



SONORAN MEDICAL: TEEN PATIENT HEALTH HISTORY



Today's Date: _____

Name: _____

Name you prefer to be called: _____

Date of Birth: _____

Race: _____

Ethnicity: _____

Preferred Language: _____

Current Medications:

(include strength and how often taken)

1. _____
2. _____
3. _____
4. _____

Pharmacy Name: _____

Pharmacy Phone: (____) _____

Pharmacy Cross Streets: _____

Allergies to Medications: (include effect)

1. _____
2. _____
3. _____
4. _____

List Past Surgeries: (include year done)

1. _____
2. _____
3. _____
4. _____

List Past/Chronic Medical Problems:

1. _____
2. _____
3. _____

Have you ever had any of the following? (Dates)

Chicken Pox _____

Asthma _____

Seizure _____

Heart Problems _____

Concussion _____

Please provide a copy of your immunization records

Family History: (blood relatives only)	Was cause of death?	Relationship to you?
Heart Disease		
Cancer Breast		
Cancer Colon		
Cancer of Lung		
Cancer of Ovaries		
Cancer of Prostate		
Cancer of Uterus		
Stroke		
Depression		
Diabetes		
High Cholesterol or Triglycerides		
High Blood Pressure		
Thyroid Disease		
Other		

Social History:

Who do you live with? _____

What year are you in school? _____

Any tobacco users at home? _____

Do you have pets? _____

What Type? _____

Females:

What age did you start your period? _____

How many pregnancies? _____

Live Births: _____ Miscarriages: _____

Abortions: _____

	How much?	How often? (day/wk/mo)	Age Start - Stop
Cigarette?			-
Cigarette- If restarted			-
Cigar?			-
Chew?			-
Pipe?			-
Vape?			-
Marijuana?			-
Alcohol? Type:			-
Caffeine?			-
Illegal Drugs?			-
Other?			-



Sonoran Medical Centers
19875 N. 51st Avenue
Glendale, AZ 85308
Phone: (623) 581-8998
Fax: (623) 581-6461

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip Code: _____

I hereby authorize

Name of facility: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____ Fax: _____

to disclose the following Protected Health Information pertaining to the patient listed above to Sonoran Medical Centers.

Options below must be completed in order to release records.

For the Following Purpose:

- checkbox New Primary Care Physician
checkbox Personal Records
checkbox Consultation with Specialist
checkbox Insurance Company
checkbox FMLA/Disability
checkbox Other (Specify) _____
checkbox Other (Specify) _____

Information to be Released:

- checkbox All Records
checkbox Records from _____ to _____
checkbox Office Note
checkbox Radiology Report checkbox Lab result
checkbox Other
checkbox Billing Statements
checkbox FMLA/Disability Forms (please mark above if records to be released also)

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.

I understand that Sonoran Medical Centers will not condition treatment on whether I sign this Authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that the above-named facility has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the mailing address listed above. I understand the revocation will not apply to information that has already been released in response to this Authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives this information.

I understand that this authorization will expire one (1) year from date of signing unless specified below.

Desired Expiration Date _____

Signature _____

Date _____

Print Name _____

Relationship to Patient (if not patient) _____



Consent for Treatment of a Minor

I give permission for my child, _____, date of birth _____ to be medically evaluated and treated at Sonoran Medical Centers. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or blood test) in the course of the evaluation. I accept responsibility for provider charges and laboratory fees.

This consent applies to:

1. Complete provider check-up (including blood and urine samples)
2. Hearing, vision, and blood pressure screening
3. Immunizations (in addition to this form, parental/guardian consent for specific immunization would still be needed prior to injection)
4. First aid and emergency care
5. Prescription and treatment for illness
6. Referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

Mark **ONE** of these selections:

With Parent/Guardian Present – restricted to medical care when parent or guardian is in office (excludes emergency care and items required under Arizona/Federal laws)

Names of Parent(s)/Guardian(s) _____

Without Parent/Guardian Present

I give permission for my child to be medically evaluated and treated at Sonoran Medical Centers in my absence. My child will be accompanied by:

himself/ herself

babysitter (name) _____

other (name, relationship) _____

I give permission for the provider to share any relevant health information with the person listed above who is accompanying my child.

If there are any services that you do not consent to in your absence, please list:

This consent will remain in effect until the patient’s 18th birthday, until amended, or until revoked in writing (whichever is earlier).

Child’s name

Today’s Date

Parent or Guardian Signature

Parent or Guardian Name

