# TEXAS HEALTH CARE, P.L.L.C.

P.O. Box 961205
Fort Worth, Texas 76161-1205

PHYSICIAN: _____
BEING SEEN TODAY

LOCATION: _____ DATE: _____

## PATIENT REGISTRATION INFORMATION

*If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.*

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ ____ ____ ___/___/___ ____ S M D W O
LAST FIRST MI SEX MM / DD / YY DATE OF BIRTH AGE MARITAL STATUS

Address: _____ _____ ____ _____ (____) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (____)_____ Day Phone: (____)_____ Email: _____

Race_____ Language_____ Ethnicity ❒ Hispanic/Latin ❒ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (____) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

## RESPONSIBLE PARTY AND BILLING INFORMATION

*Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.*

Patient Relationship to Responsible Party: Child ____ Other _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ____ ____ ___/___/___ ____ S M D W O
LAST FIRST MI SEX MM / DD / YY DATE OF BIRTH AGE MARITAL STATUS

Address: _____ _____ ____ _____ (____) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (____) _____ (____)
WORK PHONE EXT

## OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

Spouse's Work Phone: (____) _____ (_____) Occupation: _____
EXT

## PRIMARY INSURANCE

*Please complete the information below and provide a copy of the insurance card.*

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ____ ____ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ _____ _____
STREET CITY ST ZIP

## SECONDARY INSURANCE

*Please complete the information below and provide a copy of the insurance card.*

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ____ ____ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

## WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

## ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

## REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

## ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Texas Health Care, P.L.L.C. (THC), and it's physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that THC has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to THC, 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, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

**Patient Name:** _____ **Account No.** _____ **DOB:** ____/____/____

**Initial Visit Medical History Form (p. 1): Please provide the following medical information to the best of your ability:**

| Date: | Age: | List any ALLERGIES TO MEDICATIONS: |
|---|---|---|
| What problems are you here for today? | | |
| | | |
| | | |

**Past Medical History:**

1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

| | Yes | No | | | Yes | No | |
|---|---|---|---|---|---|---|---|
| Diabetes (Circle: Type I / Type II) | | | | Stomach or Intestinal problems | | | |
| Hypertension (high blood press) | | | | Allergy problems/therapy | | | |
| Thyroid problems | | | | Kidney problems | | | |
| Heart Disease/cholesterol probs | | | | Mental Retardation | | | |
| Respiratory problems | | | | Cancer | | | |
| Bleeding disorder | | | | Tuberculosis | | | |
| HIV infection / AIDS | | | | Other Medical Diagnosis | | | |

2) Please list any operations (and dates) you have ever had (including tonsils & adenoids)

3) Please give your Pharmacy contact information (address and phone number)

**Social History:**

| | Yes | No | | |
|---|---|---|---|---|
| Do you use tobacco? | | | List type and how much: | |
| If no, did you use it previously? | | | List type and how much: | When did you quit? |
| Do you drink alcohol? | | | List type and how much: | |
| Do you use recreational drugs? | | | List type and how much: | |
| Increased risk HIV exposure? | | | | |

What is your occupation?

**Family History:**

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:

If yes, please indicate which relative(s) have the problem

| | Yes | No | | | Yes | No | |
|---|---|---|---|---|---|---|---|
| Heart problems / murmurs | | | | Cancer | | | |
| Allergy | | | | Bleeding disorder | | | |
| Diabetes | | | | Anesthesia problems | | | |
| Thyroid problems | | | | | | | |

| | | | |
|---|---|---|---|
| | | See attached dictation | Reviewed by: |

Patient Medical History Form - Review of Systems: Date: _____

Patient Name: _____ DOB:_____

Please **CIRCLE** the "Yes" or "No" box to indicate whether your presently have any of the following symptoms.

| | | | |
|---|---|---|---|
| General: | Fatigue | yes | no |
| | Lethargy (Daytime Sleepiness) | yes | no |
| | Weight gain | yes | no |
| | Weight loss | yes | no |
| ENT: | Headache | yes | no |
| | Hearing loss | yes | no |
| | Ear noises | yes | no |
| | Decreased sense of smell | yes | no |
| | Facial pain | yes | no |
| | Nasal congestion | yes | no |
| | Sneezing | yes | no |
| | Hoarseness | yes | no |
| | Problem snoring, apnea | yes | no |
| | Throat clearing | yes | no |
| Eyes: | Watery/itchy eyes | yes | no |
| | Eye pain | yes | no |
| Respir: | Cough | yes | no |
| | Dyspnea (shortness of breath) | yes | no |
| | Hemoptysis (coughing up blood) | yes | no |
| | Wheezing | yes | no |
| Cardiac: | Palpitations | yes | no |
| GI: | Difficulty swallowing | yes | no |
| | Heartburn | yes | no |
| | Odynophangia (throat pain) | yes | no |
| | Choking | yes | no |
| Neuro: | Dizziness | yes | no |
| | Passing out/fainting | yes | no |
| | Numbness/tingling | yes | no |
| | Seizures | yes | no |
| Psych: | Anxiety | yes | no |
| | Depression | yes | no |
| Skin: | Rash | yes | no |
| Heme/Lym: | Bleeding problems | yes | no |
| | Easy bruising | yes | no |
| | Swollen glands | yes | no |
| Immunological: | Allergies | yes | no |

# MEDICATION LIST

**PATIENT'S NAME:** DOB:

**MEDICATION ALLERGIES:**

**REACTIONS:**

| MEDICATION | DOSE (MG) | TIMES TAKEN | WHAT FOR | PRESCRIB. DR | BEGAN |
|---|---|---|---|---|---|
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# Privia Medical Group North Texas

## HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ○ OK to leave a message with detailed information
  - ○ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ○ OK to leave message with detailed information
  - ○ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of **NORMAL** test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of **ABNORMAL** test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- ☐ Yes
- ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- ☐ Yes
- ☐ No

**ADVANCED DIRECTIVE**

Do you have an advanced directive (Living Will)?

- ☐ Yes
- ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate