AMG Senior Medical Group

Tel: 801-716-7008 434 W. Ascension Way #225 info@asf-amg.com
Fax: 888-990-1557 Murray, UT 84123 www.amgseniormedical.com

Patient Demographics

Name: _____ **DOB:**_____**Gender**:_____

SSN: _____ **Facility Name:**_____

Mailing Address: _____

Billing Address: _____

Patient Phone: _____(May we leave detailed voicemails?) **YES** ____ **NO** ____

Primary Contact: _____ **Relationship:** _____

Primary Contact email: _____

Contact Phone:_____(May we leave detailed voicemails?) **YES** ____ **NO** ____

Would you like to be contacted for appointment reminders? YES ____ **NO** ____

Would you like access to our online patient portal? (Must have email access) **YES** ____ **NO** ____

Please list your Preferred Pharmacy (with address)

_____

Race: (Please Check One)
- ☐ American Indian /Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Decline to Specify

Ethnicity: (Please Check One)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Specify

Height: _____

Weight: _____

Tobacco History:
- ☐ Never Smoker
- ☐ Current Smoker
- ☐ Previous Smoker

Quit Date: _____
Number of years? _____
Number of packs per day? _____

Insurance

(Fill in below and send copies of insurance cards, front and back)

Medicare #: _____ **Medicaid #:** _____

Private/Supplemental Insurance: _____

Policy #: _____ **Group #:** _____

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Consent Form

Use and Disclosure of Protected Health Information
I, the below signed voluntarily consent and authorize Amazing Medical Associates INC d/b/a AMG Senior Medical Group (AMG going forward) to use and disclose my Protected Health Information to carry out medical treatment, payment and healthcare operations.

Authorization for Insurance Payment
We will bill your insurance; however, the insurance company makes the final determination of your eligibility. I agree to pay any portion of the charges not covered by insurance. I authorize payment of insurance benefits to AMG for services provided to me.

Authorization to Leave Voice Mail and/or Email
I authorize AMG staff to leave messages by voice or email at my home reminding me of scheduled medical appointments and other medical services for myself and/or my family members. I understand, however, that no message will be left regarding confidential medical information unless specifically authorized by my doctor and myself.

Disputes:
You should notify us of discrepancies immediately. To initiate a dispute, please email our Executive Director, Nathan Blasier, at nblasier@asf-amg.com or call 801-716-7008.

Consent to Treat:
I voluntarily request a physician or nurse practitioner and other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care with this practice. I understand if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). You have the right to discuss all treatment plans with your practitioner. If you have concerns regarding any test or treatment recommended by your health care practitioner, we encourage you to ask questions.

By signing this form, I voluntarily consent to AMG's use and disclosure of my protected health information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing. I understand this consent will be valid and will remain in effect if I am a current patient of AMG. I understand I have the right to review the Notice of Privacy Practices for a more complete description of such uses and disclosures prior to signing this consent. I have read this form, or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Printed Name and Relationship	Signature	Date

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Patient Diagnosis Checklist

Name: _____ **DOB:**_____**Gender:**_____

Phone:_____**Insurance:**(with policy number)_____

Please circle any current disease/symptom you currently have or have had in the last 12months.

☐ Cancer	☐ Anxiety	☐ Congestive Heart Disease	COPD ☐
☐ Liver Disease	☐ Depression	☐ Stroke	☐ Renal Disease
☐ Heart Murmur	☐ Suicidal Thoughts	☐ Diabetes	☐ Dementia/Alzheimer's
☐ Epilepsy	☐ Racing Thoughts	☐ Immune Disorder	☐ Pneumonia
☐ Asthma	☐ Insomnia	☐ Varicose Veins	☐ Fibromyalgia
☐ Hypertension	☐ Recurrent Infection	☐ Thyroid Problems	☐ Chronic Pain
☐ Abnormal Chest X-Ray	☐ Shortness of Breath	☐ Vision Loss	☐ Chronic Wound
☐ Anorexia	☐ Stomach problems	☐ Edema	☐ Recurrent Falls
☐ Unsteady Gait	☐ Weakness	☐ Dialysis	☐ Chemo/Radiation

Please circle if you have had any of the following in the last 6 months.

☐ Recurrent ER Use ☐ Skilled Nursing Facility Stay Rehabilitation Facility Stay ☐

☐ Increase in medications Hospice Assistance ☐ Home Health Assistance ☐

Preferred Hospital: _____PCP Name:_____

PCP Practice Name: _____ PCP Number: _____

Home Health/Hospice Agency used: _____ Date of discharge: _____

Skilled Nursing/Rehabilitation Facility used: _____Date of discharge: _____

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Medication /Allergy List

Patient Name: _____ DOB: _____

CURRENT PRESCRIPTION MEDICATIONS

(may attach med list if you prefer)

Name of Medication	Strength of Medication	Frequency
Example: Lisinopril	*Example: 10 mg*	*Example: 1 pill every morning*

CURRENT OVER-THE-COUNTER MEDICATIONS AND SUPPLEMENTS

Name of Medication/Supplement	Strength of Medication	Frequency

ALLERGIES

□ No Known Drug Allergies □ Environmental/Seasonal Allergies □ Latex Allergy

List Allergies	Reaction

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Release of Information Form

I, _____ DOB: _____ hereby authorize and request for:

(please list providers you've seen in the last 18 months)

Provider	Phone	Address
Provider	Phone	Address
Provider	Phone	Address

To release all medical records in your possession, concerning my illness and/or treatment during the past 2 (two) years from this request to the below named.

AMG Senior Medical Group
434 West Ascension Way, Suite 225
Murray, UT 84123

Secure Fax: 888-990-1557

Secure Email: schedule@asf-amg.com

Signature of Responsible Party: _____ Relationship: _____

Print Name of Responsible Party: _____ Date: _____

Who may we share your protected health information with? ** If an individual is not listed, we will not release any information about you. **		
Name:	**Relation:**	**Phone Number:**