DALLAS COMPREHENSIVE MEDICAL CARE

NEW PATIENT INTAKE FORM

DATE _____

PATIENT INFORMATION

NAME (Last, First, MI) _____ DOB _____ AGE _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____ SSN _____ ☐ MALE ☐ FEMALE

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

REFERRED BY _____

INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)

NAME (Last, First, MI) _____ DOB _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

SSN _____ RELATION TO PATIENT _____

INSURANCE COMPANY _____ BENEFIT PHONE _____

SUBSCRIBER ID _____ GROUP NUMBER _____

RELEASE OF INFORMATION

I authorize Dallas Comprehensive Medical Care, PLLC and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records, and other health related items on my behalf.

What level of information may we release?

- ☐ All information including medical diagnoses, medications, lab results, and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).
- ☐ Information including medical diagnoses, medications, and lab results only.
- ☐ No information whatsoever.

To whom may we release information? (please list names & phone numbers)

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing, and that the revocation will not apply to information already released in response to this authorization.

FINANCIAL AND GENERAL POLICY SIGNATURE

I have read and understand Dallas Comprehensive Medical Care Financial and General Office Policies. My signature indicates compliance and understanding of these policies. I also understand that a copy of these policies will be provided to me upon request.

_____ _____

Signature of Patient/Guardian Date

DALLAS COMPREHENSIVE MEDICAL CARE

NAME _____

REASON FOR VISIT TODAY

REASON FOR VISIT TODAY (chief complaint): _____

_____

SYMPTOMS PRESENT FOR: _____ ☐ DAYS ☐ WEEKS ☐ MONTHS

PLEASE EXPLAIN _____

_____

_____

ARE YOU PREGNANT? ☐ NO ☐ YES BREAST FEEDING? ☐ NO ☐ YES

CURRENT MEDICATIONS AND ALLERGIES

CURRENT MEDICATIONS

_____

_____

_____

_____

_____

MEDICATION ALLERGIES

☐ NO KNOWN DRUG ALLERGIES

PLEASE LIST MEDICATION
AND FOOD ALLERGIES _____

_____

_____

HAVE YOU TAKEN ANTIBIOTICS IN THE LAST 6 WEEKS?

☐ NO ☐ YES WHICH? _____

PHARMACY NAME _____ PHARMACY PHONE _____

PHARMACY ADDRESS/CROSS STREET _____

TREATMENT CONSENT AND AUTHORIZATION

I hearby authorize Dallas Comprehensive Medical Care, PLLC to furnish to any designated attorney or insurance company all information necessary to file a health insurance claim form or to obtain reimbursement. I hereby assign all medical and/or surgical benefits to which I am entitled (including Medicare and other government sponsored programs, private insurance and any other health plans) to Dallas Comprehensive Medical Care, PLLC. I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. Also, I hereby authorize the disclosure of heath information in any data format regarding my treatment, hospitalization and/or outpatient care to Dallas Comprehensive Medical Care, PLLC. I understand that this facility will maintain medical records in accordance with state requirements and are hereby released from all legal responsibility or liability that may arise from this authorization. By my signature below, Dallas Comprehensive Medical Care, PLLC is fully authorized to disclose such information when requested. The foregoing information is true and correct to the best of my knowledge.

If indicated, I authorize Dallas Comprehensive Medical Care to communicate with my pharmacist by phone or electronically to verify prescription medications, dosages and refill information. I understand this consent includes all medications prescribed by Dallas Comprehensive Medical Care as well as other physicians.

_____ _____

Signature of Patient /Guardian Date

DALLAS COMPREHENSIVE MEDICAL CARE

PAST MEDICAL HISTORY			
	PATIENT	FAMILY MEMBER	IF YES, PLEASE COMMENT
High Blood Pressure	☐ NO ☐ YES	☐ NO ☐ YES	
High Cholesterol	☐ NO ☐ YES	☐ NO ☐ YES	
Heart Disease / Heart Attack	☐ NO ☐ YES	☐ NO ☐ YES	
Heart Failure	☐ NO ☐ YES	☐ NO ☐ YES	
Stroke or TIA	☐ NO ☐ YES	☐ NO ☐ YES	
Asthma or COPD	☐ NO ☐ YES	☐ NO ☐ YES	
Lung Disease / Tuberculosis	☐ NO ☐ YES	☐ NO ☐ YES	
Sleep Apnea	☐ NO ☐ YES	☐ NO ☐ YES	
Kidney Disease or Stones	☐ NO ☐ YES	☐ NO ☐ YES	
Reflux or Ulcers	☐ NO ☐ YES	☐ NO ☐ YES	
Hepatitis / Liver Disease	☐ NO ☐ YES	☐ NO ☐ YES	
Colitis or Diverticulitis	☐ NO ☐ YES	☐ NO ☐ YES	
Diabetes	☐ NO ☐ YES	☐ NO ☐ YES	
DVT or PE (Blood Clot)	☐ NO ☐ YES	☐ NO ☐ YES	
Anemia	☐ NO ☐ YES	☐ NO ☐ YES	
Cancer	☐ NO ☐ YES	☐ NO ☐ YES	
Depression / Anxiety	☐ NO ☐ YES	☐ NO ☐ YES	
Dementia	☐ NO ☐ YES	☐ NO ☐ YES	
Neurological Disease	☐ NO ☐ YES	☐ NO ☐ YES	
Other	☐ NO ☐ YES	☐ NO ☐ YES	
Other	☐ NO ☐ YES	☐ NO ☐ YES	

PLEASE LIST OTHER PHYSICIANS YOU SEE ON A REGULAR BASIS _____

_____

_____

_____

PRIOR SURGERIES	PRIOR HOSPITALIZATIONS
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

DALLAS COMPREHENSIVE MEDICAL CARE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

OCCUPATION: _____

SMOKING HISTORY: ☐ NEVER SMOKED

☐ QUIT, DATE _____

☐ CURRENT SMOKER ☐ CIGARETTES _____ PACKS PER DAY ☐ CIGARS _____ PER WEEK

ALCOHOL INTAKE: HOW MANY DAYS A WEEK DO YOU DRINK? _____

HOW MANY DRINKS DO YOU HAVE AT ONE TIME? _____

EXERCISE : HOW MANY DAYS A WEEK DO YOU EXERCISE? _____

PLEASE DESCRIBE _____

FAMILY HISTORY

ARE YOUR PARENTS LIVING? ☐ NO ☐ YES

IF NOT, PLEASE LIST AGE / CAUSE OF DEATH.

_____

NAMES AND AGES OF SIBLINGS (LIVING AND DECEASED)

_____

NAMES AND AGES OF CHILDREN

_____

PREVENTATIVE MEDICINE

COLONOSCOPY	☐ NO ☐ YES	WHEN & BY WHOM?
MAMMOGRAM	☐ NO ☐ YES	WHEN & BY WHOM?
PAP SMEAR	☐ NO ☐ YES	WHEN & BY WHOM?
PROSTATE EXAM	☐ NO ☐ YES	WHEN & BY WHOM?
BONE DENSITY	☐ NO ☐ YES	WHEN?
TETANUS	☐ NO ☐ YES	WHEN?
PNEUMOVAX	☐ NO ☐ YES	WHEN?
SHINGLES VACCINE	☐ NO ☐ YES	WHEN?
ANNUAL FLU VACCINE	☐ NO ☐ YES	WHEN?
DENTAL EXAM	☐ NO ☐ YES	WHEN?
EYE EXAM	☐ NO ☐ YES	WHEN?
DERMATOLOGY EXAM	☐ NO ☐ YES	WHEN?

DALLAS COMPREHENSIVE MEDICAL CARE

PATIENT PORTAL AUTHORIZATION

Our patient portal allows established patients to communicate more easily with us. The portal is not intended for 'Web Visits' or new problems. Instead, it will make regular communication more flexible. The portal is a voluntary option and is free of charge to all patients.

Through the portal, you can:

- Update your contact and insurance information.
- Check your medication list, medical history and your visits.
- Get your lab results quickly.
- Email us securely.

We want your records to be complete and correct. Let us know if there is any problem with your records. Sometimes we may use medical jargon in your records and it can lead to confusion. If something doesn't make sense, let us know.

Privacy matters. We will never sell/trade/abuse your e-mail address. The patient portal is protected just like all other interactions with our office. We also think it's important for you to protect privacy on your end, and we recommend that you protect your user name and password to avoid misuse. We take security seriously, too. Computer networks do have real risks. We use appropriate technologies to protect your health information. We follow all security laws, including HIPAA and HITECH.

Bedside manner is complicated via email. It's easy to misread information or emotion. We'll try to keep things brief and clear on the Portal. We really appreciate your help on that, too. If a message takes a long time to write, it's probably something better done in person at an office visit.

If we have troubles, abuse or 'Spam', we may need to change policies, suspend accounts, or even terminate the portal.

You can access the portal day or night, but we don't have a 24 hour presence on our end. As a safeguard, the portal should not be used for pressing issues. If you are experiencing an emergency or have an urgent medical need, you should call our office. If it's after hours, we recommend that you go to Urgent Care, the Emergency Room or call 911.

By signing below, I understand there are pros and cons to using the patient portal for communications with the clinic. I have had a chance to discuss my concerns with the office and have my questions answered. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, we will assign you a username and password. This will be sent to you via email, to the address we have on file.

By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth above.

_____ _____

Signature Date

_____

Printed Name