Updated Patient Information

DOB: ________________ Male: ______ Female: ______ Social Security: ______________________________

First Name: _________________________ Last Name: ________________________ MI: _____ Suffix: ____

Updated Mailing Address: ____

City: _______________________________________ State: _________________ Zip: ______________

Home Number: ________________________ Cell: ______________________ Work: ________________

Email: _______________________________________ Single: _______ Married: _____ Other: _________

Partner's Name: _______________________________ School/Employer: __________________________

Emergency Contact: ____________________________ Phone #: _________________________________

Preferred Provider: _____________________________ Preferred Pharmacy: _______________________

Referred by: Newspaper [ ] Friend [ ] Relative [ ] Pharmacy [ ] Other [ ] Name: __________________________

Responsible Party

Responsible Party's Name: _______________________________ Phone #: __________________________

Address: ____ Employer: ___________________________

Insurance Information

Primary Insurance: ___________________________
ID#: _______________________________________
Group #: ___________________________________
Policy Holder: _______________________________
Policy Holder DOB: ___________________________

Secondary Insurance: __________________________
ID #: ______________________________________
Group#: ____________________________________
Policy Holder: _______________________________
Policy Holder DOB: ___________________________

Authorization for Release of Information

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance companies or third party carriers and request that the payment is made directly to the billing entity. I also request that payment of benefits from my secondary insurance carrier be paid to the billing entity until otherwise notified.

Signature of Patient/Guardian: ______________________________________ Date: __________________

1) I understand that I am financially responsible for any balances not covered by my insurance.
2) I understand that patient responsibility are due at the time of service.
3) I understand that a copy of my insurance card must be shown at each visit.
4) I understand that I will be charged a fee of $25 if I do not keep my appointment or cancel within 24 hours. This fee will increase by $10 each additional time an appointment is missed or not cancelled within 24 hours. We reserve the right to dismiss you after the third time you miss or fail to cancel within 24 hours.

I understand that that I am responsible for providing a referral from my PCP, (primary care physician), should my insurance require one and if one is not received my appointment will be cancelled.

Signature of Patient/Guardian: ______________________________________ Date: __________________

Personal Medical History

Past Surgeries: ______________________________
Specialists: ______________________________

Last Annual Physical Exam: _______/_______ Last Labs: _______/_________

Immunizations:	Month / Year		Month / Year		
Flu:	______/______	Annual Exam:	_______/_______	Exercise Stress Test:	______/ _______
Tetanus:	______/______	Pap:	_______/_______	Echocardiogram:	______/ _______
Pneumonia:	______/______	Mammogram:	_______/ _______	Lung Function Test:	______/ _______
Shingles:	______/______	Colonoscopy:	_______/_______	Ultrasound of Arteries:	______/ _______

Social History

Wears Glasses/Contact: Yes ____ No ____
Hearing Aids: Yes ____ No ____
Dentures: Yes ____ No ____
Cane/Walker: Yes ____ No ____

Living with: __________________________
Job: FT/PT/None
Education: Elem/HS/College/ Grad

	Never	Past	Current
Alcohol:	[ ]	[ ]	[ ]
Tobacco:	[ ]	[ ]	[ ]
Recreational Drug:	[ ]	[ ]	[ ]

Diagnosis	Self	Mom	Dad	Siblings	Grandparents	Other
Asthma:						
Arthritis:						
Cancer of __________						
COPD/Emphysema:						
Diabetes:						
Depression/Suicidal						
Glaucoma/Cataract/Mac Degen						
Heart Disease:						
Heart Attack:						
Heart Attack < 55 yrs ago						
High Blood Pressure:						
High Cholesterol:						
Hypoglycemia/Low Blood Sugars:						
Hypothyroidism:						
Overweight:						
Stroke:						
Seizure:						
Smoker:						

Allergic to what medication: ______________________________
____

Medications	Over the Counter	Supplements/Vitamins
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Would losing weight help you feel better or enjoy life better? Yes _____ No _____

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of North Texas Family Medicine

Print Name of Patient: ______________________________ Patient Date of Birth: ________________

Signature of Patient: ______________________________ Date: ____________________________

List 3 Pharmacies of Choice

1) ______________________________ Location: ______________________________
2) ______________________________ Location: ______________________________
3) ______________________________ Location: ______________________________

*** We reserve the right to perform urine drug tests or any similar test to determine appropriate use of controlled substance. You have the right to decline the test, **however** some of your medications may **not** be able to be filled. **Examples: Diet, pain, sleep, and /or anxiety pills.**

Instructions for Releasing Medical Information

Please initial Yes or No on each question

1) Speak only to me Yes _______ No _______
2) Ok to give message to my spouse Yes _______ No _______
3) Ok to leave message on voicemail/machine Yes _______ No _______

    *With Details Yes _______ No _______

    *Call back number only Yes _______ No _______

4) Please list names of individuals that are allowed to receive medical information.

    *If patient is a minor, list individuals that are allowed to bring and consent to medical treatment in case parent/guardian is not able.

Name: __________________________ Relationship: ______________ Phone # ________________

Name: __________________________ Relationship: ______________ Phone # ________________

Name: __________________________ Relationship: ______________ Phone # ________________

Name: __________________________ Relationship: ______________ Phone # ________________

Legal Guardian

I, ____________________________, am legal guardian of ______________________________

as their (relationship) ______________________________ .

Signature: ____ Date: ______________

North Texas Family Medicine

1340 North HWY 377, Suite #110
Pilot Point, TX 76258
Phone: 940-668-0860

6700 FM 902 Suite # 404
Lake Kiowa, TX 76240
Phone: 940-686-6836

Notifications and Authorizations

PLEASE DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND FULLY UNDERSTAND ITS CONTENTS

Financial Policy

Our office is a participating provider for most managed care plans. It is the patient's responsibility to provide their current insurance card at each visit. If you fail to provide your current insurance card, it will be necessary to reschedule your appointment or we accept you as a "self-pay" patient and expect you to pay at time of service and we will not file an insurance claim for that date of service. Payment for any co-pay, deductible, or co-insurance is expected at the time of check-in. For services rendered to minor patients, we expect payment from the adult accompanying the patient at the time of service. **Please note: Verification of insurance coverage is *not* a guarantee of coverage. You will be considered responsible for all fees not covered by your insurance. Insurance companies frequently misquote benefits and you are ultimately responsible to know your insurance benefits.**

Lab

As a convenience to our patients we have a draw station on site. If your insurance requires you to use any other lab besides LabCorp, it is your responsibility to notify the medical assistant or healthcare provider. You may receive a bill from the lab as well.

Assignment of Benefits

I authorize North Texas Family Medicine to release any information necessary to my insurance carrier(s) to process medical claims. I assign all insurance benefits to be paid directly to North Texas Family Medicine. A photocopy of assignment is to be considered as valid as the original.

General Consent for Treatment

I have requested medical services from North Texas Family Medicine for myself and/or dependent. I give permission to North Texas Family Medicine to examine and treat myself and/or my dependent as they deem necessary.

Cancellation/No Show Policy

There will be a fee assessed for a missed appointment unless you advise us one business day prior to your appointment.

_______________________________________ Patient / Guardian Signature

_________________ Date