BEST CHOICE PRIMARY CARE

PATIENT INFORMATION

Patient Name:______________________DOB:__________Gender:___
Driver's License:___________________SSN:_____________________
Home Phone:______________________Cell:______________________
Address: _________________________________Zip Code_________
Email:____
Employer: ________________________Position:_________________
Employer Address:________________________Phone:____________
Preferred Pharmacy:_______________________Phone:____________

EMERGENCY CONTACT INFORMATION

1.Name:_____________________________Relationship:___________
Phone:____________________Alternate Phone:__________________
2.Name:_____________________________Relationship:___________
Phone:____________________Alternate Phone:__________________
Is the patient a dependent? ___Guardian Name:_________________
Guardian Phone:____
Is the patient married?_______Spouse Name:____________________
Spouse Phone:____

INSURANCE

Insured Party:__________________________DOB:______________
Relation to Patient:__________________________
Company:____________________________Phone:_________________
Address:____
Policy No:____________________________Group No:_____________
Dual Coverage?____2nd Insurance:______________________________
Policy No:____________________________Group No:_____________
Payment Method:____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and copay are due at the time of service. I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_________________________________ _________________________________

Signature **Date**

BEST CHOICE PRIMARY CARE

PATIENT MEDICAL INFORMATION

NAME:_________________________GENDER:__DOB:________DATE:_________

ALLERGIES:____

List ALL medications you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you do not know, please call your pharmacist to confirm.

________________________ ________________________ ________________________
________________________ ________________________ ________________________
________________________ ________________________ ________________________

PERSONAL MEDICAL HISTORY (Please circle all that apply.)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia
(irregular heartbeat)
Arthritis
Asthma
Bipolar
Bladder Problems/
Incontinence
Bleeding Problems
Cancer:__________
Headaches
Crohn's Disease
COPD/Emphysema
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)

Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease
High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Muscular Degeneration
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)
Rheumatoid Arthritis
Seizure Disorder

Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis
Colonoscopy Date:________
Normal/Abnormal

Females:
Have you ever been pregnant?
Yes / No
Last Menstrual Period
Date:________
Normal/Abnormal
Mammogram
Date:________
Normal/Abnormal
Dexa
Date:________
Normal/Abnormal
Pap
Date:________
Normal/Abnormal

Other medical problems not listed above:

____

SURGICAL HISTORY

_____________________________ _____________________________

_____________________________ _____________________________

BEST CHOICE PRIMARY CARE

Patient Name ___________________________

SOCIAL/CULTURAL HISTORY:

Education Level: Elementary High School Vocational College Graduate

Current Living Situation: Single Family Household Multi-generational Household
Homeless Skilled Nursing Facility

Are there any vision problems that affect your communication? Yes No

Are there any hearing problems that affect your communication? Yes No

Are there any limitations to understanding or following instructions, either written or verbal problems that affect your communication? Yes No

Smoking/Tobacco: Current Past Never Type___________Amt/Day________Years______

Alcohol: Current Past Never Drinks/Week______________

Recreational Drugs: Current Past Never Type_____________________

Are you sexually active? Yes No

Are there any personal problems or concerns at home, work, or school you would like to discuss? Yes No
____

Are there any cultural or religious concerns you have related to our delivery of care? Yes No

Are there any financial issues that directly impact your ability to manage your health? Yes No

How often do you get the social and emotional support you need?

Always Usually Sometimes Rarely Never

Comments/Other concerns: ____

FAMILY HISTORY:

FATHER Living Age Deceased Age

Alcoholism	Bipolar	Depression	HighBloodPress	Stroke
Anemia	Cancer _____	DVI(BloodClot)	Kidney Disease	Diabetes
Asthma	COPD/Emphysema	Heart Disease	Migraines	ThyroidDisord
Arthritis	Dementia	HiCholesterol	Osteoporosis	

MOTHER Living Age Deceased Age

Alcoholism	Bipolar	Depression	HighBloodPress	Stroke
Anemia	Cancer_____	DVI(BloodClot)	Kidney Disease	Diabetes
Asthma	COPD/Emphysema	Heart Disease	Migraines	ThyroidDisord
Arthritis	Dementia	HiCholesterol	Osteoporosis	

SIBLINGS____

Other Medical Providers you see on a regular basis: ____
____

Patient Signature__________________________________**Date**_______________________

BEST CHOICE PRIMARY CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT: ______________________________Facility: *BEST CHOICE PRIMARY CARE*

Phone: _______________________________Email: ______________________________

Would you like our correspondence with you to be marked "Confidential"? Yes ☐ No ☐

May we identify ourselves over the phone? Yes ☐ No ☐

I have been given a copy of Best Choice Primary Care's *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that Best Choice Primary Care has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the website at www.bestchoiceprimarycare.com .

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

____ __________________________

Signature of Patient or Personal Representative Date

____

Print Name

____

Personal Representatives Title

HIPAA DISCLOSURE

I, _______________________________, hereby authorize Best Choice Primary Care to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: ___________________________DOB:____________ Relationship:______________

Name: ___________________________DOB:____________ Relationship:______________

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: ___________________________Clinic:____________ Phone:_________________

Doctor: ___________________________Clinic:____________ Phone:_________________

Signature____________________________________**Date:**_______________________

BEST CHOICE PRIMARY CARE

Allergy Questionnaire

Would you like to discuss allergy testing/immunotherapy? Yes / No

If yes, please answer the following questions. Circle one:

1. Do you experience itchy or watery eyes, runny nose, plugged-up nose, or sneezing?
   Yes No
2. What time of year are your symptoms worst?
   Spring Summer Fall Winter All year
3. Do you have asthma?
   Yes No
4. Do you get frequent sinus infections or ear infections?
   Yes No
5. Do you have pets?
   Yes No
6. Do you have ongoing or chronic cough?
   Yes No
7. Have you tried taking antihistamines such as Claritin (loratadine), Allegra (fexofenadine), Zyrtec (cetirizine), Benadryl (diphenhydramine), Dimetapp (brompheniramine) Chlortrimeton (chlorpheniramine)?
   Yes No
8. Have you ever had a severe reaction to a bee sting (i.e., swelling of mouth or throat, difficulty breathing, or been to the emergency room?
   Yes No
9. Do you have eczema or other itchy rashes?
   Yes No

BEST CHOICE PRIMARY CARE

How Did You Hear About Us?

- **Insurance Directory / Facebook / Instagram**
- **RealSelf**
- **Patient Pop**
- **Newsletter / Magazine Ad**
- **Texas Weddings/SA Bridal Extravaganza**
- **Referred by Friend:______________________**
  Other:________________________________

Like us on Facebook & follow us on Instagram
@bestchoiceprimarycare
Leave us a review!

BEST CHOICE
PRIMARY CARE

Patient Registration Form
Disclosures & Consents

Patient Full Name: _______________________________ Date of Birth: _____________________

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Best Choice Primary Care, PLLC or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefits. I understand and agree that I will be responsible for any co-pay or balance due that Best Choice Primary Care, PLLC is unable to collect from my insurance carrier whatever reason. J

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Best Choice Primary Care, PLLC or the physicians on my behalf.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to, such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Best Choice Primary Care, PLLC to that effect in writing.

LAB/X-RAY/DIAGNOSTIC/SERVICES:

I understand that I may receive a separate bill if my medical are includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee.

PATIENT SIGNATURE: ______________________________________ DATE: _____________

GUARANTOR
SIGNATURE: ____ DATE: ______________

GUARANTOR'S
PRINTED NAME: ____

BEST CHOICE PRIMARY CARE

Best Choice Primary Care, PLLC
A Nurse Practitioner Driven Practice

Phone: (210) 474-6020
Fax: (855) 772-9540
www.bestchoiceprimarycare.com

MEDICAL RELEASE of RECORDS Form:

I, ____(Print Name), request that the following clinic:

Doctor/Clinic Name: ____

Phone: ____

Fax: ____

Release the following record for ____

DOB: ____________________________________

[ ] immunization record

[ ] labs/xrays within the past year

[ ] last wellness exam

[ ] all clinical notes

Signed: ____________________________________Date: _____________________

PLEASE FAX TO:

Jan Elliott MSN, APRN, FNP-C
Best Choice Primary Care
5525 Blanco Rd Ste 102, SAT 78216
(210) 474-6020 FAX: 855-772-9540

BEST CHOICE PRIMARY CARE

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _______

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

BEST CHOICE PRIMARY CARE

Patient Health Questionnaire-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use a check mark to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	_____ +	_____ +	_____ +	_____

= Total Score: _____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Created by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroehnke and colleagues, with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.