Patient Information

DOB: _____ Male: _____ Female: _____ Social Security: _____

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

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: _____
Responsible Party SS #: _____

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: _____

Name: _____ **Date of Birth:** _____

Past Medical History ___None

Select all that apply chronically to you with the year you were first diagnosed:

___Asthma
___Allergies
___Anxiety
___Arthritis
___Atrial Fibrillation
___BPH/Prostate
___Bipolar Disorder
___Blood Clot
___Cancer: _____
___Chronic Fatigue
___Congestive Heart
___COPD
___Coronary Artery Dis.
___Cataract
___Dementia/Memory
___Depression

___Diabetes
___Diverticulosis
___Eating Disorder
___Fibromyalgia
___GERD/Reflux
___Glaucoma
___Gout
___Hashimoto
___Headache/Migraine
___Heart Attack
___Heart Disease
___Heart Murmur
___Hepatitis
___High Blood Pressure
___High Cholesterol
___HIV/Aids

___Hormone Disorder
___Hypothyroidism
___Insomnia
___Kidney Disease
___Leg/Foot Ulcers
___Liver Disease
___Menopausal
___Osteoporosis
___Overweight
___Pacemaker
___Peripheral Vascular Dis.
___Seizures
___Sleep Apnea
___Stomach Ulcer
___Stroke
___Substance Abuse

Other: _____

Blood Type: ___

Medical Surgeries: **None:** ___ (Put the year)

___Tonsillectomy ___Partial Hysterectomy ___Heart Bypass Other:
___Appendix out ___Total Hysterectomy ___Heart Stents _____
___Gallbladder out ___Vasectomy _____

Past Major Illness or Injuries: **None:** ____ (Put the year)

___Pneumonia ___Tuberculosis
___Underimmunized ___Chronic UTI
___Kidney Stone

Other: _____

Preferred Pharmacy: _____ ___Prefer 30 day Refills

Mail order Pharmacy: _____ ___Prefer 90 day Refills

Compound Pharmacy: _____

Prosthesis/Implants:

___Glasses/Contacts
___Dentures
___Hearing Aid
___Cane/Walker/Crutches
___Wheelchair/Scooter

Take Over the Counter:

_____
_____
_____

Current Prescriptions:

_____
_____
_____
_____
_____
_____

Medication Allergies:

_____
_____

Past Medical Tests: **None:**___

MRI: _____
US: _____
CT Scan: _____

List Other Medical Providers:		Last Visit Date:	Next Visit Date (estimate):
Dentist:			
Eye Doctor:			
Cardiologist:			
Dermatologist:			
Gastroenterologist:			
Neurologist:			
Orthopedist:			
Surgeon:			
Endocrinologist:			
Urologist:			
Gynecologist:			
Pain Management:			
Counselor:			
Psychiatrist:			
Other:			

Family Medical History: ___Healthy/Adopted/Unknown

	Mother	Father	Sibling	Child	Grandparent	Other
Arthritis:	___	___	___	___	___	
Asthma:	___	___	___	___	___	
Dementia:	___	___	___	___	___	
Depression:	___	___	___	___	___	
Diabetes:	___	___	___	___	___	
Heart Disease:	___	___	___	___	___	
High Blood Pressure:	___	___	___	___	___	
High Cholesterol:	___	___	___	___	___	
Kidney Disease:	___	___	___	___	___	
Overweight:	___	___	___	___	___	
Osteoporosis:	___	___	___	___	___	
Stroke:	___	___	___	___	___	
Substance Abuse/Tobacco:	___	___	___	___	___	

Immediate Family Member had a Stroke, Heart Attack, Open Heart Surgery, Heart Stent < 55 years old: ___

Other: _____

Social History

Smoking Status:

___ Never Smoked ___Former Smoker ___Electronic Cigarette

___ Passive Second-hand Smoke Quit Date: ___<3m ___4m-2yr ___2-9 yr ___>10 yrs

___Smokeless Tobacco Years Smoked: ___<5yr ___6-19 yr ___20yrs

___Current Every day Smoker Packs per day: ___<1 ___1-9 ___>10

Substance Use: **More:**

Soda or Energy Drink (Coffee/Monster): ___None ___1-3/wk ___4-7/week ___>8/week _____

Alcohol intake: ___None ___1-3/wk ___4-7/week ___>8/week _____

Illicit Drug use: ___None ___<1 wk ago ___1- 4wks ago ___>4wks ago

Employment:

Full time: _____ Student: _____

Part time: _____ Retired: _____

Unemployed: ___ Volunteer: _____

Current History of Home:

Live with: _____ # of Adults in Home: ___

Primary Caretaker: _____ # of Children in Home: ___

Daycare: _____

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 NTFM to update computer system including my medical information as deemed necessary. 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