ABC MEDICAL CENTER

Always the Best Care!

HOW DID YOU HEAR ABOUT US?
(MARK ALL THAT APPLY)

- ☐ RADIO
- ☐ MAIL
- ☐ INTERNET
- ☐ FAMILY OR FRIEND_____
- ☐ OTHER _____

Patient Information

Patient Name:_____ DOB:_____
Home Address:_____ Apt#:_____
City:_____ State:_____ Zip:_____ ❑ Male ❑ Female
SSI:_____ Home Phone #:_____
Cell Phone #:_____ Employer:_____
Work #:_____ Email:_____
May we contact you at work? ❑ Yes ❑ No

Emergency Contacts

Name:_____ Home Phone #:_____
Relationship to the patient:_____ Cell Phone #:_____
Name:_____ Home Phone #:_____
Relationship to the patient:_____ Cell Phone #:_____

I authorize that payments go directly to ABC Medical Center, PA/Dr. Ricardo J Martinez on all charges made by medical services provided to the above patient. I am aware that any charges that are not covered by my health insurance are my responsibility. I also authorize the release and request of any information needed to be able to process claims made for such services.

Past Medical History

Have you ever had:

❑ Diabetic	❑ Heart Murmur	❑Crohn'sDisease
❑ High Blood Pressure	❑ Pneumonia	❑ Colitis
❑ High Cholesterol	❑ Pulmonary Embolism	❑Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis

❑ Cancer (Type)_____

❑ Stroke	❑ Stomach or Peptic Ulcer	❑ Rheumatic Fever
❑ Leukemia	❑ Epilepsy (seizure)	❑ Tuberculosis
❑ Psoriasis	❑ Cataracts	❑ HIV / AIDS
❑ Angina	❑ Kidney Disease	
❑ Heart Problems	❑ Kidney Stones	

Other Medical Conditions (please list):

_____

Women's Reproductive History

Age of your first period:_____ Last Menstrual Cycle:_____

# of Pregnancies:_____ # of Miscarriages:_____

# of Abortion:_____

Have you reached menopause? ❑ Yes ❑No If so, at what age? _____

Do you have regular periods? ❑Yes ❑No

Current Medications

Drug allergies: ❑ Yes ❑No To what? _____

Please explain:_____

Please list any medications that you are taking now. Including non-prescription medications and vitamins or supplements:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

HABITS

Alcohol: ❑ None ❑ Yes How often? ❑ Daily ❑ Weekly ❑ Occasionally
What kind?_____
Tobacco: ❑ None ❑ Yes ❑ Chew or ❑ Smoke How many daily?_____
Caffeine: ❑ None ❑ Yes What kind? _____ How many per day? _____
Other Recreational Drugs: ❑ None ❑ Yes What kind? _____
How often? _____
Do you drive? ❑ Yes ❑ No Do you always wear a seatbelt? ❑ Yes ❑ No
Do you exercise? ❑ Yes ❑ No How often? _____

Past Surgical History (indicate date if known)

❑ None

❑ Cataracts _____ ❑ Lasik _____

❑ Tonsillectomy _____ ❑ Thyroidectomy _____

❑ Adenoidectomy _____ ❑ Coronary Bypass _____

❑ Cardiac Stents _____ ❑ Pacemaker_____

❑ Heart Valve _____ ❑ Gallbladder_____

❑ Appendectomy _____ ❑ Bowel/Stomach Resection_____

❑ Hemorrhoidectomy _____ ❑ Bariatric Surgery_____

❑ Hysterectomy_____ ❑ Endoscopy_____

❑ Colonoscopy_____ ❑ Hernia_____

❑ Spinal Surgery_____ ❑ Tubal Ligation_____

❑ Bladder Surgery_____ ❑ Prostate Surgery/resection_____

❑ C-Section_____ ❑ Orthopedic/joints_____

❑ Other _____

Family History:

Mother:
❑ Diabetes
❑ High Blood Pressure
❑ High Cholesterol
❑ Hypothyroidism
❑ Epilepsy
❑ Stroke
❑ Cancer_____

Father:
❑ Diabetes
❑ High Blood Pressure
❑ High Cholesterol
❑ Hypothyroidism
❑ Epilepsy
❑ Stroke
❑ Cancer_____

_____ _____

Patient Signature **Date**

I acknowledge that the above information has been filler out to the best of my knowledge.

Client Acknowledgment

Patient Name:_____ DOB:_____

"I understand that, in the opinion of Always Best Care Medical Center Providers and staff, the service or items that I have requested to be provided to me on _____ (date) may not be covered under my insurance health plan as being reasonable and medically necessary for my care. I understand that the HHSC or it's health insurance agent determines the medical necessity of the service or item that I request and receive. I also understand that I am responsible for my payment of the service or item I request and receive, if this service or items are determined not to be reasonable and medically necessary for my care"

"Yo comprendo que, segun la opinion de Always Best Care Medical Center y sus Proveedores, es posible que mis Aseguranza Médica no cubra los servicios o los análisis que el proveedor solicite _____ (fecha) por no considerarlos una necesidad para mi salud. Comprendo que mi seguro médico o el agente de seguros de salud determinan la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicite y reciba, si estos servicios y provisiones no son razonable necesarios para mi salud"

_____ _____

Member Signature
Firma del Miembro

Date
Fecha

_____ _____

Provider Representative
Representante del Proveedor

Date
Fecha

Immunizations and testing required for Immigration

The following immunizations are required:

Name of the Immunization	Age Required	Price
Mumps, Measles & Rubella (MMR)	1 year old and over	$100
Tetanus Shot (TDAP)	11 years and over	$25
Varicella (chicken pox)	1 year and over	$155
Influenza (Flu Shot) Oct. 1st - March 31st	6 months and over	$30

If the patient is between the age of 2 and 15 years of age, it is a requirement to be up to date on all vaccines according to the immunization schedule provided by the Department of Health and Human Services. A shot record is required for proof of immunization.

You will also be tested for the following:

1. **QUANTIFERON TB GOLD** **$200**

Is a blood test that aids in the detection of mycobacterium tuberculosis, the bacteria that causes tuberculosis. The results will be ready in 4-5 business days. The TB skin test is no longer valid by immigration.

2. **SYPHILIS EXAM** **$15**

Syphilis is a bacteria infection caused by sexual contact. Blood test will be done for this exam. If the result is negative you will not need any more testing. However, if the result is positive you will need to consult with the doctor and receive treatment. You will need to follow up in 2 weeks.

3. **GONORRHEA EXAM** **$100**

Gonorrhea is a sexual transmitted disease. A urine sample will be needed for this test, if the results is negative you will not need any more testing. However if the result is positive you will need to consult with the doctor and receive treatment. You will also need to follow up in two weeks.

PHYSICAL EXAM **$100**

Your final price may vary based on which immunizations are needed.

By signing below I have read, understood and agreed to the above information regarding the INS exam, its procedures and prices, and a copy, if requested, has been provided for my own personal records.

_____ _____

Patients Signature **Date**

PLEASE FILL OUT ACCORDING TO YOUR IMMIGRATION DOCUMENTS.

PRINT CLEARLY

First Name:_____

Middle Name:_____

Last Name:_____

Date of Birth:_____ Gender: ❑ Male or ❑ Female

Address:_____

Phone Number:_____

City of Birth:_____ Country of Birth:_____

A-Number: (If Any)_____

Note: THERE WILL BE A CHARGE OF $25 FOR ANY CORRECTIONS THAT NEED TO BE MADE AFTER THE FINAL PAPERWORK IS DONE.

By signing below, I certify that all the information is true and correct.

_____ _____

Patient Signature **Date**