NEW PATIENT INFORMATION

- ☐ Bedford
- ☐ Lewisville
- ☐ Benbrook
- ☐ Justin
- ☐ Boyd

Even though we at Your Family Medical (YFM) are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, Opana, and methadone.

- Please bring your driver's license and insurance cards along with your completed new patient paperwork to your scheduled appointment. Payment for services are expected at the time of service (co-pays, co-insurance, private pay). We accept cash and credit cards (Visa, American Express, MasterCard, and Discover).
- **If you have been instructed to obtain imaging reports and/or films by our staff, please bring them to your appointment. Our office requires these as part of your consultation.** ***If we do not have your films at the time of your appointment, you may be rescheduled.***
- NO CHILDREN are allowed in the clinic. Many of our patients are in wheelchairs and walkers and we see too many people to have children in the clinic. You will not be seen if you bring your children.
- If English is your second language, in order to provide you with the best health care service, please make arrangements for someone to accompany you to your visit who can translate. We want you to fully understand your diagnosis and prognosis and to answer any questions you may have.

Your Appointment is: ________________________

****If you have not filled out or completed the New Patient Packet, please arrive <u>30 minutes prior to your appointment</u>.**

We wish to make your visit as comfortable as possible, so please do not hesitate to contact us if you have any questions or concerns.

NAME:___________________________________ Date of Birth:_______________ DATE:____________

Is this your legal name? ☐Yes ☐No

If no, LEGAL NAME: _____________________________ FORMER NAME(S)? ______________________

____ _______________________________________

NEW PATIENT INTAKE

Patient's Age ______ Gender: M ☐ F ☐

STREET ADDRESS: ____

CITY: ______________________________________ STATE: _________________ ZIP: _______________

HOME PHONE: _________________ CELL PHONE: _______________ WORK PHONE: ________________

SSN: ______________________________ DRIVER'S LICENSE #: ___________________________________

MARITAL STATUS: ☐ Married ☐ Widowed ☐ Single ☐ Divorced

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino PREFERRED LANGUAGE: ___________________

RACE: ☐Native American ☐Asian ☐Black/African-American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Other

RELIGION: ____ EDUCATION: _________________________

E-MAIL: ____☐@yahoo.com ☐@gmail.com ☐@hotmail.com

PREFERRED METHOD OF COMMUNICATION: ☐Home phone ☐Cell phone ☐Work Phone ☐E-mail

REFERRING PHYSICIAN: ___________________________ PRIMARY CARE PHYSICIAN: ______________________

OTHER PHYSICIANS: ____

EMERGENCY CONTACT: _____________________________________ RELATIONSHIP: _____________________

EMERGENCY PHONE: ____________________________________ PHONE TYPE: _____________________

RESPONSIBLE PARTY INFORMATION

NAME: ____ DATE OF BIRTH:______________________

ADDRESS:____

RELATIONSHIP: ______________________________ PHONE: ______________ SSN: _________________

EMPLOYER: _____________________________________ EMPLOYER PHONE:______________________

NAME:_____________________________________ Date of Birth:________________ DATE:_____________

INSURANCE INFORMATION

INSURANCE COMPANY: ____ **(Provide card to front desk)**

INSURED'S NAME:____ DATE OF BIRTH:___________________

INSURED'S SSN: _________________________

RELATIONSHIP TO PATIENT ☐Self ☐Spouse ☐Dependent

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Your Family Medical or insurance company to release any information required to process my claims.

Patient/Guardian Signature _______________________________________ Date _____________________

PAST MEDICAL HISTORY

Please indicate if you have suffered from any of the following medical conditions. ***Also note the year these occurred.***

_______AIDS or HIV
_______Arthritis
_______Asthma
_______Cancer
_______Chronic skin disease
_______Depression
_______Diabetes
_______Emphysema
_______Fibromyalgia
_______Gallbladder
_______Gonorrhea
_______Gout
_______Headaches/migraine
_______Heart disease/attack
_______Heart failure
_______Heart murmur
_______Hepatitis
_______Herpes infection
_______High blood pressure
_______Hormone problems
_______Insomnia
_______Irregular heart beat
_______Jaundice
_______Kidney disease
_______Kidney Stones
_______Liver disease
_______Lupus
_______Menopause
_______Multiple sclerosis
_______Nervous breakdown
_______Other blood abnormality
_______Other venereal disease
_______Panic attacks
_______Peptic ulcer disease
_______Peripheral vascular disease
_______Pneumonia
_______Prostate enlargement
_______Rheumatic heart
_______Schizophrenia/bipolar
_______Seizures/convulsions
_______Shingles
_______Stroke
_______Syphilis
_______Thyroid
_______Tuberculosis
_______Urinary infection

Other: __________________
____
____
____

NAME:___________________________________ Date of Birth:_______________ DATE:____________

PAST SURGICAL HISTORY

__________________________Date/Year_________ _______________________Date/Year_________

__________________________Date/Year_________ _______________________Date/Year_________

__________________________Date/Year_________ _______________________Date/Year_________

FAMILY HISTORY

List any disease, illness, or ailments in your IMMEDIATE FAMILY. (i.e. mother-breast cancer, father - diabetic, grandfather - heart disease)

____

____

SOCIAL HISTORY

Occupation: ____

Do you smoke? ☐Yes ☐No How many packs/day?_________________ Years?_______________

Drink alcohol? ☐Yes ☐No How much?___________________

Use any other drugs (marijuana, cocaine, etc.)? ☐Yes ☐No If yes, what?_____________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Live Alone? ☐Yes ☐No If no, who do you live with? _______________________________________

REPRODUCTIVE HISTORY

Women:

Age when menstrual cycle began: _______ Date of last period: ____________

Difficulty with periods? ☐Yes ☐No

Total pregnancies_________ How many live births? _________

Miscarriages or abortions? ☐Yes ☐No How many? ________

Any medical problems associated with pregnancy or any other gynecological illnesses? ☐Yes ☐No

History of breast disease? ☐Yes ☐No Do you perform regular breast exams? ☐Yes ☐No

Date of last PAP smear_______________ Date of last mammogram________________

NAME:_________________________________ Date of Birth:______________ DATE:___________

REPRODUCTIVE HISTORY

Men:

Do you perform regular testicular self-exams? ☐Yes ☐No

Any problems with testicular, prostate, or infertility? ☐Yes ☐No If yes, please explain:____________

ALLERGIES ____

PHARMACY Name:__________________Location:______________________________________

CURRENT MEDICATIONS **include dosage and frequency for each

Medication	Dosage	Frequency

REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that needs further explanation please indicate such and explain in additional notes section.

General	YES	NO
Loss of appetite	☐	☐
Fever or chills	☐	☐
Eyes	☐	☐
Blurred vision	☐	☐
Loss of vision	☐	☐
Head/ear/nose/throat	☐	☐
Hoarseness	☐	☐
Trouble swallowing	☐	☐
Cardiovascular	☐	☐
Chest pain	☐	☐
Leg swelling	☐	☐
Varicose veins	☐	☐

Respiratory	YES	NO
Shortness of breath	☐	☐
Wheezing	☐	☐

Gastrointestinal	YES	NO
Nausea and vomiting	☐	☐
Ulcers	☐	☐
Blood in stool	☐	☐
Change in bowel habits	☐	☐
Kidney/bladder/urine	☐	☐
Painful urination	☐	☐
Frequent urination	☐	☐

Musculoskeletal	YES	NO
Significant pain/stiffness	☐	☐
Skin	☐	☐
Rash	☐	☐
Frequent rashes	☐	☐

NAME:____________________________________ Date of Birth:_______________ DATE:____________

Neurological	**YES**	**NO**
Tremor	☐	☐
Seizures	☐	☐
Stroke	☐	☐

Psychiatric	**YES**	**NO**
Mental Illness	☐	☐
Suicide Attempt	☐	☐
Depression	☐	☐
Drug/Alcohol addiction	☐	☐
Difficulty with sexual activities	☐	☐

Endocrine	**YES**	**NO**
Thyroid disease	☐	☐

Hematological/Lymphatic	**YES**	**NO**
Easy bruising	☐	☐

Immunologic	**YES**	**NO**
Enlarged/swollen lymph glands	☐	☐

Mark all that apply:	**YES**	**NO**
Recent weight loss	☐	☐
Low energy/fatigue	☐	☐
Double Vision	☐	☐
Eye pain	☐	☐
Hearing loss	☐	☐
Ear pain	☐	☐
Palpitations	☐	☐
Orthopnea	☐	☐
Chronic cough	☐	☐
Heartburn	☐	☐
Constipation	☐	☐
Hemorrhoids	☐	☐
Blood in urine	☐	☐
Change in urinary pattern	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Tingling	☐	☐
Suicidal Thoughts	☐	☐
Trouble sleeping (insomnia)	☐	☐
Heat/cold tolerance	☐	☐
Easy bleeding	☐	☐

Additional Notes:____

____

____

____

PATIENT CONSENT AND AUTHORIZATION

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

CONSENT TO TREAT

I, ________________________________ (Patient name) give permission for Your Family Medical to give me medical treatment and I allow Your Family Medical to file for insurance benefits to pay for the care that I receive.

I understand that: ***(Please initial each)***

_______Your Family Medical will have to send my medical records information to my insurance company.

_______I must pay my share of the costs.

_______I must pay for the cost of the services if my insurance does not pain or I do not have insurance.

_______I understand that I have the right to refuse any procedure or treatment.

_______I have the right to discuss all medical treatments with my provider.

Patient Signature: ________________________________ **Date:** ____________

Parent or Guardian Name (PRINTED): __________________________________

Parent or Guardian Signature: ____

PATIENT CONSENT (PHI)

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
AND ANTI-DISCRIMINATION POLICY.

I, ___________________________(Patient name), hereby state that by signing this Consent, I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Novice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3) I understand that, and consent to the following appointment reminders that will be used by the Practice: (a) a postcard mailed to me at the address provided by me; and (b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; (c) text message to my mobile phone.
4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees with a requested restriction, then the restriction is binding on the Practice.
6) I understands that this consent is valid for seven years. I further understand that I have the right to revoke this Consent in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8) I understand that if I do not sign this Consent evidencing my consent to uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

ANTI-DISCRIMINATION POLICY

Initials_______ Discrimination or harassment against any member of Your Family Medical (i.e. physicians, nurse practitioners, office staff, or patients) because of age, ancestry, color, disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, gender, gender identity and/or expression, marital or parental status, national origin, pregnancy, race, religion, sexual orientation, veteran's status, or any other categories protected by federal or state law is prohibited and will not be tolerated, nor will any person for those reasons be excluded from the participation in or denied the benefits of any program or activity within Your Family Medical.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_______________________________________ _______________________________________

Name of Individual (PRINTED) Signature of Individual

_______________________________________ _______________________________________

Signature of Legal Representative Relationship
(Attorney-in-Fact, guardian, or parent if a minor)

Date Signed: ______________________

Witness: _________________________________ Title:_________________________

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of patient or representative

____
Date

____
Witness (YFM Employee) Title of Witness

List any person(s) you wish to have access to your medical information, including portal access:

NAME: ____ RELATIONSHIP:_____________________

NAME: ____ RELATIONSHIP:_____________________

NAME: ____ RELATIONSHIP:_____________________

FINANCIAL POLICY AGREEMENT

As part of our ongoing commitment to treating our patients with complete courtesy, dignity, and respect, we regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our billing specialists prior to treatment.

INSURANCE AND PATIENT RESPONSIBILITY

Initials_____ Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable copays, co-insurance payments, and deductibles for the insurance companies with whom we are contracted. YFM accepts cash, in-state personal checks, Visa, MasterCard, Discover, and American Express. There is a $30.00 service charge for returned checks.

Initials_______ I understand that if I have insurance I am the responsible party and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above. YFM bills participating insurance companies as a courtesy to our patients. Patients are expected to pay their deductible and/or co-insurance/copay at the time of service. ***You must present an insurance card at each visit. If you or your dependent(s) do not present a valid insurance card at the time of your visit, you will be responsible for the visit cost in full.***

PATIENT RESPONSIBILITY

Initials_______ I understand that some, or perhaps all of the services I receive may be non-covered or not considered reasonably necessary by my insurance company. In the event that my insurance company determines a service to be non-covered, I understand that I will be responsible for the service(s) performed. The physicians in the office will be unable to change their normal course of treatment due to non-covered services or limitations of my insurance benefits. Payment for non-covered services will be due at the time of service or upon receipt of a statement from YFM.

PAYMENT ARRANGEMENTS

Initials_______ I understand that patients with an outstanding balance of 30 days or more overdue must make payment arrangements prior to scheduling appointments. Payment plans must be set up by the patient in person and will automatically be deducted from the credit/debit card specified in that arrangement.

MINOR PATIENTS

Initials_______ Regardless of marital status, YFM will look to the adult accompanying the patient for payment due at the time of service is rendered to the minor patient. If a parent other than the one accompanying the patient to the office is legally responsible for the account, a copy of the court decree with need to be submitted to the office. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. In addition, minor cannot receive medical treatment without the signed consent of a parent or legal guardian.

CLAIMS SUBMISSION

Initials_______ I understand that YFM will submit my claims and assist me in any way they reasonably can to help get my claims paid. I understand that my insurance company may need me to supply certain information directly to them and it is my responsibility to comply with their requests.

NON-PAYMENT

Initials_______ I understand that statement balances must be paid within 30 days to avoid late payment penalty charges. If my account is over 90 days past due, I will receive a letter stating that I have 20 days to pay my account in full. Partial payments will not be accepted unless arranged in advance with a signed payment arrangement in place. I understand that if a balance remains unpaid, YFM may refer my account to a collection agency. Any collection agency fees, in addition to my unpaid balance, will be my responsibility.

MISSED APPOINTMENTS AND LATE CANCELLATIONS

Initials_____ I understand that if I am unable to make an appointment, I must call within 24 hours prior to your appointment time to reschedule. If I fail to notify YFM prior to missing my scheduled appointment, I understand that I will be charged a NO SHOW FEE of $25.00 for an office visit and $50 for a procedure. This must be paid prior to scheduling any future visit. Frequent missed appointments/no show, or chronic rescheduling may result in termination of physician/patient relationship and release from YFM.

Patient Signature or
Authorized Representative:____

Printed Name of above: ____

Date: ________________

PATIENT AUTHORIZATION FOR MEDICAL DISCLOSURE
(BY TELEPHONE OR FAX)

Please fill out this form and give to the Front Desk.

The patient authorizes this clinic to disclose medical information regarding clinical care and diagnoses, including laboratory results and medical history to those listed below: (i.e. family physician, referring physician, family members, attorney, etc.)

Primary Care Physician____

Telephone _______________________________

Name____

Telephone _______________________________ Relationship _____________________________

Name____

Telephone _______________________________ Relationship _____________________________

Name____

Telephone _______________________________ Relationship _____________________________

I hereby request and authorize YFM to release and send the following information:

☐ Complete Record

☐ Complete Hospital Records

☐ Records from ________ to ________ only.

☐ Records concerning the following conditions only: ___________________________________

____

This consent is in effect until revoked in writing. Our office requires patient consent in writing for all information requests not related to billing requirements.

______________________________________ ______________________

Name of Patient (PRINTED) **Date**

____ ______________________________________

Signature of Patient or Legal Guardian **Relationship to Patient**

SLEEP HISTORY AND EXAMINATION FORM

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

Your physician requests that you complete this Sleep History Form which evaluates the need for you to have a user-friendly home sleep test. The home sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Date:___________ Name:________________________________ Date of Birth:____________ Age:_____

Phone:___________________Home Address:____

Physician Name:_________________________________ Height________ Weight____lbs. BMI_______

1) Have you ever been given a CPAP device? ☐Yes ☐No (Date________)
2) Are you comfortable with your CPAP and satisfied with its use? ☐Yes ☐No
3) How many hours do you sleep on average per night? ☐Less than 4 hrs. ☐More than 4 hours

Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale:

0 = never 1 = slight 2 = moderate 3 = high

1) Being a passenger in a motor vehicle for 1 hour or more? 0 1 2 3 4
2) Sitting and talking to someone. 0 1 2 3 4
3) Sitting and reading. 0 1 2 3 4
4) Watching TV. 0 1 2 3 4
5) Sitting inactive in a public place. 0 1 2 3 4
6) Lying down to rest in the afternoon. 0 1 2 3 4
7) Sitting quietly after lunch without alcohol. 0 1 2 3 4
8) In a car, while stopped for a few minutes in traffic. 0 1 2 3 4

Part I

1) Have you been told that you snore or grind your teeth at night? ☐Yes ☐No
2) Do you wake unrefreshed, tired, feeling sleepy most of the time or need to nap? ☐Yes ☐No
3) Does your family have a history of premature death in sleep? ☐Yes ☐No
4) Do you have diabetes? ☐Yes ☐No
5) Have you ever been told you have coronary artery disease? ☐Yes ☐No
6) Do you have high blood pressure? ☐Yes ☐No
7) Have you ever experienced irregular heart rhythms? ☐Yes ☐No
8) Do you have heart disease? ☐Yes ☐No
9) Do you have lung disease? ☐Yes ☐No
10) Do you suffer from depression? ☐Yes ☐No

11) Do you take sleep medication? ☐Yes ☐No
12) Do you experience morning headaches? ☐Yes ☐No
13) Do you take sleep medication? ☐Yes ☐No
14) Do you suffer from restless leg syndrome? ☐Yes ☐No
15) Do you suffer from insomnia? ☐Yes ☐No
16) Do you suffer from narcolepsy? ☐Yes ☐No

PART II

1) Have you ever been diagnosed with sleep apnea? ☐Yes ☐No
2) Do you wake from sleep with chest pain or shortness of breath? ☐Yes ☐No
3) Has anyone said that you seem to stop breathing while sleeping? ☐Yes ☐No
4) Is your neck size larger than 15”(female) or 16.5”(male)? ☐Yes ☐No
5) Have you ever had a stroke? ☐Yes ☐No
6) Have you ever been told you have congestive heart failure? ☐Yes ☐No
7) Do you have or did you even have atrial fibrillation? ☐Yes ☐No
8) Do you wake up from sleep choking or gasping for air? ☐Yes ☐No
9) Do you wake or bother bed partner with legs kicking or moving? ☐Yes ☐No
10) Do you sleep walk, talk, or act out dreams? ☐Yes ☐No

Actual Neck Size ☐

Patient Signature: ____ Date:______________

If patient presents with positive screening or sleep apnea a home sleep study will be ordered. ☐

Physician Signature: ______________________________________ Date:______________

Mallampati Score: _____________ ☐Teeth marks on tongue ☐Overbite or recessive chin