PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Social Security Number _____ Male ☐ Female ☐

Referred by _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race ☐ American Indian ☐ Asian ☐ Black/African American

☐ Pacific Islander ☐ White ☐ Decline to specify

Ethnicity Hispanic or Latino ☐ Yes ☐ No

☐ Decline to specify Primary language _____

Patient resides in ☐ Private Home ☐ Facility ☐ Independent living

Address where patient resides _____

Unit # _____ Gate Code # _____ City _____ State _____ Zip _____

Patient Home Phone _____ Mobile Phone _____

Facility Name _____ Phone _____ Fax _____

Facility contact name _____ Phone _____

Case manager name _____ Phone _____

Guardian name _____ Phone _____

Primary emergency contact name _____ Phone _____

☐ I DO have an active Medical Power of Attorney (MPOA) making all of my medical decisions on my behalf (MPOA documents required).

MPOA Name _____ Phone _____

Address _____ Email _____

☐ I DO NOT have an active Medical Power of Attorney (MPOA). I am solely responsible for making all medical decisions for myself.

I give Geriatric Solutions permission to discuss my personal health information, which may contain confidential HIV/AIDS-related information, communicable-disease-related information, and information relating to mental health and/or alcohol/drug use, with the following individual(s) and/or organization(s):

Name _____ Relation _____ Phone _____ ☐ Ok to leave message

Name _____ Relation _____ Phone _____ ☐ Ok to leave message

Name _____ Relation _____ Phone _____ ☐ Ok to leave message

Name _____ Relation _____ Phone _____ ☐ Ok to leave message

The above-mentioned individual(s) is/are granted access to the below selected categories of my Health Record:

☐ Entire record ☐ Test Results ☐ Appointments ☐ Medications

☐ Billing ☐ Other:_____

GERIATRIC
SOLUTIONS

1510 E. Flower St. Phoenix, AZ 85014 (602) 954-0444 FAX (602) 952-7146 **geriatricsolutions.org**

A program of Hospice of the Valley

Patient Name _____ Date of Birth _____

I give Geriatric Solutions permission to communicate messages regarding appointments, referrals, and test results as follows:

☐ You may leave messages on my voice mail. Phone _____

☐ Other (please specify) _____

☐ I give permission for medical records to be mailed to my home, if requested, by phone or fax.

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing Geriatric Solutions in writing, which will take effect on the date of receipt by Geriatric Solutions. This document replaces and nullifies any previous designations made.

Patient Signature _____ Date _____

Patient Representative/MPOA Signature _____ Date_____
(if applicable)

INSURANCE INFORMATION

Guarantor Information (if not patient)

Bill to _____ Email _____

Address _____ City _____ State _____

Zip _____ Home phone _____ Mobile/Work _____

Relationship to Patient _____

Primary Insurance

Medicare ID (Required) _____

Subscriber name _____ ☐ Self ☐ Other _____

Plan Name _____ Group #/Name _____

Policy ID # _____ Phone _____

Address _____

Secondary Insurance

Subscriber name _____ ☐ Self ☐ Other _____

Plan Name _____ Group #/Name _____

Policy ID # _____ Phone _____

Address _____

Tertiary Insurance

Subscriber name _____ ☐ Self ☐ Other _____

Plan Name _____ Group #/Name _____

Policy ID # _____ Phone _____

Address _____

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

Patient Representative/MPOA Signature _____ Date _____

☐ I hereby authorize release of medical information necessary for direct payment to Geriatric Solutions HOV, LLC.

☐ I understand I am ultimately responsible for my bill whether or not covered by my insurance.

Insured Signature _____ Date _____

Patient Representative/MPOA Signature _____ Date _____

MEDICAL HISTORY

Previous Primary Care Provider (PCP) _____ Phone _____

Fax _____ Address _____

Drug Allergies/Sensitivities _____

Pharmacy name _____ Address _____

Phone _____ Fax _____

Pharmacy name _____ Address _____

Phone _____ Fax _____

Patient Height _____ Patient Weight _____

Chronic Medical Problems List	

Surgical History	Date

Hospitalizations	Date

Patient Name _____ Date of Birth _____

Specialist (Name)	Specialist Address/Phone

Which medical conditions do you have now or have you had in the past? Please check all that apply.

Gastrointestinal Tract

- ☐ None
- ☐ Heartburn/Reflux/GERD
- ☐ Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Liver Disease/Cirrhosis
- ☐ Diverticulitis
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Other (Specify)

_____

Heart

- ☐ None
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Aortic Stenosis
- ☐ Heart Valve Program
- ☐ Angina
- ☐ High Cholesterol
- ☐ Heart Murmur

Nervous System

- ☐ None
- ☐ Dementia or Alzheimer's Disease
- ☐ Parkinson's disease
- ☐ Stroke
- ☐ Epilepsy or seizures
- ☐ Neuropathy/nerve damage
- ☐ Depression
- ☐ Anxiety
- ☐ Other (specify)

_____

Endocrine

- ☐ None
- ☐ Thyroid overactive (high)
- ☐ Thyroid underactive (low)
- ☐ Diabetes
- ☐ Other (specify)

_____

Eye & Ear

- ☐ None
- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Hearing aid
- ☐ Other (specify)

_____

Kidney & Urinary Tract

- ☐ None
- ☐ Frequent Bladder Infections
- ☐ Kidney Disease
- ☐ Enlarged Prostate
- ☐ Urinary Incontinence
- ☐ Kidney Stones
- ☐ Other (specify)

_____

Lungs

- ☐ None
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Respiratory Disease
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Aspiration Pneumonia

Podiatry

- ☐ None
- ☐ Bunions
- ☐ Corns
- ☐ Hammertoes
- ☐ Plantar Fasciitis
- ☐ Warts
- ☐ Others (specify)

_____

Bones & Joints

- ☐ None
- ☐ Gout
- ☐ Lower Back Pain
- ☐ Osteoporosis
- ☐ Arthritis (indicate location)

_____

- ☐ Joint Pain (indicate location)

_____

Patient Name _____ Date of Birth _____

Other Health Problems

- ☐ None
- ☐ Thrombosis/Blood Clots
- ☐ Syncope (loss of consciousness)
- ☐ Fainting
- ☐ Anemia
- ☐ Hernia

Cancer (indicate location)

- ☐ None
- ☐ Breast
- ☐ Skin
- ☐ Prostate
- ☐ Colon/Rectum
- ☐ Lung

MEDICATION LIST

Name of Medication	Dosage	Frequency

MEDICAL TESTING

Mammogram	Date _____	Pap smear	Date _____	X-Ray	Date _____
Colonoscopy	Date _____	Blood work	Date _____	Bone density	Date _____
Echocardiogram	Date _____	Dental exam	Date _____	Vision testing	Date _____
Skin cancer screening	Date _____				
Prostate exam/PSA	Date _____				

VACCINATIONS

PNA (pneumonia)	Date _____	Flu (Influenza)	Date _____
Tetanus (Tdap)	Date _____		
Shingles (Zostavax)	Date _____		

Patient Name _____ Date of Birth _____

ACTIVITIES OF DAILY LIVING (CHECK ALL THAT APPLY)

Bowels
- ☐ Continent of bowels
- ☐ Incontinent of bowel at all times
- ☐ Occasional bowel incontinence

Urine
- ☐ Continent of urine
- ☐ Incontinent of urine
- ☐ Occasional incontinence

Ambulatory
- ☐ Ambulatory
- ☐ Non-ambulatory
- ☐ Bed-confined

Transfers
- ☐ Does not require assistance
- ☐ Requires minimal assistance
- ☐ Requires moderate assistance
- ☐ Requires 100% assistance
- ☐ Bed-confinement status

Bath/Grooming
- ☐ Does not require assistance
- ☐ Requires assistance
- ☐ Independent with dressing and grooming
- ☐ Requires assistance with dressing and grooming

Diet
- ☐ Regular
- ☐ Pureed
- ☐ Thickened liquids
- ☐ Special diet

_____

Feeding
- ☐ Independent
- ☐ Requires assistance
- ☐ Requires cueing

Assisted Device
- ☐ Wheelchair
- ☐ Walker
- ☐ Cane
- ☐ Motorized scooter

ADDITIONAL COMMENTS