1960 Physician Associates

PCP & INTERNAL MEDICINE

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name: (Last)______________________________(First)______________________________(MI) __________________

Address: ____

City, State, Zip: ____

Home:__________________________Cell:______________________Work: ________________________________

E-Mail Address:____DOB: __________________________

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Sex: ☐Female ☐Male ☐Transgender

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Other ☐Declined

Language: ☐ English ☐ Spanish ☐ Other: ________________

Ethnicity: ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number:_______ - _______ - _______

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)____________________________(First)____________________________(MI) ______________

Date of birth: ________/________/__________ Sex: ☐ Female ☐ Male

Social Security Number:_______ - ______ - _______ Phone number: ________________

Address: ____

City, State:_______________________________ZIP: ____________________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

Primary Insurance: ________________________________ Member ID: __________________ Group Number: ______________

Secondary Insurance: ______________________________ Member ID: __________________ Group Number: ______________

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)____________________________________ (First)________________________________

Phone number:____

Emergency contact relationship to patient:____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that 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).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:____________________________Date: ____________________________

Printed name of patient or personal representative:__________________________Relationship to patient: ________________________

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HEALTH HISTORY

Name: ____ DOB: __________________ Date: __________________

Reason for visit today: ____

Are you allergic to any medications? ☐Yes or ☐No (If yes, please list.)

Allergic to the following medications	Type of Allergic Reaction

List the name and dosage of the medications you are currently taking:

Current Medications	Dosage

Pharmacy information:

Name:____Phone number: ____________________________________

Address: ____

Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Retired

Employer Name: ____ Occupation: ____________________________________

Employer Address: _______________________________________ City/State/Zip Code: _____________________________

Last colonoscopy: __________ Last Flu Vaccine: ___________

Last Pneumonia Vaccine: __________ Last Shingles Vaccine: ____________

FOR FEMALES ONLY:

Last menstrual cycle: __________ Last mammogram: __________ Last pap smear: __________

Are periods regular? ☐ Yes ☐ No Number of Pregnancies: __________ Number of Live Children: __________

Do you have pain with periods? ☐ Yes ☐ No Number of Miscarriages: __________ Number of Abortions: ___________

Is Flow: ☐ Normal ☐ Heavy ☐ Light ☐ Spotting

Any History of abnormal pap smears? ☐ Yes ☐ No If so when: ____

How did you hear about us? Circle any that apply:

AdvertisementHospital Insurance Family/Friend Social Media Website Other: ________

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MEDICAL HISTORY

Name: ______________________________ DOB: ______________ Date: ______________

PAST MEDICAL HISTORY:

_____Allergies
_____Anemia
_____Angina (chest pain)
_____Anxiety
_____Arthritis
_____Asthma
_____Atrial fibrillation
_____BPH (enlarged prostate)
_____Blood clots
_____Cancer, Type _____
_____CVA (stroke)
_____COPD (emphysema)
_____CAD (heart disease)
_____Crohn's disease
_____Depression
_____Diabetes
_____Gallbladder disease
_____GERD (reflux)
_____Hepatitis C
_____High cholesterol
_____High blood pressure
_____Irritable bowel syndrome
_____Liver disease
_____Migraine headaches
_____MI (heart attack)
_____Osteoarthritis
_____Osteoporosis
_____Peptic ulcer disease
_____Renal disease (kidneys)
_____Seizure disorder
_____Thyroid disease
_____AIDS/HIV

SURGERIES: (*Indicate the **DATE/YEAR** if known*)

_____Angioplasty
_____Colostomy
_____Appendix
_____Arthroscopy knee
_____Back surgery
_____CABG (open heart surgery)
_____Carpal tunnel release
_____Cataract
_____Cholecystectomy (gallbladder)
_____Ear tube/BMT
_____Colectomy (colon removed)
_____Small bowel resection
_____Gastric bypass
_____Hernia repair
_____Hip replacement
_____Knee replacement
_____LASIK
_____Liver biopsy
_____Mastoidectomy
_____Pacemaker
_____Thyroidectomy
_____Tonsillectomy
_____Tympanoplasty

Gender Specific Male:
_____Prostatectomy
_____TURP
_____Vasectomy

Gender Specific Female:
_____Breast augmentation
_____Bilateral tubal ligation
_____Breast biopsy
_____Cesarean section
_____D & C
_____Hysterectomy
_____Mastectomy
_____Breast reduction

ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY:

____
____
____

FAMILY HISTORY:

	Mother	Father	Sister	Brother	Other
ADD/ADHD					
Alcoholism					
Allergies					
Alzheimer's disease					
Asthma					
Blood disease					
Coronary artery disease (heart disease)					
Premature heart disease (male <55 yr., female <65 yr.)					
Cancer, Type					
CVA (stroke)					
Depression					
Developmental delay					
Diabetes					
Eczema					

	Mother	Father	Sister	Brother	Other
Hearing deficiency					
High cholesterol					
High blood pressure					
Irritable bowel syndrome					
Learning disability					
Mental illness					
Migraines					
Obesity					
Osteoarthritis					
Osteoporosis					
Peripheral vascular disease (blood clots)					
Renal (kidney) disease					
Seizure disorder					
Other:					

SOCIAL HISTORY:

Tobacco Use Details

☐ Current everyday smoker
☐ Current some day smoker
☐ Former smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker
☐ Never smoker
☐ Smoker, status unknown
☐ Unknown if ever smoked

Alcohol Use Details

☐ Do not drink
☐ Drink daily
☐ Frequent drink
☐ Hx of alcoholism
☐ Occasional drink

Illicit Drug Use

☐ Intravenous drug use
☐ Illicit drug use
☐ No illicit drug

REVIEW OF SYSTEMS

Name: ____ DOB: __________________ Date: __________________

GENERAL
☐ Fever
☐ Night sweats
☐ Chills
☐ Cold intolerance
☐ Fatigue
☐ Daytime drowsiness
☐ Weight gain
☐ Weight loss
☐ Excessive thirst
☐ Excessive hunger
☐ Anorexia

CARDIOVASCULAR
☐ Chest pain
☐ Palpitations
☐ Difficulty breathing at rest
☐ Difficulty breathing with activity
☐ Difficulty breathing when laying down
☐ Shortness of breath
☐ Shortness of breath during sleep
☐ Lower extremity edema
☐ Varicosities

SKIN
☐ Dry hair
☐ Brittle hair
☐ Hair loss
☐ Dry skin
☐ Itching
☐ Hives
☐ Rash
☐ Bruising
☐ New moles
☐ Skin sores
☐ Skin lumps

EYE, EAR, NOSE, MOUTH & THROAT
☐ Change in vision
☐ Loss of vision
☐ Blurred vision
☐ Double vision
☐ Eye redness
☐ Eye pain
☐ Tearing
☐ Purulent discharge
☐ Difficulty hearing
☐ Hearing loss
☐ Ear pain/earache
☐ Tinnitus
☐ Nasal congestion
☐ Nasal discharge
☐ Nosebleed
☐ Sneezing
☐ Snoring
☐ Lip/mouth/tongue sores
☐ Sore throat
☐ Difficulty swallowing
☐ Painful swallowing
☐ Gum bleeding
☐ Dental problems
☐ Hoarse voice
☐ Change in voice quality

GASTROINTESTINAL
☐ Abdominal pain
☐ Rectal pain
☐ Nausea
☐ Vomiting
☐ Vomiting blood
☐ Flatulence
☐ Constipation
☐ Diarrhea
☐ Fecal incontinence
☐ Clay-colored stools
☐ Greasy stools
☐ Tarry stools
☐ Blood in stools
☐ Foul smelling stools

URINARY
☐ Painful urination
☐ Blood in urine
☐ Increased urination
☐ Decreased urination
☐ Increased nighttime urination
☐ Urge symptoms
☐ Urinary incontinence

HEMATOLOGIC
☐ Easy bruising
☐ Difficulty stopping blood flow
☐ Lymph node enlargement
☐ Lymph node tenderness

NEUROLOGICAL
☐ Headaches
☐ Vertigo
☐ Lightheadedness
☐ Fainting
☐ Blackouts
☐ Numbness
☐ Tingling
☐ Tremor
☐ Lack of coordination
☐ Weakness
☐ Difficulty speaking
☐ Memory loss
☐ Difficulty concentrating

GENITAL/REPRODUCTIVE
☐ Changes in libido
☐ Sexual dysfunction
☐ Painful intercourse
☐ Genial discharge

MEN ONLY
☐ Erectile dysfunction

WOMEN ONLY
☐ Breast lump
☐ Breast pain
☐ Nipple discharge
☐ Menorrhagia
☐ Bleeding between periods
☐ Excessive pain with menses
☐ Postmenopausal
☐ Postmenopausal vaginal bleeding
☐ Hot flashes

NECK
☐ Neck pain
☐ Neck stiffness
☐ Neck lumps
☐ Neck swelling

RESPIRATORY
☐ Difficulty breathing
☐ Cough
☐ Cough productive of sputum
☐ Coughing up blood
☐ Wheezing

MUSCULOSKELETAL
☐ Muscle pain
☐ Back pain
☐ Tender joints
☐ Muscle cramps
☐ Muscle weakness
☐ Decreased muscle strength
☐ Limp paralysis
☐ Difficulty walking
☐ Limp

PSYCHIATRIC
☐ Change in mood
☐ Depression
☐ Anxiety
☐ Nervousness
☐ Sleep disturbance
☐ Suicidal ideation
☐ Hopelessness
☐ Worthlessness
☐ Delusions
☐ Hallucinations

WRITTEN NOTICE FOR FINANCIAL OBLIGATIONS

Name: ____ DOB: _________________ Date: _________________

This clinic is a hospital outpatient department of 1960 Physican Associates. Medicare requires us to inform you that you will incur a coinsurance liability to the hospital that you would otherwise not incur if the services were furnished in an entity that is not hospital−based and to provide you with a notice of your potential financial liability for the hospital service(s).

Financial Agreement

- I acknowledge, that as a courtesy, 1960 Physican Associates may bill my insurance company for servicesprovided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.
- I understand the actual amount of the coinsurance liability to the hospital may be different from any estimate provided.
- Actual coinsurance liability will be based on services rendered and subject to financial determination by Medicare program.
- Coinsurance liability for hospital services is separate from the Medicare coinsurance liability that may be owed for a physician or professional services rendered in conjunction with hospital services.

Third Party Collection. I acknowledge 1960 Physican Associates may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to 1960 Physican Associates any insurance or other third-party benefits available for health care services provided to me. I understand 1960 Physican Associates has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to 1960 Physican Associates) I agree to forward all health Insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applyingfor payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to 1960 Physican Associates by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for 1960 Physican Associates or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect anyamounts I may owe. I expressly agree and consent that 1960 Physican Associates or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or 1960 Physican Associates or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations.Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have read the foregoing and understand that I will incur a liability to the hospital for Medicare coinsurance as permitted by law and that I have received a copy of this notice.

Patient/patient representative signature:______________________________________Date: ____________________

If you are not the patient, please identify your relationship to the patient. Mark relationship(s) from list below:

☐Spouse ☐Guarantor
☐Parent ☐Healthcare Power of Attorney
☐Legal Guardian ☐Other (please specify): ___________________________

ADVANCE DIRECTIVES INFORMATION SHEET

An **advance directive** is a legal document that tells your family, friends and healthcare professionals the care you would like to have if you become unable to make medical decisions. Through advance directives, you can make legally valid decisions about your future medical treatment.

You do not need a lawyer to complete your advance directives. However, you should be aware that each state has its own laws for creating advance directives.

There are three advance directives recognized in Texas:

• The **Texas Medical Power of Attorney** appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. Your attending physician must certify in writing that you are unable to make health care decisions and file the certification in your medical record. If you would like more information and a copy of the Texas Medical Power of Attorney form, please ask the front desk staff.

• A **living will**, officially known in Texas as the Directive to Physicians and Family or Surrogates, describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will should be signed, dated and witnessed by two people, preferably individuals who know you well but are not related to you and are not your potential heirs or your health care providers. If you would like more information and a copy of the Directive to Physicians and Family Members form, please ask the front desk staff.

• The **Out-of-Hospital Do Not Resuscitate (DNR) order** provides you with the right to withhold or withdraw cardiopulmonary resuscitation (CPR) or other treatments such as defibrillation and artificial ventilation. If you would like more information and a copy of the Texas Department of Health Services Standard Out of Hospital Do Not Resuscitate form, please ask the front desk staff.

By creating an advance directive, you are making your preferences about medical care known before you are faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

In order to make your directive legally binding, you must sign it, or direct another to sign it, in the presence of two witnesses who must also sign the document.

It is our responsibility to inform all competent adult patients about Advance Healthcare Directives and ask whether they have one in place. The staff is instructed to know the different types of advance directives. All staff members know where to direct patients who have questions or want more information about advance directives. If a patient provides an advance directive to 1960 PHYSICAN ASSOCIATES Physicians, the physicians and staff should know the patients' decisions related to treatment.

1960 Physician Associates

ADVANCE DIRECTIVES CONFIRMATION FORM

Name: ____ DOB: _________________ Date: _________________

Under Texas law you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas any person age 18 years or old who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

Advance Healthcare Directives Confirmation:

☐**YES**, I have an Advance Healthcare Directives *(select which advance directive you have below).*

☐Texas Durable Medical Power of Attorney

☐Living Will, officially known as the Directive to Physicians and Family or Surrogates

☐Out of Hospital Do Not Resuscitate (DNR)

****If you have selected YES, please provide a copy of your advance directive to the front office staff.*

☐**NO**, I do not have Advance Healthcare Directives *(select which advance directive you have below).* I understand that I can request more information about advance directives.

☐I have received the information sheet about advance directives.

☐I would like additional information about the three advance directives recognized in Texas.

Patient signature:____Date: ________________

1960 Physician Associates

AUTHORIZATION TO COMMUNICATE AND DISCLOSE PROCTED HEALTH INFORMATION

Name: ____ DOB: _________________ Date: _________________

Notice of Privacy Practice/clinics

______________*(Patient/Representative initials)* I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected HealthInformation to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	NAME	RELATIONSHIP	PHONE NUMBER
1			
2			
3			
4			

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.

• I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
• I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.

Communications about My Healthcare

I agree the provider, or an agent of the provider or an independent physician's office may contact me for thepurposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, securitypurposes and/or the practice's/clinics health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Imagesand/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. Theseinstructions may include, but not be limited to post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.
Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliatedlocations that share an electronic health record in which you have a relationship.

Patient signature:____**Date:** _________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Section A: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. *(optional)*:
Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):	
PHI Recipient Name:	Address/City/State/Zip	Phone Number: Fax Number:
PHI Sender Name:	Address/City/State/Zip	Phone Number: Fax Number:

☐ **Release of Records** ☐ **Request of Records**

Purpose of Disclosure:

☐Continued Care/Treatment ☐Disability ☐Attorney/Litigation ☐Other: ___________________________

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐All PHI in record ☐History and Physical ☐Consult Report ☐Operative Report ☐Progress Notes		☐Physician Orders ☐Laboratory ☐Imaging/Radiology ☐Nursing Notes ☐Medication Record		☐Demographics ☐Rehabilitation Services ☐Special Test/Therapy ☐Itemized Bill/Claims ☐Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric,HIV testing, HIV results or AIDS information. ________________ (Initials) If not, applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and my treatment will not continued upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: