Arizona Specialized
GYNECOLOGY

DR. JOSEPH BROOKS, M.D.
300 West Clarendon Avenue , Suite 100
Phoenix, Arizona 85013
(602) 265-1112
ArizonaSpecializedGynecology.com

New Patient Record

Today's Date: ____________________
(la fecha)

Patient Info

First Name: ____________________
(nombre)

Last Name: ____________________
(apellido)

DOB: ____________ SS#: ____________
(fecha de nacimiento) (numero de seguro social)

Address: ____________________
(direccion)

City: ____________________
(ciudad)

State: ____________ Zip: ____________
(estado) (numero de zona postal)

Home Phone: ____________________
(numero de telefono)

Cell Phone: ____________________
(numero de celular)

Work Phone: ____________________
(numero de trabajo)

Employer: ____________________
(nombre de trabajo)

Employer Phone: ____________________
(numero de trabajo)

Responsible Party (la persona responsable)

Name: ____________________
(nombre)

DOB: ____________ SS#: ____________
(fecha de nacimiento) (numero de seguro social)

Address: ____________________
(la direccion de la persona responsable)

Employer: ____________________
(empleado)

Employer Phone: ____________________
numero de telefono)

Allergies

1. ____________________
2. ____________________
3. ____________________

Referring Doctor (nombre del doctor que le deo referencia)

Referring Dr.: ____________________

Phone (numero de telefono): ____________________

Address (direccion): ____________________

City (ciudad): ____________________

State: ____________ Zip: ____________
(estado) (numero de zona postal)

Primary Insurance (primer seguro)

Name of Insurance: ____________________

ID#: ____________________

Group # (numero de grupo): ____________________

Phone: ____________________

Cardholder: ____________________

Cardholder's DOB: ____________________

Copay $ ____________________

Secondary Insurance (seguro segundo)

Name of Insurance: ____________________

ID#: ____________________

Group # (numero de grupo): ____________________

Phone: ____________________

Cardholder: ____________________

Cardholder's DOB: ____________________

Copay $ ____________________

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Examination Consent

I hereby consent to an examination(s) and diagnostic procedures by Joseph Brooks, M.D. and any assistant(s) he may require for diagnostic treatment. I understand that he frequently has nursing students and Doctors rotate through his office for learning purposes. I may opt not to have them present at the time of my exam and will notify the Dr. or his assistant immediately. Otherwise, I consent to treatment

Signature: ______________________________ Date: ____________________
(su firma dandole Dr. Brooks permiso para su examen) (la fecha)

Records Release: Copies and Verbal

I hereby authorize the office of Joseph Brooks, M.D. to release any and all medical information including all information referencing drug, alcohol abuse, mental health and HIV status to my insurance company necessary to process claims or for any other needs they may have. This also includes transfer of records for prior authorization requests. This authorization may also be used to send medical records to my referring physician or Primary Care Physician. T here are times that Dr. Brooks may refer his patients' to another physician for specialty care of a different type. This physician may need medical records first, by signing below you give permission for the office of Dr. Brooks to send your records. M y signature below will act as my consent each time my records are requested during my care with Joseph Brooks, M.D. (unless I have made a special request) and will be in effect throughout my care in his office. I f necessary these records may be faxed to any of the above mentioned facilities using my signature below as consent. The office of Joseph Brooks, M.D. will not use your name or any medical information with your name for any type of advertisement.

I hereby authorize the office of Joseph Brooks, M.D. to release any medical information verbally. This includes information to my insurance company necessary to process any claims or for prior authorization. Information may be shared verbally with my referring physician, primary care physician, or any office that Dr. Brooks has referred me to. This includes any insurance company I am applying to, laboratories, pharmacies, Testing.

Signature: ______________________________ Date: ____________________
(su firma para mandar copia de su documento medico a otra oficina medico y seguro) (la fecha)

Direct Payment

I hereby authorize direct payment to Joseph Brooks, M.D. (Arizona Vulva Clinic,PLLC). for the surgical and /or medical treatment I receive in his office. If any, otherwise payable to me under terms of my insurance. I understand that if he does not participate with my insurance I am fully responsible for payment at the time of service.

Signature: ______________________________ Date: ____________________
(su firma para pago directo al Dr. Brooks de su seguro) (la fecha)

*** PLEASE KEEP IN MIND THAT NO NAMES, NUMBERS OR PATIENT INFORMATION IS EVER USED FOR THE STATEMENT BELOW***

Photographs / Slides

IT HAS BEEN EXPLAINED TO ME THAT DURING MY EXAMINATION PHOTOGRAPHS OR VIDEO TAPING MAY NEED TO BE DONE. I HAVE BEEN ASSURED THAT THESE PHOTOS DO NOT HAVE MY NAME OR AN I.D. (OF ANY TYPE) THAT INDICATE THEY ARE OF ME. I UNDERSTAND THAT THE VIDEOTAPING AND PHOTOS (SLIDES) ARE FOR EDUCATIONAL TEACHING ONLY. I FULLY UNDERSTAND THAT THESE PHOTOS THAT ARE MADE INTO SLIDES ARE NONRETURNABLE TO THE PATIENT.

Signature: ______________________________ Date: ____________________
(su firma para crear video durante una serugia y fotos de examen. La oficina de Dr. Brooks no usa nombres o numero de identificacion. Solamente usamos los videos y fotos para educacion. Estos videos y fotos no se venden y no se restituible a las pacientes.)

PLEASE NOTE THAT DR. BROOKS' CHARGES ARE NOT IN ANY WAY CONNECTED TO OUTSIDE CHARGES SUCH AS: LABORATORIES, RADIOLOGY DEPARTMENTS PATHOLOGY DEPARTMENTS AND / OR PHARMACIES. Recuerde que los cobros solamente son de Dr. Brooks.