ESSENTIAL
FAMILY HEALTH & WELLNESS

Congratulations on your decision to move further on the path to optimal health! We're here to educate and support you as part of our commitment to partnering with you to bring about better health. Please fill out this form as completely and as accurately as possible.

GENERAL INFORMATION

Date: _____

Name _____ Preferred Name: _____

Primary Street Address _____ Unit No. _____

City _____ State _____ Zip Code _____

Date of Birth _____ SS# _____

Age _____ ☐ Female ☐ Male Ethnicity _____

Home Phone _____ Relationship/Marital Status _____

Cell Phone _____ Best way to reach you _____

Work Phone _____ Best time to reach you _____

Email Address _____

Current Occupation _____ Employer _____

Emergency Contact

Name _____ Phone _____

Relationship _____

Address _____ Unit No. _____

City _____ State _____ Zip Code _____

How did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance _____ Policy Holder | Guarantor _____ D.O.B. _____

ID/Policy # _____ Group # _____

Address _____ Unit No. _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Secondary Insurance _____ Policy Holder | Guarantor _____ D.O.B. _____

ID/Policy # _____ Group # _____

Address _____ Unit No. _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

PHARMACY INFORMATION

PRIMARY PHARMACY

Name _____ Phone Numbers: _____

Address _____ Unit No. _____

City _____ State _____ Zip Code _____

Email Address _____ Fax _____

COMPOUNDING/SUPPLEMENT PHARMACY

Name _____ Phone Numbers: _____

Address _____ Unit No. _____

City _____ State _____ Zip Code _____

Email Address _____ Fax _____

MEDICAL CARE HISTORY

PREVENTIVE TESTS

Check box if yes and provide date	**DATE**
☐ Full Physical Exam	
☐ Bone Density	
☐ Colonoscopy	
☐ Cardiac Stress Test	
☐ EKG	
☐ Hemoccult (stool test for blood)	
☐ Mammogram	
☐ PAP Smear	
☐ PSA	
☐ Shingles Vaccine	
☐ Pneumovax	
☐ Other _____	
☐ Other _____	
☐ Other _____	
☐ Other _____	

SURGICAL HISTORY

Check box if yes and provide date	**DATE**
☐ Appendectomy	
☐ Hysterectomy	
_____ Ovaries Removed: Right (R) / Left (L) / Both(B)	
☐ Gall Bladder	
☐ Hernia	
☐ Tonsillectomy/Adenoidectomy	
☐ Joint Replacement - Knee/Hip	
☐ Heart Surgery (type) _____	
☐ Angioplasty or Stent	
☐ Pacemaker	
☐ Other _____	
☐ Other _____	
☐ Other _____	
☐ Other _____	

HOSPITALIZATIONS

Date	**Reason for Hospitalization**

SPECIALIST CARE

Please list all physicians currently managing your care.

Physician Name	**Medical Specialty**	**Issue(s) Being Managed**

PERSONALIZED HEALTH STRATEGY

Please describe your top 2 health goals you seek to strategically improve:

GOAL #1

GOAL #2

Please answer the following questions to the best of your ability:

When was the last time you felt well?

Did something trigger your change in health?

MEDICATION HISTORY

CURRENT MEDICATIONS

Medication	*Strength*	*Dosing Schedule*	*Start Date (month/year)*	*Reason for Use*

CURRENT NUTRITIONAL SUPPLEMENTS *(VITAMINS/MINERALS/HERBS/HOMEOPATHY)*

Supplements	*Strength*	*Dosing Schedule*	*Start Date (month/year)*	*Brand of Supplement*

ALLERGIES (*ENVIRONMENTAL, CHEMICAL, FOOD & DRUGS*)

Allergen	**Associated Symptoms**	**Treatment needed, if applicable**

MEDICAL HISTORY

DISEASES | DIAGNOSES | CONDITIONS

Check the appropriate box and provide the date of onset
☑ **Past Condition** (pc) ☑ **Ongoing Condition** (oc)

pc	oc	**GASTROINTESTINAL**	Date of onset
☐	☐	Irritable Bowel Syndrome	
☐	☐	Crohn's Disease	
☐	☐	Ulcerative Colitis	
☐	☐	Gastritis or Peptic Ulcer	
☐	☐	GERD (Acid Reflux)	
☐	☐	Celiac Disease	
☐	☐	Other:_____	

pc	oc	**CARDIOVASCULAR**	Date of onset
☐	☐	Heart Attack	
☐	☐	Poor Circulation	
☐	☐	Stroke	
☐	☐	High Cholesterol	
☐	☐	Arrhythmia (irregular beat)	
☐	☐	Hypertension (high blood pressure)	
☐	☐	Heart Valve Disease	
☐	☐	Other _____	

pc	oc	**METABOLIC|ENDOCRINE**	Date of onset
☐	☐	Type 1 Diabetes	
☐	☐	Type 2 Diabetes	
☐	☐	Hypoglycemia (low blood sugar)	
☐	☐	Metabolic Syndrome	
☐	☐	Insulin Resistance or Pre-diabetes	
☐	☐	Obesity|Overweight	
☐	☐	Hypothyroidism (underactive)	
☐	☐	Hyperthyroidism (overactive)	
☐	☐	Polycystic Ovarian Syndrome (PCOS)	
☐	☐	Infertility	
☐	☐	Pituitary/Adrenals	
☐	☐	Other _____	

pc	oc	**NEUROLOGIC|PSYCHIATRIC**	Date of onset
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Bipolar Disorder	
☐	☐	Headaches	
☐	☐	Migraines	
☐	☐	ADD/ADHD	
☐	☐	Autism	
☐	☐	Multiple Sclerosis	
☐	☐	Seizures	
☐	☐	Eating Disorder (Anorexia/Bulimia)	
☐	☐	Trauma/PTSD	
☐	☐	Parkinson's Disease	
☐	☐	Other _____	

pc	oc	**GENITAL AND URINARY**	Date of onset
☐	☐	Kidney Stones	
☐	☐	Interstitial Cystitis	
☐	☐	Frequent Urinary Tract Infections	
☐	☐	Frequent Yeast Infections	
☐	☐	Erectile or Sexual Dysfunction	
☐	☐	Urinary Incontinence	
☐	☐	Other _____	

pc	oc	**MUSCULOSKELETAL|PAIN**	Date of onset
☐	☐	Osteoarthritis	
☐	☐	Fibromyalgia	
☐	☐	Gout	
☐	☐	Chronic Pain Syndrome	
☐	☐	Other _____	

pc	oc	**AUTOIMMUNE|INFLAMMATORY**	Date of onset
☐	☐	Asthma	
☐	☐	Chronic Sinusitis	
☐	☐	Bronchitis	
☐	☐	COPD or Emphysema	
☐	☐	Pneumonia	
☐	☐	Sleep Apnea	
☐	☐	Lupus	
☐	☐	Rheumatoid Arthritis	
☐	☐	Immunodeficiency	
☐	☐	Other _____	

pc	oc	**DERMATOLOGIC**	Date of onset
☐	☐	Eczema	
☐	☐	Psoriasis	
☐	☐	Vitiligo	
☐	☐	Acne	
☐	☐	Other _____	

pc	oc	**CANCER**	Date of onset
☐	☐	Lung Cancer	
☐	☐	Breast Cancer	
☐	☐	Colon Cancer	
☐	☐	Ovarian Cancer	
☐	☐	Uterine Cancer	
☐	☐	Cervical Cancer	
☐	☐	Skin Cancer	
☐	☐	Bladder Cancer	
☐	☐	Prostate Cancer	
☐	☐	Other _____	
☐	☐	Other _____	
☐	☐	Other _____	

GENERAL RISK ANALYSIS

Please place age at diagnosis where appropriate	Mother	Father	Brother (s)	Brother (s)	Sister (s)	Sister (s)	Child(ren)	Child(ren)	Child(ren)	Child(ren)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still alive)														
Age at death														
Colon Cancer														
Breast Cancer														
Other Cancer type:														
Other Cancer type:														
Heart Disease														
Stroke														
Hypertension														
Obesity | Overweight														
Diabetes														
High Cholesterol														
Arthritis (60+ years old)														
Multiple Sclerosis														
Rheumatoid Arthritis | Lupus | Psoriasis														
Ulcerative colitis | Crohn's Disease														
Irritable Bowel Syndrome (IBS)														
Celiac Disease														
Asthma | Chronic Bronchitis														
Eczema | Hives														
Food Allergies or Sensitivities														
Environmental Sensitivities														
Multiple Chemical Sensitivities														
Dementia | Parkinson's														
Substance Abuse (alcoholism, drugs)														
Depression														
Anxiety														
PTSD | Trauma														
ADHD														
Autism														
Thyroid Disorders														
Other:														
Other														
Other:														

FEMALE HISTORY

OBSTETRIC HISTORY

☐ Pregnancies _____ ☐ Cesarean _____ ☐ Vaginal Deliveries _____

☐ Miscarriage _____ ☐ Abortion _____ ☐ Living Children _____

☐ Postpartum Depression _____ ☐ Toxemia _____ ☐ Baby over 8 lbs. _____

☐ Breastfeeding _____ (months) ☐ Gestational Diabetes _____

MENSTRUAL HISTORY

Age of first period: _____ Last Menstrual Period:_____ Frequency/Length: every _____ days for _____days long

Describe your **current** menstrual cycle: ☐ Regular ☐ Irregular ☐ Absent

Details: _____

Current contraception: ☐ Birth Control Pill ☐ IUD ☐ Condom ☐ Vasectomy ☐ Hysterectomy ☐ None

Total years of hormonal contraception use: _____

Date of Last PAP: _____ History of Abnormal PAP: ☐Yes ☐ No If yes, date of abnormal PAP:_____

MENOPAUSE HISTORY

Are you in menopause (no menses in last 12 months)? ☐ No ☐ Yes If yes, what age:_____

If yes, ☐ Natural ☐ Surgical removal of ovaries, reason _____

Current Menopausal Symptoms:

☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness

☐ Night Sweats ☐ Sleep Problems ☐ Postmenopausal Bleeding ☐ Loss of Control of Urine

☐ Headaches ☐ Palpitations ☐ Weight Gain ☐ Depression or Anxiety

Current use of hormone replacement therapy:

☐ Traditional Prescription_____(months/years)

☐ Bioidentical Hormone Replacement Therapy_____(months/years)

☐ None

Previous use of hormone replacement therapy:

☐ Yes_____ (year stopped) ☐ No

☐ Traditional Prescription_____(months/years)

☐ Bioidentical Hormone Replacement Therapy_____(months/years)

Current women's disorders/hormonal imbalances:

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Heavy Periods

☐ Painful Periods ☐ Infertility ☐ Menstrual Migraines ☐ PMS

MALE HISTORY

Date of Last PSA:_____ PSA Level: ☐ 0-1 ☐ 2-4 ☐ 5-10 ☐ >10

Current Andropause Symptoms:

☐ Fatigue ☐ Irritability ☐ Erectile Dysfunction ☐ Decreased Libido ☐ Enlarged Prostate

☐ Urgency/Hesitancy/Change in urinary stream ☐ Nocturia (urination at night) ____(times per night)

LIFESTYLE INFORMATION

SMOKING

Currently smoking: ☐ No ☐ Yes How many years ___Packs per day ___

Previous smoking: ☐ No ☐ Yes How many years ___Packs per day ____Quit Date:_____

Second hand smoke exposure: ☐ No ☐ Yes ☐ Current ☐ Past

ALCOHOL

How many drinks currently per week (e.g. **1serving = 5 oz wine, 12 oz beer, 1.8 oz liquor**)?

☐ None ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9+ ☐ Throughout the week ☐ Weekends mostly

Have you ever felt you needed to cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

Have you ever felt guilty about drinking? ☐ Yes ☐ No

DEPRESSION SCREENING (PHQ-2)

RATE: 0 = not at all to 4 = highest

Little interest or pleasure in doing things in the last 2 weeks? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ declines

Feeling down, depressed, or hopeless in the last 2 weeks? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ declines

OTHER SUBSTANCES

Briefly describe any recreational drug use (answer n/a if not applicable):

_____

_____

CAFFEINE

Daily Caffeine Intake:

Coffee _____ oz _____ cups Tea _____ oz _____ cups

Soda _____ oz _____ quantity Other_____ oz ____quantity

EXERCISE

Current Physical Activity:

Activity	Number of Sessions (weekly)	Duration (minutes or hours)

Obstacles or challenges with exercise: ☐ Time ☐ Pain ☐ Energy ☐ Other _____

LIFESTYLE INFORMATION

STRESS / COPING

RATE: 1=lowest to 5= highest

What is the current level of stress in your life? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Please rate your daily stressors: Work _____ Family ____ Social ____ Finances ____

Which stress management practices do you utilize?

☐ Prayer ☐ Breathing ☐ Meditation ☐ Yoga ☐ Tai Chi ☐ Other _____

SLEEP/REST

RATE: 1=poor to 5= great

Please rate the quality of your sleep. ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What is the average number of hours you sleep per night? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ >10

What issues do you have with your sleep? _____

Do you snore? ☐ Yes ☐ No

Do you have gaps in breathing? ☐ Yes ☐ No

Please list any sleep aids (prescription or natural) or other methods tried/used: _____

DIGESTIVE | DIETARY HISTORY

Briefly describe your consumption habits related to meals, snacks, and beverages.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Which food allergies, intolerances, and/or sensitivities do you experience? When did they begin?_____

_____

_____

How many bowel movements do you have in a typical day ☐ <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4

If <1, how often do you have a bowel movement: every_____days

Describe your typical bowel movement (check all that apply)

☐ Hard	☐ Soft	☐ Alternating diarrhea/constipation	☐ Complete
☐ Pellet-like	☐ Loose	☐ Mucus in stool	☐ Incomplete
☐ Watery	☐ Strange color/odor	☐ Large	☐ Floating

READINESS ASSESSMENT

RATE: 1 = not willing to 5 = very willing

Please rate your readiness to improve your health and wellbeing: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

MEDICAL SYMPTOMS QUESTIONNAIRE

Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.0 - ***Never or almost never*** have the symptoms

1 - ***Occasionally*** have it, the effect is **not severe**
2 - ***Occasionally*** have it, the effect is **severe**
3 - ***Frequently*** have it, the effect is **not severe**
4 - ***Frequently*** have it, the effect is **severe**

HEAD
_____ Headaches
_____ Dizziness
_____ Faintness
_____ Insomnia
_____ ***TOTAL***

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under the eyes
_____ Blurred or tunnel vision
(*does not include near or far-sightedness*)
_____ ***TOTAL***

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ ***TOTAL***

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ ***TOTAL***

MOUTH
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/Discolored tongue, gums, lips
_____ Canker sores
_____ ***TOTAL***

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ ***TOTAL***

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ ***TOTAL***

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ ***TOTAL***

DIGESTION
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ ***TOTAL***

JOINTS/MUSCLES
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ ***TOTAL***

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ ***TOTAL***

ENERGY/ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ ***TOTAL***

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ ***TOTAL***

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression/Sadness
_____ ***TOTAL***

OTHERS
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ ***TOTAL***

GRAND TOTAL_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I _____ give permission to ESSENTIAL FAMILY HEALTH & WELLNESS, LLC, to release any information, verbally or written, on my behalf to the following persons.

PLEASE PRINT

NAME _____

Phone: _____ Relationship to Patient: _____

NAME _____

Phone: _____ Relationship to Patient: _____

NAME _____

Phone: _____ Relationship to Patient: _____

NAME _____

Phone: _____ Relationship to Patient: _____

I give permission to leave messages via: ☐ Voicemail ☐ Patient Portal ☐ Email

This notice will expire upon written notice as provided by the patient to ESSENTIAL FAMILY HEALTH & WELLNESS, LLC.

_____ _____

Patient/Guardian Signature Date

_____

Print Patient Name

INFORMED CONSENT REGARDING E-MAIL OR INTERNET USE OF PROTECTED PERSONAL INFORMATION

Essential Family Health & Wellness LLC, provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward an e-mail to other recipients without the original sender's permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.
   b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.
2. It is the policy of Essential Family Health & Wellness, that all e-mail messages sent or received, that concern the diagnosis, or treatment, of the patient will be a part of that patient's protected personal health information and we will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Essential Family Health & Wellness will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes an agreement with the following conditions:
   a. All e-mails to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, Dr. Susan Del Sordi, her team, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
   b. The office may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.
   c. We at Essential Family Health & Wellness, will endeavor to read e-mail promptly but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, an e-mail must not be used in a medical emergency.
   d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
   e. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis and/or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; behavioral health, mental health, or developmental disability; or alcohol and drug abuse.
   f. Essential Family Health & Wellness, cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication. However, Dr. Susan Del Sordi and her team are not liable for improper disclosure of confidential information not caused by its employees' gross negligence, or willful and wanton misconduct.
   g. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Essential Family Health & Wellness, staff of any type of information you do not want to be sent by e-mail.
   h. It is the responsibility of the patient to protect their password or other means of access to an e-mail sent, or received, from Essential Family Health & Wellness, LLC, to protect confidentiality. Essential Family Health & Wellness is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of email may be withdrawn at any time by fax or email to:
ESSENTIAL FAMILY HEALTH & WELLNESS, LLC
Fax: 480.285.2182
info@efhwc.com

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Print Name: _____

Signature: _____ Date: _____

FINANCIAL POLICY

This policy has been put in place to ensure that financial payments due are recovered so that we may continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our staff will be glad to answer your questions and further discuss these policies with you.

PLEASE CAREFULLY READ EACH OF THE FOLLOWING STATEMENTS AND SIGN BELOW:

I understand that if I expect my medical insurance to be billed, and I do not have my insurance card, and/or co-payment, my appointment may be rescheduled until such time that I can provide the required documents or payments.

I understand I am financially responsible for any co-payments, deductibles, coinsurance, and all charges which are not covered by my insurance. I understand that verification of coverage is not a guarantee of the payment of benefits. My insurance company determines benefit payments. I understand I will be responsible for the portion not covered by my insurance.

I understand that if I am unable to make a scheduled appointment, I need to contact the office at least 24 hours prior to my scheduled appointment. **A $75 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST A 24-HOUR ADVANCED NOTICE.**

I understand there is a **$35 charge** for a Non-Sufficient Funds (NSF) check.

I understand there may be a **$25 - $75** charge for all forms deemed appropriate, filled out by the Physician (e.g., Disability, FMLA, etc.). When dropping forms off, I must allow 5 - 7 business days for completion.

I understand there may be a **$40 - $150** charge for retrieval of my **FULL MEDICAL RECORD**

I understand if my account is not paid in full within **90 days,** I may be turned over to a collection agency for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

I have read and understood the above Financial Policy and I agree to abide by its terms.

_____ _____

Signature of the Patient /or Patient's Legal Representative **Date**

_____ _____

Print Name

If not the patient, state your relationship with the patient and describe your authority to act on behalf of the patient

PORTAL AUTHORIZATION CONSENT FORM

I,_____ (**PRINT** patient full name) am voluntarily registering for access to the Patient Portal website for Essential Family Health & Wellness. I understand that by supplying my email address, I will receive communication from Essential Family Health & Wellness and/or Elations Health EHR. This communication will be for the purpose of providing information about the Patient Portal, including web address, user name and password, when I have a message from the office, when my health records are available for access, etc. The Patient Portal is not designed to replace the face-to-face encounter with your physician. Rather, it is designed to supplement those encounters. Please do not use the Patient Portal for urgent messages. We will normally respond to non-urgent inquiries within 24 hours but no later than 3 business days (Monday – Friday) after received

Please note that all communications will become a permanent record in your chart.

I understand that my privacy is a top priority for Essential Family Health & Wellness and they will not sell or give away my email to any third party.

I agree to not hold Essential Family Health & Wellness or any of its staff or physicians liable for network or security infractions beyond their control.

I am responsible for ensuring that Essential Family Health & Wellness has my current email address and I agree to inform the office immediately if it changes.

By signing below, I acknowledge and agree that I will use my own patient portal account to access the patient's portal information and that I will comply with all usage requirements and terms and conditions of use for the patient portal, including but not limited to my agreement not to share login or password information, to establish a confidential login name and password, to maintain all data in a secure manner, and to ensure that my email address is current at all times. I understand that if my e-mail is not current, I will not receive notification of messages sent to me. I acknowledge that access to the patient portal is provided as a convenience to patients and their authorized representatives and may be revoked at any time for any reason.

Preferred Email Address: _____

Signature: _____ Date: _____

Print Name: _____ _____

Relationship to the Patient (Parent, Legal Guardian, Power of Attorney for Health Care, etc.)

Essential Family Health & Wellness
Susan Del Sordi, DO
Melchiorra M. Mangiaracina, DO
Lexine Hebets, MD
Sara Huschke Emery, MS, ANP
Kathleen B. Rickard, DNP, APRN, FNP-C
Bianca Leung, PA-C, MS, RD

11209 N Tatum, Suite 160
Phoenix, AZ 85028

Phone: 480-285-2180 Fax: 480-285-2182 or 480-285-2181

AUTHORIZATION FOR MEDICAL RECORD RELEASE

PATIENT NAME _____

DOB _____

CURRENT DOCTOR WHO HAS THE MEDICAL RECORD IS:

NAME _____

OFFICE _____

ADDRESS _____

_____

_____

PHONE _____

FAX _____

PLEASE SEND:

- ☐ ECG (most recent)
- ☐ LABS (most recent)
- ☐ CURRENT MEDICATION LIST
- ☐ PATH REPORTS X 3 YRS
- ☐ RADIOLOGY X 3 YRS
- ☐ CONSULTS (GI, CARDIO, ETC) X 3 YRS
- ☐ H&P, D/C SUMMARIES - HOSPITAL NOTES X5 YRS

PATIENT SIGNATURE _____ DATE: _____