouble controlling temper	Never	Occasionally	Often	Daily
Loss of libido or interest in sex	Never	Occasionally	Often	Daily
Acting impulsively (reckless spending, gambling, risky sex, dangerous activities)	Never	Occasionally	Often	Daily

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Personal Risk Factors for Cardiovascular Disease (check all that apply)

- ☐ History of coronary artery disease or known atherosclerosis/plaque in vessel
- ☐ Limited exercise less than 3 hours per week
- ☐ Central obesity (BMI >30, waist > 40 inches in men, >35 inches in women)
- ☐ High triglycerides (>150)
- ☐ High C-reactive protein inflammatory marker

Risk Factors for Personal Safety (check all that apply)

- ☐ Ever drive or ride in a vehicle without wearing seatbelts
- ☐ Often drive above speed limit
- ☐ Ever use cell phone or become distracted while driving
- ☐ Ever drive when sleepy or fell asleep while driving
- ☐ Ever drink more than 4 alcoholic beverages in one day
- ☐ Ever drink to the point of blacking-out
- ☐ Ever drive after drinking alcohol or ride with possibly impaired person
- ☐ Use prescription pain relievers (narcotics), sleeping pills, or tranquilizers
  - ☐ Ever drive a car within 24 hours of use of such medicines
- ☐ Ever used illegal or street drugs
- ☐ No working smoke detectors in home
- ☐ Ride a bike, roller blade, skate, ski, or ride horses without a helmet
- ☐ Other high risk activities (motorcycles, scuba diving, sky-diving, etc.)
- ☐ Had unprotected intercourse in the past year (n/a if monogamous)
- ☐ Ever feel threatened verbally or physically
- ☐ Exposure risks
  - ☐ UV radiation (sun or frequent air travel)
  - ☐ Other radiation (x-ray, nuclear, occupational)
  - ☐ Asbestos
  - ☐ Lead
  - ☐ Mercury
  - ☐ Other heavy metals
  - ☐ Well water
  - ☐ Fumes
  - ☐ Chemicals or poisons

Use of Complimentary or Alternative Therapies (check all that apply)

- ☐ Acupuncture
- ☐ Herbal Remedies including Chinese or Ayurvedic
- ☐ Naturopathy/Homeopathy
- ☐ Chiropractic or Osteopathic Manipulation
- ☐ Chelation
- ☐ Other:

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Additional Information

Please use this space to complete any of the above questions or provide other relevant information:

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

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