



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

Insurance Information

Insurance Name: _____ Coverage Date: _____
Subscriber Name: _____
Member ID: _____ Group Number: _____

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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (Type) _____ | | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or Peptic Ulcer | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizure) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney Stones | |

Other Medical Conditions (please list):

Women's Reproductive History

Age of your first period: _____ Last Menstrual Cycle: _____
of Pregnancies: _____ # of Miscarriages: _____
of Abortions: _____

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. _____

Pharmacy

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____

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 filled 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



Always the Best Care!

Authorization to Request Medical Information

Date: _____

Patient Name : _____ DOB: _____

I authorize and request that _____
and/or staff release a copy of my medical records to:

****** IF MORE THAN 40 PAGES PLEASE MAIL OUT!! ******

ALWAYS BEST CARE MEDICAL CENTER

DR. RICARDO J MARTINEZ

8 MEDICAL PKWY, PLAZA 2 SUITE 106

FARMERS BRANCH, TX 75234

PHONE: 972-406-2896

FAX: 972-406-2767

This request cover the following records to be released:

I understand that my records are confidential and can not be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be in subject to re-disclosure by the recipient and no longer protected, I understand that the specific information to be released may include, but is not limited to: history, diagnosis and /or treatment of a drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment can not be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of the testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has taken reliance upon the authorization.

This authorization will expire One Hundred and Eighty (180) days from the date of my signature unless I revoke the authorization before that.

Signature of patient or Legal Authorize Representative

Date

Printed Name/Relationship to Patient



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HIPPA CONSENT FORM

I, _____, DATE OF BIRTH (___/___/___) HEREBY GIVE MY
WRITTEN CONSENT FOR

NAME: _____
NAME: _____
NAME: _____
NAME: _____

TO SPEAK WITH DR. MARTINEZ AND HIS STAFF MEMBERS ABOUT MY :

() APPOINTMENT NEEDS (SCHEDULE, RESCHEDULE, CONFIRMATION, ETC.)

() LABS/RADIOLOGY RESULTS

() PROCEDURES RESULTS

() MEDICATION AND MEDICATION MANAGEMENT

() INSURANCE BENEFITS, GUARANTOR INFORMATION, AUTHORIZATION, CHANGES, AND
OUTSTANDING BALANCES.

() ENTIRE MEDICAL RECORDS.

() I DO NOT GIVE PERMISSION FOR DR. MARTINEZ OR HIS STAFF TO SPEAK TO ANYONE
REGARDING ANY OF MY PRIVATE HEALTH INFORMATION. THE ONLY PERSON THAT DR.
MARTINEZ AND HIS STAFF ARE ALLOWED TO SPEAK TO REGARDING MY PRIVATE HEALTH
INFORMATION IS MYSELF AND/OR REFERRING PHYSICIAN IF I HAVE ONE.

I UNDERSTAND THAT THIS CONSENT IS BINDING, AND DR. MARTINEZ AND STAFF MUST HAVE
WRITTEN NOTIFICATION SHOULD I CHOOSE TO REVOKE THIS PERSON FROM HAVING ACCESS
TO THE ABOVE INFORMATION DR. MARTINEZ AND HIS STAFF WILL ONLY SHARE THE
INFORMATION THAT I HAVE CHOSE WITH:

PATIENT SIGNATURE: _____

PATIENT PRINT: _____

DATE: _____

WITNESS: _____