Patient Information

Last Name _____ First Name _____ Middle _____

Mailing address_____ Apt # _____

City _____ State _____ Zip _____

Cell _____ Home or Work _____

Email _____ DOB_____

Male _____ Female _____ Social Security # _____

Emergency Contact _____ Phone # _____

Responsible Party

Responsible Party _____ Phone # _____

Social Security # _____ Employer _____

Relationship to Patient _____

Mailing Address _____

Insurance Information

Primary Insurance _____ ID # _____

Group # _____ Policy Holder _____ Policy Holder DOB _____

Secondary Insurance _____ ID # _____

Group # _____ Policy Holder _____ Policy Holder DOB _____

Instructions for Releasing Medical Information

Please **initial** yes or no on each question

-Speak only to me	Yes_____	No_____
-ok to give message to my spouse	Yes_____	No_____
-ok to leave message on voicemail	Yes_____	No_____
*with details	Yes_____	No_____
*call back number only	Yes_____	No_____

Please list names of individuals that can receive medical information.
*If patient is a minor, list individuals that can bring and consent to medical treatment in case parent/guardian is not able.

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

Legal Guardian

I, _____, am the legal guardian of _____

as their (relationship)_____.

_____ _____

Signature of Patient/Guardian Date

Notifications and Authorizations

PLEASE DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND FULLY UNDERSTAND ITS CONTENTS

Financial Policy

Our office is a participating provider for most managed care plans. It is the patient's responsibility to provide their current insurance card at each visit. If you fail to provide your current insurance card, it will be necessary to reschedule your appointment, or we can accept you as a "self-pay" patient and full payment is due at time of service. We will not file to your insurance company for this date of service after the fact. Payment for any co-pay, deductible, or co-insurance is due at the time of service during check-in. for services rendered to minor patients, we expect payment from the adult accompanying the patient at the time of service. Please note: verification of insurance coverage is ***not*** a guarantee of coverage. You will be considered responsible for all fees not covered by your insurance. You are ultimately responsible to know your insurance benefits.

Lab

As a convenience to our patients we have a draw station on site. If your insurance requires you to use any other lab besides Quest, it is your responsibility to notify the medical assistant or healthcare provider. You may receive a bill from the lab as well. If you have questions regarding your Quest bill, call 1-800-694-0247.

Assignment of Benefits & Authorization to Release Information

I authorize North Texas Family Medicine to release any information necessary to my insurance carrier(s) to process medical claims. I assign all insurance benefits to be paid directly to North Texas Family Medicine.

General Consent for Treatment

I have requested medical services from North Texas Family Medicine for myself and/or dependent. I give permission to North Texas Family Medicine to examine and treat myself and/or my dependent as they deem necessary.

Cancellation/No show policy

There will be a fee assessed for a missed appointment unless you advise the office 24 hours prior to your appointment. The first cancellation/no show charge is $25 and the fee will increase by $10 for each additional appointment that is not cancelled within 24 hours or is a no show.

HMO Insurance Polices

If you are required to choose a Primary Care Physician on your insurance, it must be done ***prior*** to your appointment. If your visit(s) are not covered by your insurance due to an NTFM provider not being the PCP listed, the charges will be your financial responsibility.

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices for North Texas Family Medicine.

_____ _____

Signature of Patient/Guardian Date

Controlled Substance Agreement

Patient Name_____ DOB_____

Prescriptions_____

_____

Review to include but not limited to opioids, benzodiazepines, barbiturates, and carisoprodol

In following National and State Regulations and Guidelines, we have reviewed the need and safe use in prescribing your medication with you. These medications have been reviewed online with all registered pharmacies and prescribers as per required from Texas PMP (Prescription Monitoring Program) in compliance with the Texas Health and Safety Code, §481.0764(a).

For all new pain medicines, Texas Pharmacies commonly are only permitted to allow 7 days' worth of opioid medications. Once follow up is done with an office visit, then further are considered for longer periods, such as 30 to 90 days' worth. No refills are permitted unless reviewed with a documented office visit per state regulations every 30 to 90 days.

As the patient: (please initial)

___ I take responsibility for the safe use of my medication and will only take it when necessary.

___ I will not share or sell my medication to others at any time. I will return all unused medication to the pharmacy or office for proper disposal.

___ I agree to annual and random urine drug screening. If I cannot, then I understand I will not receive my prescription.

___ I understand when I have a urine drug screen, I will not receive my prescription if:

-other narcotic non-prescribed medication are found

-I state I have taken my prescription in the last 30 days however the urine drug screen does not indicate this

___ I realize I must plan ahead, and refill requests will not be honored without an office visit.

___ I will only use one pharmacy and one prescriber for the medication unless issued by and emergency room in which case I will provide written documentation of at my next visit.

_____ _____

Signature of Patient/Guardian Date

Preferred Pharmacies

1_____ Location _____

2_____ Location _____

3_____ Location _____

** We reserve the right to perform urine drug tests or any similar tests to determine appropriate use of controlled substances. You have the right to decline the test*, however* some of your medications may not be able to be filled. Examples: diet, pain, sleep, anxiety

Social History

Are you sexually active? Yes No

Smoking status:

___never smoked ___former smoker ___electronic cigarette
___Passive secondhand smoke ___Smokeless tobacco ___current every day smoker
Packs per day: ___ less than 1 ___1 - 2 packs ____3 or more
Years smoked: ___ less than 5 years ___6-19 years ____ 20 years or more
Quit Date: ___ less than 3 months ___ 4month-2 years ____ 2-9 years ____ more than 10 years

Substance use:

Soda or energy drink (coffee/monster) ___none ___1-3/wk ___4-7/wk ___>8/wk
Alcohol intake: ___none ___1-3/wk ___4-7/wk ___>8/wk
Illicit drug use: ___none ___<1 wk ago ___1-4 wks ago ___>4 wks ago

Employment:

Full time: ____ Part time: ____ Unemployed: ____ Retired: ____ Volunteer: ____

Current history of home:

Lives with: _____ # of adults in home: _____ # of children in home: _____
Primary caretaker: _____ Daycare: _____

Please list any other medical providers you see, last visit date and next visit date. (dentist, eye doctor, cardiologist, dermatologist, gastroenterologist, neurologist, orthopedist, surgeon, endocrinologist, urologist, gynecologist, pain management, counselor, psychiatrist, other)

Doctor name & specialty	Last visit	Next visit

Current prescriptions, over the counter medicines, supplements or vitamins:

Name	Dosage	Frequency	Reason Prescribed

Are you allergic to any medications or other substances? YES NO *if yes, please list below:

_____

_____

Past Medical History
Please check any that apply to you:

___Asthma	___Coronary Artery Disease	___Headache/Migraine	___Leg/Foot Ulcers
___Allergies	___Cataract	___Heart Attack	___Liver Disease
___Anxiety	___Dementia/Memory	___Heart Disease	___Menopausal
___Arthritis	___Diabetes	___Heart Murmur	___Osteoporosis
___Atrial Fibrillation	___Depression	___Hepatitis	___Overweight
___BPH/Prostate	___Diverticulosis	___High Blood pressure	___Pacemaker
___Bipolar disorder	___Eating disorder	___High Cholesterol	___Peripheral Vascular Dis.
___Blood clot	___Fibromyalgia	___HIV/AIDS	___Seizures
___Cancer: _____	___GERD/Reflux	___Hormone Disorder	___Sleep Apnea
___Chronic Fatigue	___Glaucoma	___Hypothyroidism	___Stomach Ulcer
___CHF	___Gout	___Insomnia	___Stroke
___COPD	___Hashimoto	___Kidney Disease	___Substance Abuse

Women:
Please list your last menstrual period: _____ Birth control: _____ Menopause: _____

Prosthesis/Implants:
___Glasses/contacts ___Dentures ___Hearing Aid ___Cane/Walker/Crutches ___Wheelchair/Scooter

Blood Type: _____

Surgeries: (list the year)

			Other
____Tonsillectomy	____partial Hysterectomy	____total hysterectomy	_____
____appendectomy	____Gallbladder removed	____Heart Stent	_____
____Vasectomy	____Heart bypass		_____

Family Medical History: ____Healthy/Adopted/Unknown

	Mother	Father	Sibling	Child	Grandparent	Other
Arthritis	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Cancer: _____	_____	_____	_____	_____	_____	_____
Dementia	_____	_____	_____	_____	_____	_____
Depression or Anxiety	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Overweight	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Substance abuse	_____	_____	_____	_____	_____	_____
Suicide	_____	_____	_____	_____	_____	_____

Other:
_____

Has any immediate **family member** had a stroke, heart attack, open heart surgery, heart stent or sudden death **<55 years old?** _____

Medical Records Release

I hereby authorize: Name_____
Address: _____
_____
Phone: _____
Fax: _____

To release to: North Texas Family Medicine
1340 North HWY 377, Ste 110
Pilot Point, TX 76258
Phone 940-686-0860
Fax 940-686-5834

The information contained in the medical record of:

Patient _____ DOB _____

Information Requested:

_____ History & physical _____Progress / clinical Notes

_____ Discharge summary studies _____ Labs / Xrays / Diagnostics

_____ Operative Report _____ Mental Health Information

_____ Drug / Alcohol Use or Abuse _____ HIV / AIDS testing/results/diagnosis

_____ The Complete Record _____Other

For the purpose of:

_____Follow up care _____ Personal Concerns

_____Legal Needs _____ Other_____

By signing this authorization, I authorize the facility listed above to disclose my protected health information (PHI) to North Texas Family Medicine. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke the authorization in writing except to the extent the facility listed above has acted in reliance upon this authorization. My written revocation must be in writing to the facility listed above.

_____ _____
Signature Date

If the above-named person is under the age of 18 or has a legal appointed guardian, the designated legal guardian must sign release. Proof of guardianship may be required.