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

Insurance Information

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

Parent Guardian

Patient Name:_____ DOB:_____
Home Address:_____ Apt#:_____
City:_____ State:_____ Zip:_____ ❑ Male ❑ Female
Home Phone#:_____

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. _____

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 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 **Date**
Firma del Miembro **Fecha**

_____ _____

Provider Representative **Date**
Representante del Proveedor **Fecha**

ABC MEDICAL CENTER

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 CENTER 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

Release For Medical Treatment For a Minor (Child)

I the undersigned affirm that I am the legal Parent/guardian of _____, I hereby authorize the following person(s) to give consent for medical treatment of my child in my absence.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Restrictions:_____

_____

Known Drug Allergies:_____

_____

_____ _____

Print Name **Witness**

_____ _____

Signature of parent/guardian **Date**

_____

Relationship to minor/child