Jeffrey R. LeSueur, M.D., P.C.
5448 S. White Mountain Rd., Suite 140
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TODAY'S DATE: _____

DEMOGRAPHIC INFORMATION

Last Name | Legal First Name | MI | Preferred Name

Primary Phone # | Secondary Phone# | Email address

DOB | Age | Gender: M F | Marital Status: M □ S □ D □W □ | Student: Yes □ No □ N/A □ 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 □Retired
□Caucasian □ Other/Decline to say		□Not employed

Family Physician | Referring Physician | Preferred Pharmacy/What city or town?

Parent/Guardian's Name (if patient is a minor) | Relationship to Patient | Phone #

INSURANCE INFORMATION

☐ ****Check if Photo ID is provided**** ***(not needed if you are billing your own insurance)***

☐ ****Check if insurance card(s) provided****

☐ ****Check if this visit is to be billed to Worker's Comp****

☐ ****Check if this visit is related to an auto accident****

Policy Holder's Name (if different from patient's) | **Policy Holder's DOB** | *Relationship to patient*

Policy Holder's Name (if different from patient's) | **Policy Holder's DOB** | *Relationship to patient*

Primary Insurance (if card is *not* provided) | Policy # / Group #

Secondary Insurance (if card is *not* provided) | Policy # / Group #

CONTACT METHODS *(select all you prefer; BE SURE TO ADD OUR PHONE TO YOUR CONTACTS)*

☐ Letter

☐ Text (at this time, we can text appointment information only)

☐ Phone call (please check one option) ☐ do not leave message ☐ message with callback number only ☐ detailed message

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/Relationship (if signing for patient): _____

HEALTH HISTORY

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

Patient Name:_____ DOB:_____ Height:_____Weight:_____

Reason for visit: _____

☐ **Yes** ☐**No** **Were imaging/labs/studies done?**
If yes, what/when/where? _____

☐**Yes** ☐**No** **Do you have a history of use or do you currently use tobacco products?** *(circle one)*
If yes, which product? _____ **What quantity?** _____ ***packs per day/week***
Year quit, if applicable: _____

☐**Yes** ☐**No** **Do you have a history of drinking or do you currently drink alcohol?** *(circle one)*
If yes, what type(s)? _____ **What quantity?** _____ ***drinks per day/week***
Year quit, if applicable: _____

☐**Yes** ☐**No** **Do you have a history of or currently have a problem with substance abuse?**
If yes, with what? _____ **Year quit, if applicable:** _____

PAST MEDICAL HISTORY Have you ever had the following: (Please mark yes or no.**)**

Condition	No	Yes	Condition	No	Yes	Condition	No	Yes	Additional information:
Headache/Migraines			Gallbladder Disease			Sleep Apnea			_____
Seizures			Jaundice			Measles			_____
Hearing Loss			Thyroid Disorder			Mumps			_____
Hypertension			Diabetes			AIDS or HIV+			_____
Edema			Eczema			Chickenpox			_____
Heart Disease			Urticaria(Hives)			Tuberculosis			_____
Pneumonia			Arthritis			Hay Fever			_____
Asthma			Bone Disorders			Cancer			_____
Esophageal Reflux			Colon Inflammation			Meningitis			_____

PAST SURGICAL HISTORY ☐ *NONE* ☐ **Check if a separate list is provided****

Surgery	Year	Surgery	Year	List other surgeries/hospitalizations:	Year
Adenoidectomy ☐Yes☐No		Neck/Thyroid ☐Yes☐No			
Tonsillectomy ☐Yes☐No		Sinus Surgery ☐Yes☐No			
Ear Tubes ☐Yes☐No		Nasal Surgery ☐Yes☐No			
Ear Surgery ☐Yes☐No					

FAMILY HISTORY

	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 ☐		Other Family History:	
		Kidney Stones ☐			

MEDICATION ALLERGIES: ☐ ***NONE*** ☐ ***Check if a separate list is provided***

_____

_____

Current Medications (include OTC) ☐ *NONE* ☐ **Check if separate list is provided****

NAME	DOSAGE	FREQUENCY

REVIEW OF SYSTEMS - PLEASE INDICATE THE PATIENT'S PERSONAL HISTORY BELOW

(Being thorough helps us to help you; please review carefully and mark all that apply.)

General Health Symptoms	**Gastrointestinal (GI)**
□Fatigue	□Decreased appetite
□Fever	□Anorexia
□Chills	□Heartburn
□Sweating heavily at night	□Nausea
□Recent weight loss □Recent weight gain	□Vomiting □with blood
Head Symptoms	□Abdominal pain □cramping
□Headache	□Jaundice
□Sinus pain	□ Diarrhea □ Constipation
Neck Symptoms	**Genitourinary (GU)**
□Neck Pain	□ Blood in the urine □ Odor to urine
Eye Symptoms	□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**
□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	**Musculoskeletal**
□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	□Joint stiffness
□Nasal Discharge □Nose Bleeds (epistaxis)	**Neurological**
□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	□Involuntary movements
□Chest pain	□Difficulty with balance
□Palpitations	□Tingling
□Slow heart rate □Fast heart rate	□Numbness
□Hand joint swelling □Ankle joint swelling	**Psychological**
□Soft tissue swelling of foot	□Depression
Pulmonary Symptoms	**Integumentary (Skin)**
□Difficulty breathing	□Dry skin
□Shortness of breath □standing □laying down	□Scaly skin
□Waking at night with shortness of breath	□ Itchy skin
□Cough □dry cough □coughing up phlegm / □blood	□ Peeling skin
□Wheezing	□ Skin discoloration

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 a referral or authorization from your primary care physician for your visit, it is your responsibility to be sure this has been obtained prior to your appointment. Failure to obtain a referral/authorization for a visit will result in rescheduling your appointment if you do not wish to pay 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. We accept cash, check, cashier's check, Visa, Mastercard, Discover and AMEX. For returned checks, the amount of the check, plus a $30.00 fee will be due within 5 days of the check being returned.

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. If you wish to take advantage of this courtesy, we require that you provide ALL insurance information prior to being seen. Your insurance makes the final determination of your eligibility and benefits. Once the claim has been processed, you will be billed for any remaining liability. 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, payment in full is expected at the time of your visit. The fee will vary depending on the length and complexity of your visit and any additional procedures performed that day.

MINOR PATIENTS – Minor children under age 18 will not be treated without an adult present. The custodial parent who brings a minor to our office for an appointment is solely responsible for payment of all services rendered. ***We do not bill separated/ divorced parents individually.*** If a minor is brought by someone other than a custodial parent, the parent must send a signed note, granting permission. All foster parents must bring documentation from the court proving their guardianship.

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 for collection. Any dispute regarding payment of an unpaid debt shall be subject to the laws of the State of Arizona. For accounts turned over for collection, the entire balance must be paid in full before you can be seen again. If a balance is written off due to bankruptcy or a check returned for insufficient funds, future services will be on a cash only basis.

MISSED APPOINTMENTS – Patients who miss their appointment without notifying the office will incur a $35.00 charge. Please try to call 24 hours before your appointment to cancel or reschedule. Surgery patients who do not arrive for surgery and have not notified the office will incur a $250.00 charge.

NOTICE OF PRIVACY PRACTICES – In compliance with **HIPAA**, our office policies regulate how confidential patient information is used, disclosed and protected. If you would like a copy of our Notice of Privacy Practices, which explains your rights concerning the information in your health record, please ask our front office. We will provide a copy for you.

PERSON(S) WITH WHOM WE MAY SHARE YOUR PROTECTED HEALTH INFORMATION

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

EMERGENCY CONTACT ONLY (IF DIFFERENT FROM ABOVE; NO INFORMATION WILL BE SHARED)

Name_____Relationship_____Phone_____

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 and/or obtain prior authorization, as required by my insurance company. 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 accept and understand the policies listed above.

X _____X_____ Date: _____

Signature of Patient/Responsible Party Printed Name

Phone Number of Responsible Party: _____ DOB: _____