



# The Wellness Medical Clinic

1880 W Frye Road, Suite #1  
Chandler, AZ 85224  
Phone (480) 821-5500 -- Fax (480) 821-5502  
www.primarycarechandler.com

Ammar Alshiekh, MD  
Melissa L. Brown, FNP  
Morgan Adelman, PA

## Patient Information Sheet

Patient's Name : \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**LAST FIRST MIDDLE**

**Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Sex:** Male **Marital Status:** ( ) Single ( ) Married ( ) Divorced ( ) Widowed  
Female

**Address:** \_\_\_\_\_  
**STREET CITY STATE ZIP CODE**

**Primary Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Alternative Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_ **Student:** Yes / No **If YES:** Full-time/Part-time

**How did you hear about our CLINIC?**  
( ) By Friend ( ) Insurance Company ( ) Doctor: \_\_\_\_\_ ( ) Advertisement ( ) Other : \_\_\_\_\_

**Do you have a Primary Care Physician?** Yes / No, **If YES,** which Dr? \_\_\_\_\_

Dr's Address: \_\_\_\_\_ Phone# \_\_\_\_\_

Fax# \_\_\_\_\_

**Emergency Contact Information:** In Case of Emergency please contact .....

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

### Employment Information:

**Employer Name:** \_\_\_\_\_ **Employer Phone #:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_ **Position:** \_\_\_\_\_

### Insurance Information:

**Insurance Company's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Policy # / Ins ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Insurance Address:** \_\_\_\_\_

**Policy Holder's Relation to Patient:** ( ) Self ( ) Spouse ( ) Dependent ( ) Other

**Do you have a SECONDARY insurance?** Yes / No **If YES,** please fill out the following:

**Insurance Company's Name:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**Policy # / Ins ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Please provide your preferred pharmacy name and location**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name of Person Completing this Form:** \_\_\_\_\_

**Relation to Patient:** \_\_\_\_\_

**Signature of Person Completing this Form:** \_\_\_\_\_



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I hereby authorize **The Wellness Medical Clinic** to leave a detailed voice message on my answering machine regarding any medical information they may have. The number (s) acceptable to leave a voicemail are:

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Alternative Phone:** \_\_\_\_\_

**Please provide us with the names of any person or persons are allowed to share your medical information with, otherwise we may not do so even with a spouse or relative without this authorization.**

**I hereby authorize:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To receive any information concerning my medical condition or treatment at The Wellness Medical Clinic.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient's Printed Name:** \_\_\_\_\_



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### Appointment and Payment Policies

Thank you for choosing us as your Primary Care Provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have up-to-date insurance card, payment in full for each visit is required until we can verify you coverage. Knowing your insurance benefit is **YOUR** responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Co-payments and deductibles.** All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- 3. Non-covered services.** Please be aware that some – and perhaps all – off the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insures. You must pay for these services in full at the time of the visit.
- 4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- 6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **45 days**, the balance will automatically be billed to you.
- 7. Nonpayment.** If your account is over **90 days** past due, you will receive a letter stating that you have **20 days** to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. The collection agency we work with has their own surcharges that would be added to your account balance if this were to happen, those charges would be the sole responsibility of the patient. You and your immediate family members may be discharged from this practice as well for nonpayment. If this is to occur, you will be notified by regular and certified mail that you have **30 days** to find alternative medical care. During that **30-day** period, our physician will only be able to treat you on an emergency basis.
- 8. Missed appointments.** Our policy is to charge **\$50.00** for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our areas.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guideline.**

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Signature of patient or responsible party

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Date



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### HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, or U.S. mail; or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, \_\_\_\_\_, date \_\_\_\_\_ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**



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<b>Patient Name</b> <hr/> <b>Date of Birth</b> <hr/>	<b>Guardian / Support Role (if appropriate)</b> <b>Name:</b> _____ <b>Relationship:</b> _____ <b>Role:</b> <input type="checkbox"/> Next of Kin <input type="checkbox"/> Guardian <input type="checkbox"/> Caregiver
---	--

**Please provide as much detail as you are able so that we can give you the safest and best care possible.**

**What is the primary reason for your visit today?**

---

**MEDICATIONS**

**Please list any medications you are taking, with dose and frequency.**

Medication	Dosage	#per Day	Do you need refills?
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____

**Please list Vitamins, Supplements and Over the Counter Medicines**

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**ALLERGIES**



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**Please list any allergies and intolerances to medications.**

**Allergy**

**Reaction**

_____	_____
_____	_____
_____	_____

Do you have an Egg, Neomycin or Gelatin allergy?  
Do you have an allergy to intravenous contrast?

**No** \_\_\_\_\_ **Yes** \_\_\_\_\_  
**No** \_\_\_\_\_ **Yes** \_\_\_\_\_

**Please list any allergies to food or the environment.**

**Allergy**

**Reaction**

_____	_____
_____	_____
_____	_____

**MEDICAL HISTORY**

What **medical** problems have you had? Please mark **all that apply**:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Heart Attack    |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Cancer (type) _____   | <input type="checkbox"/> GERD - reflux       | <input type="checkbox"/> Osteoarthritis  |
| <input type="checkbox"/> Angina               | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Hepatitis C         | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> COPD                  | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Kidney Disease  |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Crohn's Disease       | <input type="checkbox"/> Irritable Bowel     | <input type="checkbox"/> Seizure Disease |
| <input type="checkbox"/> Atrial Fibrillation  | <input type="checkbox"/> Depression            | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Prostate Enlargement | <input type="checkbox"/> Diabetes (Type) _____ |  |  |

Other medical problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**SURGICAL HISTORY**

What **surgeries** have you had? Please mark **all** that apply and include the year that were performed, if possible.

- |  |   |
|--|---|
| <input type="checkbox"/> Angioplasty _____         | <input type="checkbox"/> Gastric Bypass _____   |
| <input type="checkbox"/> Angio w/ Stent _____      | <input type="checkbox"/> Hernia Repair _____    |
| <input type="checkbox"/> Appendectomy _____        | <input type="checkbox"/> Knee Replacement _____ |
| <input type="checkbox"/> Arthroscopic Knee _____   | <input type="checkbox"/> LASIK _____            |
| <input type="checkbox"/> Back Surgery _____        | <input type="checkbox"/> Liver Biopsy _____     |
| <input type="checkbox"/> Heart Bypass _____        | <input type="checkbox"/> Pacemaker _____        |
| <input type="checkbox"/> Carpal Tunnel _____       | <input type="checkbox"/> Bowel Resection _____  |
| <input type="checkbox"/> Cataract Extraction _____ | <input type="checkbox"/> Thyroidectomy _____    |
| <input type="checkbox"/> Gallbladder Removal _____ | <input type="checkbox"/> Tonsillectomy _____    |

**Men Only:**

- |  |  |
|--|--|
| <input type="checkbox"/> Prostate Biopsy _____         |  |
| <input type="checkbox"/> Transurethral Resection _____ | <input type="checkbox"/> Vasectomy _____ |

**Women Only:**

- |   |  |
|---|--|
| <input type="checkbox"/> Augmentation Mammoplasty _____ | <input type="checkbox"/> Mastectomy _____            |
| <input type="checkbox"/> Bilateral Tubal Ligation _____ | <input type="checkbox"/> Myomectomy _____            |
| <input type="checkbox"/> Breast Biopsy _____            | <input type="checkbox"/> Reduction Mammoplasty _____ |
| <input type="checkbox"/> Cesarean Section _____         | <input type="checkbox"/> TAH/BSO _____               |
| <input type="checkbox"/> Dilation and Curettage _____   | <input type="checkbox"/> Vaginal Hysterectomy _____  |
| <input type="checkbox"/> Hysterectomy _____             | <input type="checkbox"/> Last Menstrual Cycle _____  |

Other surgeries:

\_\_\_\_\_  
\_\_\_\_\_

Have you had any recent hospitalizations or ER visits?

\_\_\_\_\_  
\_\_\_\_\_



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**FAMILY HISTORY**

**Mother:**

**Alive**  **Deceased** (age at death )  **Cause of Death**\_\_\_\_\_

Medical Problems \_\_\_\_\_

**Father:**

**Alive**  **Deceased** (age at death )  **Cause of Death**\_\_\_\_\_

Medical Problems \_\_\_\_\_

**Siblings:**

Number of Brothers  Medical Problems \_\_\_\_\_

Number of Sisters  Medical Problems \_\_\_\_\_

**Children:**

Number of Sons  Medical Problems \_\_\_\_\_

Number of Daughters  Medical Problem \_\_\_\_\_

Have any of the women in your family had a heart attack/heart disease at age 65 or younger?

**No**  **Yes**

Have any of the men in your family had a heart attack/heart disease at age 55 or younger?

**No**  **Yes**

Any additional pertinent family history:

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

**Marital Status** \_\_\_\_\_

**Occupation** \_\_\_\_\_

**Employer** \_\_\_\_\_

**Exercise?**  No  Yes

Type \_\_\_\_\_

Hours per Week \_\_\_\_\_

**How many people other than you reside in your household?**

Spouse  Children  Grandparents  Other

**Do you have advance directives?**

**Do you have any religious beliefs that could affect your medical care?**

\_\_\_\_\_



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**TOBACCO/ALCOHOL/CAFFEINE/DRUGS**

Please check your **current Tobacco** status.     **Current**     **Never**     **Former**

Do you use **Alcohol**?     **No**     **Yes**

**Type** \_\_\_\_\_ **Amount** \_\_\_\_\_ **Frequency** \_\_\_\_\_

Do you use **Caffeine**?     **No**     **Yes**

**Type** \_\_\_\_\_ **Amount** \_\_\_\_\_ **Frequency** \_\_\_\_\_

Do you use **Illicit Drugs**?     **No**     **Yes**

**Type** \_\_\_\_\_ **Amount** \_\_\_\_\_ **Frequency** \_\_\_\_\_

**OTHER**

Do you use contraceptives?  
 No     Yes    Type: \_\_\_\_\_

Who is your **dentist**? \_\_\_\_\_

**Telephone:** \_\_\_\_\_

Do you have any dental/oral problems? \_\_\_\_\_

**PREVENTIVE CARE HISTORY**

**INDICATE DATE OF YOUR LAST:**

Tetanus Vaccine: _____	Colonoscopy: _____
Influenza Vaccine: _____	Stool Check for Blood: _____
Pneumonia Vaccine: _____	Prostate Check: _____
Shingles Vaccine: _____	Mammogram: _____
EKG/Heart Stress Test: _____	Pap Smear: _____
Chest Xray: _____	Bone Density/DEXA: _____
Visit with Eye Doctor: _____	Visit with Dentist: _____

**In the past 2 weeks, have you had little interest or pleasure in doing things?**  
 (0) Not at all     (1) Several days     (2) More than half the days     (3) Nearly every day

**In the past 2 weeks, have you been feeling down, depressed, or hopeless?**  
 (0) Not at all     (1) Several days     (2) More than half the days     (3) Nearly every day



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**Consent for Release of Patient Medical Records**

Upon change of physician we recommend that you have copies of your medical records transferred to our new provider of medical services. Having you complete medical history and pertinent records will be very valuable to your primary physician.

**Please fill out the following:**

**Patient's Full Name:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_

**Patient/Parent/Guardian Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Next of Kin** \_\_\_\_\_ **Guardian** \_\_\_\_\_ **Caregiver**  
\_\_\_\_\_ **Self**

**Date:** \_\_\_\_\_

**This is a formal request for the following records (in regards to the patient above):**

(  ) **All Available medical records**

(  ) **Any records pertaining to the following information only:**

\_\_\_\_\_

**Clinic Name:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Please send records to:**

**The Wellness Medical Clinic at 1880 W Frye Rd, Suite 1, Chandler, AZ 85224**

**Phone: 480-821-5500**

**Fax: 480-821-5502**