21321 E. Ocotillo Rd. #123
Queen Creek, AZ /8142

Jensen Family Medicine
An Integrative Approach to Wellness

Scott M. Jensen, M.D.
(480) 677-3688

Please Print

Today's Date

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)					Preferred Name (if different from First Name)
Address (Number) (Street) (Apt. No.)					Home Phone
City	State	Zip	Social Security No.		Cell Phone
Date of Birth	Age	Gender	Marital Status		Business Phone (including ext.)
Occupation					
Employer (or School) Name			Preferred Pharmacy		
Other Physicians You See			If need arises, the doctor/receptionist may leave a message on my (circle all that apply): Home Phone Cell Phone Email None		
Race Ethnicity Decline to answer Language Preference			Email Address		

SPOUSE or PARENT/GUARDIAN (If Patient is a child) INFORMATION

Full Legal Name (First) (Middle) (Last)		Relationship			Occupation
Address (If Different From Above)	City		State	Zip	Home Phone
Employer Name	Street Address	City	State	Zip	Business Phone (Ext)

INSURANCE INFORMATION

Primary Insurance Company Name		Group No.	ID/Certificate No.
Guarantor/Subscriber Full Name	Date of Birth	Relationship to Patient	
Secondary Insurance Company Name		Group No.	ID/Certificate No.
Subscriber Name, Date of Birth, and Relationship to Patient (for Secondary Insurance)			
Other Insurance Information			

EMERGENCY CONTACT INFORMATION

Person to Notify in Case of Emergency (needs to be local)			Relationship
Address (Number) (Street) (Apt. No.)			
City	State	Zip	Phone

INFORMATION FOR THE PATIENT

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.
3. If you have any questions we will, of course, be happy to assist you.

Jensen FAMILY MEDICINE
An Integrative Approach to Wellness
DR SCOTT M. JENSEN MD 480-677-3688
21321 E. OCOTILLO RD. SUITE 123, QUEEN CREEK, AZ 85142

Last Name:_____**First Name:**_____**Middle:**_____**DOB**_____

Email Address: _____

Race: (check or leave blank to decline)
O Am. Indian/Alaska Native O Asian O Black/African Am
O Hawaiian/Pacific Islander O White O Other

Ethnicity: (check or leave blank to decline)
O Hispanic or Latino O Not Hispanic or Latino

Preferred Language:_____

Do you have a Living Will: **O Yes or O No**
Do you have an Advanced Directive: **O Yes or O No**

Authorization to discuss medical information and release medical records

Name:_____**DOB**_____**Relationship**_____

Name:_____**DOB**_____**Relationship**_____

We verify your insurance eligibility prior to your appointment. You are responsible for knowing your detailed benefits and if we are in or out of network with your health insurance:
Patient Initials _____

I hereby authorize Jensen Family Medicine to release any and all information necessary to my health insurance company for the purpose of treatment and securing payment from insurance company: **Patient initials** _____

I have received, read, and understand HIPAA privacy regulations: **Patient Initials** _____

I hereby authorize Jensen Family Medicine to leave messages regarding lab results and scheduled appointments via email or phone: **Patient initials** _____

I have read received, read, and understand Functional Medicine Lab Testing consent:
Patient initials _____

Emergency contact name:_____ **Phone:**_____

Patient signature/ Guardian and **Date** of form completion:

_____

CREDIT CARD ON FILE POLICY

At Jensen Family Medicine we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. A billing fee of $20 will be added to your account for any balances that we must attempt to collect through mailing monthly statements after the first statement. An "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.

Your credit/debit card information is kept confidential and secure and payments to your card are only processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

_____ I (we), the undersigned, authorize and request Jensen Family Medicine to charge my credit/debit card, indicated below, for balances due for services rendered that my insurance company identifies as my financial responsibility.

_____ I do **NOT** authorize Jensen Family Medicine to keep my credit/debit card on file, I would like billing statements mailed and understand there is a $20 billing statement fee after the first statement.

Visa____ Master Card____ Discover____ American Express_____
Card holder name:_____
Card number:_____
Expiration date:_____/_____ CVV (3 digits on back) _____
Billing address:_____
City:_____ State:_____ Zip:_____
Signature:_____

This authorization relates to all payments not covered by my insurance company for services provided to me by Jensen Family Medicine.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Jensen Family Medicine in writing and the account must be in good standing.

Patient Name (Print):_____
Signature:_____ Date:_____/_____/_____

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FAMILY MEDICINE
An Integrative Approach to Wellness

The providers and staff of Jensen Family Medicine are here to take care of children. Our focus is on the medical, psychological and emotional health of your child-NOT legal issues involving divorce, separation, or custody agreements. That is why we ask you to read and agree to the following:

1. Either parent of legal guardian can schedule an appointment for their child, be present for the visit, and/or obtain a copy of the visit summary.. Unless there is a court order in the child's record that restricts a parent's rights, please do not ask us to limit the other parent's involvement in your child's care.
2. Payment (co-pays, deductibles, etc.) are due at the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement. We will collect payment due from the parent who brings the child to the visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing paren's responsibility to collect from the other parent.
3. Both parents/legal guardians can sign a consent to treat form. This means other persons (like grandparents, nannies, etc.) are authorized to bring your child to our practice, and can consent for treatment during that visit. We will NOT be involved in any disputes regarding named individuals on your child's consent to treat form. Both parents/legal guardians can see who is named on each other's forms; however, we will not comply with requests to eliminate names on the other's form, unless instructed by the court. Please refer these requests to your attorney.
4. Additionally, we will not:
   *Call the other parent for consent prior to treatment or inform the other parent whenever visits are scheduled.
   *Restrict either parent's / legal guardian's involvement in your child(ren)'s care, unless authorized by law.
   *Tolerate appointment scheduling/canceling patterns of behavior between parents.
5. It is both parent's responsibility to communicate with each other about the patients care office dates/visits and any other pertinent information relevant to the care of the child. Please do not ask our providers to call the non-attending parent following visits.
6. Should the issues that come between parents become disruptive to our practice or impeded the care of children, we reserve the right to discharge your family from further treatment.

_____	_____	_____
Parent / Legal Guardian signature	Print	Date
_____	_____	_____
Parent / Legal Guardian signature	Print	Date
* Does not apply _____	_____	_____
Parent/Guardian	Print	Date

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FAMILY MEDICINE

Patient Questionnaire - Adult

FIRST NAME: _____ LAST NAME: _____ DOB: _____

CHECK ALL THAT APPLIES TO PAST AND PRESENT MEDICAL CONDITIONS

- ☐ Alcohol/Drug Problem
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Cancer
- ☐ Coronary Artery/Heart Disease
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Emphysema
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Peripheral Artery Disease
- ☐ Positive TB Test
- ☐ Prostate Problem
- ☐ Seizure Disorder
- ☐ Sexual Transmitted Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers of the Stomach

IMMUNIZATIONS

Flu Vaccine	Date:
Pneumococcal Vaccine	Date:
Tetanus, Diphtheria - with or without Whooping Cough (circle one)	Date:
Shingles	Date:
Screening Tests – Gardasil	Date:

MEDICATIONS – including OVER THE COUNTER medications

NAME	DOSE & DIRECTIONS	REASON
Mammogram	Date last performed:	
Pap Smear	Date last performed:	
Colonoscopy or other cancer screening	Date last performed:	

"This form is not to be included or scanned into the patient's Medical Record"

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FAMILY MEDICINE

Patient Questionnaire - Adult

FIRST NAME: _____ LAST NAME: _____ DOB: _____

ALLERGIES TO MEDICATIONS or FOOD	REACTION/COMMENTS

OTHER MEDICAL HISTORY

_____
_____
_____
_____
_____

SURGICAL HISTORY (Check all that apply)

- ☐ Appendectomy
- ☐ Cardiac Angioplasty, Stent or Bypass
- ☐ Cardiac Catheterization
- ☐ Cesarean Section
- ☐ Gall Bladder - Laparoscopic
- ☐ Gall Bladder - Open
- ☐ Hysterectomy –Partial
- ☐ Hernia Repair
- ☐ Prostrate Surgery

OTHER SURGICAL HISTORY

_____
_____
_____
_____

TOBACCO USE (circle the appropriate answer)

SMOKING: ☐ Never ☐ Previous ☐ Current Packs per Day: ☐ Years: ☐
☐ Quit Date: ☐

ALCOHOL: ☐ Never ☐ Occasional ☐ Excessive

If you have marked yes to Alcohol use, on a weekly basis, please answer the following:

☐ # of Can(s) of beer (12oz) ☐ # of glasses of glasses (6oz) ☐ # of Drink(s) containing 0.5oz of Alcohol

DRUG USE (circle the appropriate answer) if yes, this will be discussed with the physician

☐ No ☐ Yes

"This form is not to be included or scanned into the patient's Medical Record"

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FAMILY MEDICINE

Patient Questionnaire - Adult

FIRST NAME: _____ LAST NAME: _____ DOB: _____

FAMILY HEALTH HISTORY

Family Member	Living (L) Deceased (D)* Unknown (U)	Medical Conditions Please specify Premature Heart Disease, Diabetes Mellitus , Cancer of any type, Prostate, Breast, Ovarian problems
Mother		
Father		
Mother's Mom		
Mother's Dad		
Father's Mom		
Father's Dad		
Sister		
Brother		
****** If deceased, please indicate age		

"This form is not to be included or scanned into the patient's Medical Record"