

Appt date:

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Brad Williams MD, PhD450 S. Willard St, #115 Cottonwood AZ 86326
(928) 634-0323 FAX 634-1144**PATIENT INFORMATION**

Ref Provider:	PCP:	DOB	Age:
Name:	SS#:	Sex: M/F	Marital:
Address:	Home #: () -		
Parent/Legal Guardian Name:	Phone:	Work #:	Cell:
Emergency Contact:	/	, Contact Phone:	Caregiver <input type="radio"/> Nursing Home <input type="radio"/>
May we leave a message @ your home: <input type="radio"/> YES <input type="radio"/> NO			

EMPLOYMENT INFORMATION

Employment Status:	
Employer:	Work Phone:
Is this a Workers Compensation Case? <input type="radio"/> YES <input type="radio"/> NO	

RESPONSIBLE PARTY

Account #	Name:	Relationship:
Address:	SS#:	DOB:
Phone:	<i>Patient authorizes this office to discuss their treatment with :</i>	

INSURANCE INFORMATION

<input type="radio"/>	Worker's Comp:	Adjuster/Ph#:
<input type="radio"/>	Primary Insurance:	Policy/Subscriber:
Address:	Insured Policy ID:	
City, State, Zip:	Group Number:	
Plan Phone:	Date of Birth:	
Effective Dates:	Patient Relationship to Subscriber:	
<input type="radio"/>	Second Insurance:	Policy Subscriber:
Address:	Insured Policy ID:	
City, State, Zip:	Group Number:	
Plan Phone:	Date of Birth:	
Effective Dates:	Patient Relationship to Subscriber:	

ADDITIONAL INFORMATION

Patient are required to keep their follow-up appointments, including but not limited to keeping appointments with PCPs, Physical Therapists or specialists you have been referred to – Patients are required to call the office at least 24hrs. in advance of their appointment if they are unable to make it. Patients agree to take an active part in their follow up care by complying with the recommended plan of care and, follow medical instructions.

MEDICATION REFILLS 24 – 48 hour notice is required for all medication refills. Refills will not be issued on Fridays, weekends or after business hours. The doctor will not be paged for medication refills— **NO EXCEPTIONS.**

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize Brad Williams MD PhD to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges., authorize Brad Williams MD PhD to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me. I acknowledge the privacy practice is located in the lobby and a copy will be provided upon request.

Print Name

X

Patient or Legally Authorized Individual Signature

NAME: _____

REASON FOR VISIT: _____ RIGHT LEFT BOTH

DATE OF INJURY: _____ OR WHEN DID PROBLEM START: _____

Current problem is the result of : car accident work accident accident gradual onset other

Have any X-rays or MRI's already been taken recently YES NO Date taken _____ Where/Facility _____

List all medications & supplements, dose & quantity you take on a daily basis with reason

PHARMACY OF CHOICE: _____ LOCATION _____

MEDICATION	DOSE	QTY	REASON	MEDICATION	DOSE	QTY	REASON

MEDICAL ALLERGIES YES NO If yes please list medical allergies and your reaction to the medication

ALLERGY	REACTION	ALLERGY	REACTION

PAST MEDICAL HISTORY

Surgeries, Hospitalization & Medical History	Year	Surgeries, Hospitalization & Medical History	Year

Any complications during your Surgeries & or Hospitalization: Y N _____

Have you ever had general anesthesia? Y N Problems? Y N _____

CURRENT OR PREVIOUS PROBLEMS:

- Eyes Y N Blackout/fainting Y N
- Ears/Nose/Throat Y N Digestion Y N
- Bowel movement Y N Arthritis Y N
- Diabetes Y N TB Y N
- Balance problems Y N Fibromyalgia Y N
- Numbness/tingling Y N Hepatitis Y N
- Psych problems Y N Lungs/Breathing Y N
- AIDS Y N Cancer Y N
- Bladder problems Y N Polio Y N
- High Blood Pressure Y N Epilepsy Y N
- Bleeding problems Y N High Cholesterol Y N
- Blood Clots Y N Shingles Y N

HISTORY:

Family History (Close blood relatives) Check all that apply
Heart Disease__ Diabetes__ Cancer__ Thyroid Disease__
Neurological__ High Blood Pressure__ Tuberculosis__
Kidney Disease__ Blood Disease__ Mental Illness__ Blood Clots__

Social History: Employed (occ)_____ Ret.____ Student____
Single__ Married__ Divorced__ Separated__ Widowed____
Do you live alone Y/N Pregnant (Female) Y/N Children Y/N Number ____

Exercise Daily__ Weekly__ Monthly__ Rarely__ Never__
What type Exercise/Sports/Activiites _____

Smoke Currently Y/N ____ Packs per day for ____ years
Quit Smoking This year__ > 1 year__ > 5 years__ > 10 years__ Other__

Previously Smoked ____ Packs per day for ____ years

Drink Alcohol Daily__ 1-2x/week__ 1-2x/month__ 1-2x/year__

Recreational Drugs Y/N
Currently using drugs ____ Drug of Choice _____

Patient/Legal Guardian's Signature: _____ Date: _____