# North Texas Family Medicine

***Please print clearly and complete all information so that you claim can be processed quickly and efficiently. Thank You!***

## Patient Information

**Name: (First, Middle, Last)**

**Date Of Birth:** **Age:** **Sex: Male/ Female** **Marital Status: S M W D**

**Address:**

(Street) (City) (State) (Zip)

**Phone#:** **Social Security#:** **Drivers License #:**

**Work #:** **Employer:** **Date of Employment:**

**Employers Address:** **Student: Y N Full/ Part Where?**

## Responsible Party or Spouse Information

**Name:** **Relationship To Patient:**

**Address:**

**Phone#:** **Work#:** **Social Security#:**

**Employer:**

**Employers Address:**

**Emergency Contact:**

## Insurance Information

**Insurance Name:** **Phone#:**

**Insurance Address:**

**Member Id#:** **Group#:**

**Insured's Name:** **Relationship to Patient: Self/Spouse/Dependent**

**Social Security#:** **Date of Birth:** **Sex: M/F**

**Employer:** **Phone#:**

**Address:**

***I herby assign, transfer and set over to North Texas Family Medicine, P.A., all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance***

**Patients Signature:** **Date:**

**Who may we thank for your referral?**_____

**Health History**

**Welcome to our practice as a new patient please fill out the information found below to the best of your ability.**

**Patient Name:**_____ **DOB:**_____ **Date:**_____

**Past Medical History**

***Have you ever had the following? (Circle "Yes" or "No", leave blank if uncertain)***

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Measles** | **Yes** | **No** | **Anemia** | **Yes** | **No** | **Back Trouble** | **Yes** | **No** |
| **Mumps** | **Yes** | **No** | **Bladder Infections** | **Yes** | **No** | **High Blood Pressure** | **Yes** | **No** |
| **Chicken Pox** | **Yes** | **No** | **Epilepsy** | **Yes** | **No** | **Low Blood Pressure** | **Yes** | **No** |
| **Whooping Cough** | **Yes** | **No** | **Tuberculosis** | **Yes** | **No** | **Hemorrhoids** | **Yes** | **No** |
| **Scarlet Fever** | **Yes** | **No** | **Diabetes** | **Yes** | **No** | **Asthma** | **Yes** | **No** |
| **Diphtheria** | **Yes** | **No** | **Polio** | **Yes** | **No** | **Hives or Eczema** | **Yes** | **No** |
| **Small Pox** | **Yes** | **No** | **Glaucoma** | **Yes** | **No** | **AIDS or HIV+** | **Yes** | **No** |
| **Pneumonia** | **Yes** | **No** | **Hernia** | **Yes** | **No** | **Infectious Mono** | **Yes** | **No** |
| **Rheumatic Fever** | **Yes** | **No** | **Bronchitis** | **Yes** | **No** | **Miral Valve Prolapse** | **Yes** | **No** |
| **Blood or Plasma** | | | **Migraine Headaches** | **Yes** | **No** | **Stroke** | **Yes** | **No** |
| **Transfusion** | **Yes** | **No** | **Date of Last Chest X-Ray**_____ | | | **Cancer** | **Yes** | **No** |
| **Any other Disease:** | **Yes** | **No** | | | | **What Kind?**_____ | | |

**Please List:**_____

_____

_____

**Immunization Record**

| **Date** | | **Date** | | **Date** | | **Date** | |
|---|---|---|---|---|---|---|---|
| _____ | **Hepatitis A** | _____ | **Hepatitis B** | _____ | **Influenza** | _____ | **DPT** |
| _____ | **Polio** | _____ | **Dt.** | _____ | **Tetanus** | _____ | **Toxoid** |
| _____ | **Rubeola** | _____ | **Mumps** | _____ | **Rubella** | _____ | **Prevnar** |
| _____ | **MMR** | _____ | **Pneumovax** | _____ | **Td.** | | |

| **Previous Hospitalizations/ Surgeries/ Serious Illnesses** | **When?** | **Hospital, City, State** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Medications: (Include nonprescription)** _____

_____

_____

**Patient Social History:**

**(Please Circle which applies)**

| | | | | | |
|---|---|---|---|---|---|
| **Marital Status:** | **Single** | **Married** | **Separated** | **Divorced** | **Widowed** |
| **Use of Alcohol:** | **Never** | **Rarely** | **Moderate** | **Daily** | |
| **Use of Tobacco:** | **Never** | **Previously But Quit** | **Current Packs A Day:**_____ | | |
| **Use of Drugs:** | **Never** | **Type:**_____ | **Frequency:**_____ | | |
| **Excessive Exposure at Home or Work to:** | **Fumes** | **Dust** | **Solvents** | **Air-Borne Particles** | **Noise** |

**Family Medical History:**

| | **Age** | **Diseases** | **If Deceased, Cause of Death** |
|---|---|---|---|
| **Father:** | _____ | _____ | _____ |
| **Mother:** | _____ | _____ | _____ |
| **Siblings:** | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| **Spouse:** | _____ | _____ | _____ |
| **Children:** | _____ | _____ | _____ |

## Review of systems: Please indicate any personal history below:

| Constitutional Symptoms: | | |
|---|---|---|
| Good General Health Lately | Yes | No |
| Recent Weight Change | Yes | No |
| Fever | Yes | No |
| Fatigue | Yes | No |
| Headaches | Yes | No |
| **Eyes:** | | |
| Eye disease or injury | Yes | No |
| Wear glasses/ contacts | Yes | No |
| Blurred or double vision | Yes | No |
| **Ears/Nose/ Mouth/ Throat:** | | |
| Hearing loss or ringing | Yes | No |
| Earaches or draining | Yes | No |
| Chronic sinus problem or rhinitis | Yes | No |
| Nose bleeds | Yes | No |
| Mouth Sores | Yes | No |
| Bleeding gums | Yes | No |
| Sore throat or voice change | Yes | No |
| Swollen glands in neck | Yes | No |
| **Cardiovascular:** | | |
| Heart trouble | Yes | No |
| Chest pain or angina pectoris | Yes | No |
| Palpitation | Yes | No |
| Shortness of breath (walking) | Yes | No |
| Shortness of breath (laying) | Yes | No |
| Swelling of feet, ankles or hands | Yes | No |
| **Respiratory:** | | |
| Chronic or frequent coughs | Yes | No |
| Spitting up blood | Yes | No |
| Shortness of breath | Yes | No |
| Sneezing | Yes | No |
| **Gastrointestinal:** | | |
| Loss of appetite | Yes | No |
| Change in bowel movement | Yes | No |
| Nausea or vomiting | Yes | No |
| Frequent diarrhea | Yes | No |
| Painful bowel movements or Constipation | Yes | No |
| Rectal bleeding or blood in stool | Yes | No |
| Abdominal Pain | Yes | No |

| Genitourinary: | | |
|---|---|---|
| Frequent Urination | Yes | No |
| Burning or painful urination | Yes | No |
| Blood in urine | Yes | No |
| Change in force of strain when urinating | Yes | No |
| Incontinence or dribbling | Yes | No |
| Kidney Stones | Yes | No |
| Sexual difficulty | Yes | No |
| Male tactical Pain | Yes | No |
| Female pain with periods | Yes | No |
| Female vaginal discharge | Yes | No |
| Female #of Pregnancies | _____ | |
| Female # of Miscarriages | _____ | |
| Female Date of last pap | _____ | |
| **Musculolskeletal:** | | |
| Joint Pain | Yes | No |
| Joint stiffness or swelling | Yes | No |
| Weakness of muscles or joints | Yes | No |
| Muscle pains or cramps | Yes | No |
| Back pain | Yes | No |
| Cold extremities | Yes | No |
| Difficulty walking | Yes | No |
| **Integumentary (Skin/ Breast):** | | |
| Rash or itching | Yes | No |
| Change in skin color | Yes | No |
| Change in hair or nails | Yes | No |
| Varicose veins | Yes | No |
| Breast pain | Yes | No |
| Breast lump | Yes | No |
| Breast Discharge | Yes | No |
| **Neurological:** | | |
| Migraine headaches | Yes | No |
| Light headed or dizziness | Yes | No |
| Convulsions or seizures | Yes | No |
| Numbness or tingling | Yes | No |
| Tremors | Yes | No |
| Paralysis | Yes | No |
| Head Injury | Yes | No |

| Psychiatric: | | |
|---|---|---|
| Memory Loss or Confusion | Yes | No |
| Nervousness | Yes | No |
| Depression | Yes | No |
| Insomnia | Yes | No |
| **Endocrine:** | | |
| Glandular or hormone | Yes | No |
| Excessive thirst or urination | Yes | No |
| Heat or cold intolerance | Yes | No |
| Skin becoming dryer | Yes | No |
| Change in hat or glove size | Yes | No |
| **Hematological/ Lymphatic:** | | |
| Slow to heal after cuts | Yes | No |
| Bleeding or bruising tendency | Yes | No |
| Anemia | Yes | No |
| Phlebitis | Yes | No |
| Past transfusion | Yes | No |
| Enlarged glands | Yes | No |
| **Allergic/ immunology:** | | |
| History of skin reaction or other acute Penicillin or other antibiotics | Yes | No |
| Morphine, Demerol or other narcotics | Yes | No |
| Novocain or other anesthetics | Yes | No |
| Aspirin or other pain remedies | Yes | No |
| Tetanus, antitoxin, or other serums | Yes | No |
| Iodine, merthiolate or other antiseptic | Yes | No |

Other Drugs/ Medications _____

_____

_____

Known food allergies _____

_____

_____

Environmental allergies _____

_____

_____

***To the best of my knowledge the questions on this form have bee accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.***

_____ _____

***Signature of Patient, Parent or Guardian*** ***Date***

***Doctors Review***

_____

***Doctors Signature***

**Acknowledgement of Review of Notice**
**Of Privacy Practices**

**I have reviewed this office's Notice of Privacy Practices, which explains how my personal medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.**

_____
**Printed Patient Name**

_____
**Signature of Patient, Parent, Legal Guardian, or Personal Representative**

_____
**Description of Personal Representative's Authority**

_____
**Date**

**North Texas Family Medicine**
**Consent To Release Protected Medical Information**

**In order for our practice to be HIPPA compliant and to protect your personal medical information, we must obtain your permission before releasing any of your personal medical information to anyone.**

***I,_____ give North Texas Family Medicine permission to release my personal medical information to my spouse, or other family member as given below.***

**Limitations to my release are:_____**

***Please list only information you would like for us to release.***

**You may release my protected health information to:**

**Name:_____**
**Address:_____**
**_____**
**Phone:_____**
***Whom may we release your information to?***
**Relationship:_____**
**What is this person's relation to you?**

***The reason or purposes for this release of information are as follows:_____***
**_____**

***I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:***

***Charlene Peek (Practice Manager)***
***4001 W. 15Th Street, Suite 290***
***Plano, Texas 75093***
***Phone: 972-599-2567 Fax: 972-599-2119***

***I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, or a other law provides the insurer with the right to contest a claim under the policy or policy itself.***

***I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.***

***The practice will not condition my treatment, payment, and enrollment, in a health plan, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.***

_____ _____
***Signature of Patient or Guardian*** ***Date***

***Is there a phone number where you would like for our practice to leave personal medical information such as labs, x-ray, diagnostic or prescription information, as a message should we not be able to reach you personally? _____***

# FINANCIAL POLICIES/AGREEMENT

**INSURANCE CARDS:** You will be asked to present your insurance card at every visit. Although this might be inconvenient, it is necessary. Insurance plans and ID numbers are changing in order to keep social security numbers off the ID card.

**BENEFITS:** Insurance benefits can be very confusing. Each company has many different types of policies. Our office will try to help you as best we can. However, ultimately, it is your responsibility to know your benefits, including limitations and exclusions, as you are responsible for payment. If you have any questions regarding any of this, including covered services, deductibles, maximum benefits, please contact the insurance administrator of your employer or your insurance company.

**TREATMENT:** Your treatment will be based on medical necessity. Some procedures and labs may not be covered under your particular plan. It is not our responsibility to verify that everything is covered before treatment is provided.

**MEDICATION:** We prescribe the medication that we feel is best suited to your condition. If this medication is not covered, or has a very high co-pay, we would need to be provided with alternatives that are financially acceptable to you.

**REFERRAL:** Sometimes it is necessary to refer you to a specialist for your condition. We will give you a list of doctors that we know and would recommend. When you call to schedule an appointment, you would need to verify that the specialist is part of your network. If the specialists we give you are not in your insurance network, please find a physician and let us know their name, phone and fax number in order for a referral to be done, if needed. We need at least 48 hours for referrals.

**CO-PAY:** Co-payment will be collected at check in, unless you have a co-insurance plan (e.g. 80/20). If this is your plan, we will try to calculate as best we can your estimated co-insurance after you have seen the doctor. This may take a little extra time, as we will look up the allowable charges from your insurance company. If you have a deductible, insurance companies require you to meet this before they make payment. Some PPO plans have a co-pay only for sick visits, and a deductible for other services, e.g. labs, immunizations, procedures.

**HMO/POS:** You are required to select your respective physician, Dr Adam Kaplan or Dr. Heather Akins, as your **P**rimary **C**are **P**hysician with your insurance company before your appointment. If you have not done this, your insurance will not pay for your visit and you would be responsible for payment in full. In an emergency situation, you can see the other physician in our practice with no notification to the insurance company.

**SELF PAY:** Payment is required in full at the time of service.

Thank you for choosing North Texas Family Medicine. Please let the receptionist know if you would like a copy of this for your records.

_____ _____

Patient/Legal Guardian Signature Date