



8205 N. Via De Negocio Dr.
Scottsdale, AZ 85258
Phone: 480-451-3668
Fax: 480-451-3669

2023 PATIENT INFORMATION RECORD

Please complete, print and bring this form with you to your next appointment.

*To remain HIPPA compliant, this form is not automatically saved.
If the form is not completed in advance and printed, you will have to complete
it at the time of your appointment which may delay your appointment*



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 Phone 480-451-3668 Fax 480-451-3669

2023 PATIENT INFORMATION RECORD

Patient Name: _____			
FIRST	LAST	MI	
Mailing Address: _____			
STREET	CITY	ST	ZIP
Out of State Address: _____			
STREET	CITY	ST	ZIP
Date of Birth: ____/____/____	Age: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D
S.S.#: _____ - _____ - _____	Home Phone: _____	Cell Phone: _____	
Employer: _____			
OCCUPATION		/ PHONE	
Employer Address: _____			
STREET	CITY	ST	ZIP
Emergency Contact: _____			
RELATIONSHIP		/ PHONE	
Referred by: _____			
NAME		PHONE	
Primary Care Physician: _____			
NAME		PHONE	
Spouse (or Parent, if minor): _____			
Phone: _____	Date of Birth: ____/____/____	S.S.#: _____ - _____ - _____	
Address: _____			
STREET	CITY	ST	ZIP
Employer: _____	Occupation: _____	Phone: _____	

INSURANCE INFORMATION *(It is our office policy to obtain a copy of both your insurance card(s) and a valid photo ID)*

Primary Insurance Co: _____ Phone: _____ Claims Address: _____ Policy/ID #: _____ Group/Claim #: _____ Policyholder's Name: _____ Relationship to Patient: _____ Date of Birth: ____/____/____ Phone: _____ S.S. #: _____ Employer: _____	Secondary Insurance Co: _____ Phone: _____ Claims Address: _____ Policy/ID #: _____ Group/Claim #: _____ Policyholder's Name: _____ Relationship to Patient: _____ Date of Birth: ____/____/____ Phone: _____ S.S. #: _____ Employer: _____
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Authorization to Release Information & Assignment of Benefits: I hereby authorize and assign payment of medical benefits to the provider of services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature will bind me as though I personally signed each claim. **I also authorize the release of any medical information necessary. I understand that I am responsible for all charges.** If my account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understood this office policy.

Patient/Responsible Party Signature: _____ **Date:** _____

John A. Nassar, M.D., P.C.
FINANCIAL POLICY

Dear Patient:

Thank you for choosing John A. Nassar, M.D., P.C. for your orthopaedic care. We realize that questions may arise about our payment and collection policies and this notice is designed to provide an overview of these policies. Our goal is to provide quality medical care for our patients and it is important that we work together to assure that reimbursement for our services is straightforward and timely. Our office manager or billing department will be happy to discuss these policies with you. In compliance with Arizona law, you are being advised Dr. Nassar has a direct financial interest in San Tan Surgery Center. The services provided at San Tan Surgery Center are available elsewhere (Honor Health) on a competitive basis.

INSURANCE:

1. You are directly responsible for payment of your medical care and you are expected to pay for any co-payment, deductible, or non-covered amounts at the time of service. Your insurance company may not pay for all of your health care costs. Insurance policies exclude some non-covered services; however, this does not mean that the services or tests are not necessary. It means that the insurance company may not pay for it. Please keep in mind that your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover. For your convenience, we accept VISA and MASTERCARD.
2. PRIVATE PAY patients must pay in full at time of service.
3. In order to bill your insurance company for your medical services, you must provide our office with accurate billing information and your insurance card. If you do not provide this information at each visit, please expect to pay in full at the time of the office visit for the services rendered. We reserve the right to reschedule your appointment if the applicable co-payment is not paid in full at the time of your appointment.

BILLING:

1. As a courtesy to you, we will bill your insurance company for services rendered. In order to do so, we must have complete billing information, picture identification, and your insurance card. If your insurance changes, it is your responsibility to provide us with updated insurance information.
2. Arizona law requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.
3. In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an "out of network provider" for your insurance, the deductibles and co-insurance amounts are usually higher. Your insurance policy, not our office, determines these amounts.
4. You will receive a statement every month from our office showing your account balance. Your statement will indicate which portion of the balance is due from you, and which is still being processed by your insurance company. Patient balances are due and payable in full upon receipt of your statement.
5. Delinquent accounts will be transferred to a collection agency or our attorney when payments are not made in accordance with our policy. In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for seven years.
6. FMLA and/or DISABILITY Paperwork. As a courtesy to you, we will complete the initial form. Any subsequent forms to be completed will have a charge of \$25.00 each, to be paid at the time of completion. There is no completion charge for WORKER'S COMPENSATION FORMS.
7. We require a minimum of 24 hours notice of cancellation or rescheduling of your appointment. A late cancellation and/or a no-show appointment will have a \$25.00 fee.

SURGERY:

Prior to surgery, our office verifies your insurance benefits and obtains appropriate authorizations from your insurance company. Once your insurance company determines your deductible, co-payment, and/or co-insurance amounts due for your planned surgical procedure, our office will collect the full amount of your expected patient liability, prior to your planned surgical procedure.

Please understand that maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare you deserve and expect.

I UNDERSTAND AND ACKNOWLEDGE THIS FINANCIAL POLICY.

Patient/Responsible Party Signature

Printed Name

Date

John A. Nassar, M.D., P.C.

HIPAA and Notice of Privacy Practices

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have a right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You then have the right to use another Healthcare Professional. **You have the right to request to receive confidential communications from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us.** Upon request, even if you have agreed to accept this notice alternatively (i.e. electronically), you may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. **Complaints:** you may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. We will not retaliate against you for filing a complaint. This notice was published and became effective on or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

Signature _____ Date _____

Printed Name: _____

John A. Nassar, M.D., P.C.

Patient Name: _____ Age: _____ Today's Date: _____

How did you find out about Dr. Nassar/who referred you? _____

Why are you here today? _____

How long have you had this problem? _____ Which side is involved? right left

What is your main problem? _____

- | | | | |
|--------------------------------------|------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> pain | <input type="checkbox"/> grinding | <input type="checkbox"/> weakness | <input type="checkbox"/> increased warmth |
| <input type="checkbox"/> deformity | <input type="checkbox"/> popping | <input type="checkbox"/> limp | <input type="checkbox"/> collapsing arch |
| <input type="checkbox"/> instability | <input type="checkbox"/> stiffness | <input type="checkbox"/> ulcer/sore | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> catching | <input type="checkbox"/> swelling | <input type="checkbox"/> redness | <input type="checkbox"/> open wound |

What type of pain are you having? _____

- sharp aching throbbing burning tearing

How did it start? gradually suddenly

What could have caused this? injury accident activity unknown

Have you had the same or similar problem in the past? no yes

How severe is the pain/problem? mild moderate severe

The pain/problem is: _____

- present during activity present at rest present at night
worse when starting up after rest

The pain/problem is: constant intermittent

The pain/problem is: _____

- not changing gradually getting worse rapidly getting worse
gradually getting better rapidly getting better

What makes your pain/problem worse? _____

- standing walking running jumping stairs
uneven ground hard surfaces dress shoes any shoes barefoot

What makes your problem better? _____

- rest elevation ice heat stretching
removing shoe rubbing foot comfortable shoes avoiding aggravating activities

What types of treatments have you had? _____ Does this help? _____

- | | | | |
|---|-----------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> anti-inflammatory medication | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |
| <input type="checkbox"/> pain medication | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |
| <input type="checkbox"/> compressive wrap | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |
| <input type="checkbox"/> brace | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |
| <input type="checkbox"/> physical therapy | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |
| <input type="checkbox"/> cortisone shot | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |
| <input type="checkbox"/> shoe insert | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |
| <input type="checkbox"/> custom orthotics | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |
| <input type="checkbox"/> cast | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |
| <input type="checkbox"/> cane/crutches/walker | <input type="checkbox"/> no | <input type="checkbox"/> a little | <input type="checkbox"/> a lot |

John A. Nassar, M.D., P.C.

Patient Name:	Today's Date:
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Who is your Primary Care Physician?	<input type="checkbox"/> none
Date last seen?	

Height:	Weight:
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List all your MEDICAL problems:	currently being treated?
1.	<input type="checkbox"/> yes <input type="checkbox"/> no
2.	<input type="checkbox"/> yes <input type="checkbox"/> no
3.	<input type="checkbox"/> yes <input type="checkbox"/> no
4.	<input type="checkbox"/> yes <input type="checkbox"/> no
5.	<input type="checkbox"/> yes <input type="checkbox"/> no

List all your past SURGERIES :	Year	Complications?
1.	<input style="width:50px;" type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no
2.	<input style="width:50px;" type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no
3.	<input style="width:50px;" type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no
4.	<input style="width:50px;" type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no
5.	<input style="width:50px;" type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no

List all your current MEDICATIONS :	dose/frequency?	how long taking?	
1.	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>
2.	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>
3.	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>
4.	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>
5.	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>	<input style="width:100px;" type="text"/>

List all your past ALLERGIES to medications:	reaction
1.	<input style="width:100%; height: 20px;" type="text"/>
2.	<input style="width:100%; height: 20px;" type="text"/>
3.	<input style="width:100%; height: 20px;" type="text"/>

Have you experienced **ANY PROBLEMS** with the following?

General health	<input type="checkbox"/> current	<input type="checkbox"/> previously
Eyes	<input type="checkbox"/> current	<input type="checkbox"/> previously
Ear, Nose, Throat	<input type="checkbox"/> current	<input type="checkbox"/> previously
Heart Attack	<input type="checkbox"/> current	<input type="checkbox"/> previously
Irregular heart beat	<input type="checkbox"/> current	<input type="checkbox"/> previously
High blood pressure	<input type="checkbox"/> current	<input type="checkbox"/> previously
Lungs	<input type="checkbox"/> current	<input type="checkbox"/> previously
Pneumonia	<input type="checkbox"/> current	<input type="checkbox"/> previously
Shortness of breath	<input type="checkbox"/> current	<input type="checkbox"/> previously
Stomach Ulcers	<input type="checkbox"/> current	<input type="checkbox"/> previously
Acid Reflux	<input type="checkbox"/> current	<input type="checkbox"/> previously
Osteoarthritis	<input type="checkbox"/> current	<input type="checkbox"/> previously
Rheumatoid Arthritis	<input type="checkbox"/> current	<input type="checkbox"/> previously
Gout	<input type="checkbox"/> current	<input type="checkbox"/> previously
Emotional problems	<input type="checkbox"/> current	<input type="checkbox"/> previously
Psychiatric disorders	<input type="checkbox"/> current	<input type="checkbox"/> previously
Artificial bone/joints	<input type="checkbox"/> current	<input type="checkbox"/> previously
Bone Infection	<input type="checkbox"/> current	<input type="checkbox"/> previously

Circulation	<input type="checkbox"/> current	<input type="checkbox"/> previously
Stroke	<input type="checkbox"/> current	<input type="checkbox"/> previously
Seizures	<input type="checkbox"/> current	<input type="checkbox"/> previously
Diabetes	<input type="checkbox"/> current	<input type="checkbox"/> previously
Thyroid	<input type="checkbox"/> current	<input type="checkbox"/> previously
Infection	<input type="checkbox"/> current	<input type="checkbox"/> previously
Cancer	<input type="checkbox"/> current	<input type="checkbox"/> previously
Anemia	<input type="checkbox"/> current	<input type="checkbox"/> previously
Blood Clots	<input type="checkbox"/> current	<input type="checkbox"/> previously
Easy bleeding	<input type="checkbox"/> current	<input type="checkbox"/> previously
Hepatitis	<input type="checkbox"/> current	<input type="checkbox"/> previously
HIV	<input type="checkbox"/> current	<input type="checkbox"/> previously
Drug abuse	<input type="checkbox"/> current	<input type="checkbox"/> previously
Alcohol abuse	<input type="checkbox"/> current	<input type="checkbox"/> previously
Liver	<input type="checkbox"/> current	<input type="checkbox"/> previously
Kidneys	<input type="checkbox"/> current	<input type="checkbox"/> previously
Urinary Tract	<input type="checkbox"/> current	<input type="checkbox"/> previously
Bowels	<input type="checkbox"/> current	<input type="checkbox"/> previously

Patient Name: _____	Today's Date: _____
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Surgical Risk Factors:

Have you experienced any of the following?

Please Explain any yes answers:

Blood clot in your legs or lungs	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Problems with excessive bleeding	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Latex allergy	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Sleep Apnea	<input type="checkbox"/> no	<input type="checkbox"/> yes	Do you use a CPAP? <input type="checkbox"/> no <input type="checkbox"/> yes
Problems with anesthesia	<input type="checkbox"/> no	<input type="checkbox"/> yes	
MRSA Infection	<input type="checkbox"/> no	<input type="checkbox"/> yes	

Women only:

Are you pregnant?	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Have you reached menopause?	<input type="checkbox"/> no	<input type="checkbox"/> yes	

Family History:

Family History of: Anesthesia Problems Abnormal Blood Clots Abnormal Bleeding

Major Medical Problems

Age of Death

Cause of Death

Father _____
Mother _____
Siblings _____
Children _____

Social History:

Occupation: _____					
Work Status:	<input type="checkbox"/> full time	<input type="checkbox"/> part time	<input type="checkbox"/> disabled		
Marital Status:	<input type="checkbox"/> single	<input type="checkbox"/> married	<input type="checkbox"/> divorced	<input type="checkbox"/> separated	<input type="checkbox"/> widowed
Do you have children?	<input type="checkbox"/> no	<input type="checkbox"/> yes	How many?		
Do you live alone?	<input type="checkbox"/> no	<input type="checkbox"/> yes			

Do you exercise?

no

yes

How often?

daily

weekly

rarely

never

What type of exercise?

Do you smoke?

no

yes

How many packs per day?	For how many years?
Previously smoked _____ packs per day, for _____ years.	
Quit smoking? <input type="checkbox"/> this year <input type="checkbox"/> 1 year ago <input type="checkbox"/> 5 years ago <input type="checkbox"/> >10 years ago	

Do you drink alcoholic beverages? <input type="checkbox"/> no <input type="checkbox"/> yes				
How often?	<input type="checkbox"/> daily	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly	<input type="checkbox"/> rarely
How many drinks?	<input type="checkbox"/> 1	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-6	<input type="checkbox"/> >6

Do you have a history of any alcohol, substance, or drug abuse?

no

yes

current

previous

My signature below indicates that I have provided an accurate and complete medical history:

Signature _____ **Date** _____

Printed Name _____