Name:___________________________ **DOB:**__________ **Age:**______ **Todays Date**:_______

Past Medical History:

Current Medication and Doses

Medication	Dosage	Medication	Dosage

What medications are you allergic to and what kind of reaction did you have?
____
____

Do you take herbs or supplements? Yes No
Which Ones: ____
____

Circle all diseases you currently have or have had in the past:

High Blood Pressure Elevated Cholesterol Cancer Diabetes
Thyroid Disease Heart Disease Others:_________________

Please list Hospital Admissions / Surgeries / Procedures/ Biopsies

Year		Year	

Family History:
Father: Living / Illness ______________________ Mother: Living / Illness_________________
Deceased-Cause of death_______________ Deceased-Cause of death________________
Age at death: _______ Age at death: _______

Has any parent, brother or sister had: (Please indicate which relative and age at diagnosis)
Colon Cancer Ovarian Cancer Arthritis Heart Disease
Colon Polyps Prostate Cancer Thyroid Cancer Osteoporosis

Melanoma Stroke Breast Cancer Alcoholism Lupus
Kidney Disease Diabetes Depression Glaucoma Clotting Disorder
Multiple Sclerosis Parkinson's Disease Rheumatoid Arthritis

Social History:

Occupation: ____________________________ Married / Single / Divorced / Widowed
# of children________

Alcohol: Drinks per week ________
Have you ever had problems with alcohol use? Yes / No
Have you ever felt the need to cut down on drinking? Yes / No
Have people annoyed you by criticizing your drinking? Yes / No
Have you felt the need to drink in the morning to steady your nerves or to get rid of a hangover? Yes / No

Cigarettes: ______ packs per day _____ years Quite (when)?_________
Snuff: ______per day for _______years

Coffee / Tea ________cups per day Caffeinated Sodas: per day

Do you consider yourself Heterosexual / Homosexual

Recreational drug use / Substance abuse (injections or other) Yes / No Current: Yes / No
Which substances: ___________________________________

What type of exercise do you do? ____

How often? 1-3 times a week / 5-7 days a week / Rarely / Never

Name: ____

Date: ____________

Review of Symptoms: Please circle / check all that apply to you

GENERAL:
Fatigue / Weakness
I do not feel rested when I wake up
I am not satisfied with my sleep
I am very sleepy during the day
I fall asleep easily during the day
Depression / Sadness
Unhappiness
I have felt down or hopeless for a while
I have little interest / joy in daily activities
Fearfulness
Feeling of worthlessness
Excessive irritability
Lack of motivation
Moodiness
Nervousness / Anxiety
Lack of concentration
Always feel ill
Unexplained fever >100
Frequent night sweats
Recent weight loss / gain
Allergies
Anemia
Mental Illnesses

SKIN:
Moles / changes in moles
Concerned about skin growths
Bruise easily
Rashes
Hives / Itchy Skin
Psoriasis
Dry Skin
Excessive hair growth
Hair loss

ENT:
Allergy symptoms
Frequent cold sores / mouth sores
Decreased hearing
Ringing in the ears
Frequent ear infections
Dizzy spells
Nose bleeds
Sore throat
Hoarseness
I would like allergy testing: Yes / No

EYES:
Watery Eyes
Itchy Eyes
Eye Pain
Double / Blurred vision
Other Visual Disturbances

LUNGS:
Pneumonia
Asthma/Wheezing
Persistent Cough
Coughing Blood
Snoring
Stop Breathing / gasp at night
TB positive skin test / TB

HEART / CIRCULATION:
Shortness of Breath
on exertion / lying flat
Chest Pain / Discomfort
High Blood Pressure
Heart Murmur
Palpitations / Racing heart
Irregular Puse
Fainting Spells
Swollen ankles
Leg pain with walking
Varicose Veins
Cold / Numb feet
Phlebitis – Blood Clots

GASTROINTESTINAL:
Change in bowel habits
Indigestion / heartburn
Difficulty swallowing
Persistent nausea / vomiting
Peptic ulcers
Swallowing pain
Abdominal pain
Diarrhea / Constipation
Bloody / Tarry stools
Hemorrhoids
Gall Bladder problems
Hepatitis / Jaundice

GENITAL / UROLOGY:
Hernia
Frequent Urinary Tract Infections
Painful urination in day or night
Frequent urination
Urinary leakage / Incontinence
Blood in urine
History or sexually transmitted disease

MALE:
Decreased force in urination
Erection Problems
Too rapid ejaculation
Testicle lumps / swelling

Female:
Pain / Bleeding during or after sex
Vaginal discharge / itching
Abnormal pap smear
Flushing / Menopausal symptoms
Significant pain / cramps with periods

BREAST:
Pain
Cyst / Lumps / Nodules
biopsy done: Yes or No
Nipple Discharge

Female Menstrual History:
Age at onset _____ Regular / Irregular
Flow: Heavy / Moderate / Light
____Days of flow _____Length of Cycle
# of Pregnancies _______
# of Live Births
# of Miscarriages / Other ________
Birth Control Method _______________

CENTRAL / PERIPHERAL NERVOUS SYSTEM:
Frequent Headaches
Seizures / Convulsions
Stroke
Memory Loss
Tremor / Hands shanking
Dizzy / Lightheadedness
Muscle Wasting
Numbness / Tingling Sensation

MUSCULOSKELATAL:
Arthritis
Recurrent back pain
Bone pain / fracture
Gout
Foot pain

IMMUNIZATION DATES:
Tetanus / Tdap: ___________________
Flu shot: ______________________
Pneumonia: ______________________
COVID-19 vaccine _________________

Last Mammogram: _________________
Last Pap: ______________________
Last Colonoscopy:_________________

Would you like STD /HIV testing? Yes / No
Have you been physically hurt by anyone? Yes / No
Have you ever had a blood transfusion? Yes / No

Thank you for selecting our healthcare team. We will strive to provide you with the best possible healthcare. To help us meet your needs, please fill out this form completely. You will be asked to update this information every 6 (six) months due to our changing healthcare environment. We will also ask you for a copy of your Insurance Card or cards (if you have more than one insurance) and a copy of your Driver's License.

Today's Date: ___________________________ Date of Birth: ________________________________ Patient's Last Name:

____________________________ First Name: ______________________ Middle: ________________ Address:

____ Apt #: ________________ City:

__________________________________ State: _________ Zip: ________ Sex: Female/Male (circle one) Phone #:

__________________________________ Secondary Phone #: ____________________________________ Marital Status: Married / Single /

Divorced / Widowed / Legally Separated

Email: ____ Social Security #: _______-_______-________ Emergency Contact:

___________________________ Emergency Contact Phone #: ____________________________ Emergency Contact Relationship:

____ Patient's Occupation:

____ Employer: ________________________________

Employer Phone #: _____________________________

INSURANCE POLICY HOLDER / PERSON RESPONSIBLE FOR THIS ACCOUNT

Relationship to Patient_______________________________ Phone #: ___________________________ Last Name:

______________________________________ Secondary Phone #: ___________________ First Name:

____________________________________ Middle: _____ Sex: Male / Female (circle one) Date of Birth:

_____________ Social Security #: _______-______-_______

Company Name: ____ Ph #: ________________________

ID / Policy #: ______________________________________ Group #: ___________________________ **FOR POLICY/GROUP NUMBER, BE SURE TO INCLUDE ALL CHARACTERS-LETTERS AND NUMBERS**

Other Family Members on Policy:
Name: _______________________________________ DOB: __________ Relationship: _____________ Name:
_______________________________________ DOB: __________ Relationship: _____________

Please indicate how you would like to be contacted by our office:

Primary Ph #:

Ok to leave a message on machine with detailed message / medical information Yes / No Ok to leave message with our office name and call back only Yes / No

Secondary Ph #:

Ok to leave a message on machine with detailed message / medical information Yes / No Ok to leave message with our office name and call back only Yes / No

Please initial in the blank to the left of each statement to denote agreement:

_____ I hereby authorize Family Medicine Plus to release any information concerning my condition and treatment or examination (including HIV and psychological records) rendered to me, my child or person under my legal guardianship to third party payers / health practitioners.

_____ I understand the Insurance company may not pay the actual bill for services, and I agree to be responsible for payment of all services rendered for myself, my child or the person under my legal guardianship.

_____ Patient or his / her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician that are not covered or adjusted by the insurance company.

Financial Policies:

- Copayment is due at the time of the visit. If you do not have your co-payment, we will ask that you reschedule your appointment.
- If you have not met your deductible, you are expected to pay in full at the time of the visit. • We charge the insurance carriers our "normal fees". We are paid their allowable amounts and write off the difference between those two amounts as the discount. We do not write off amounts that have gone to the deductible, non-covered services, or co-payments. • After your insurance company has paid their portion, if there is any amount not covered due to your deductible, non-covered services such as preventative care, etc., we will send you a bill for the amount due. We ask that you remit the owed amount upon receipt of the bill. • It is ultimately the patient's responsibility to be aware of their plan's limitations and restrictions on covered services.
- Failure to keep the patient's account current may result in Family Medicine Plus being unable to provide additional services except for emergencies.
- We reserve the right to charge you (not your insurance company) a $25 office fee if you do not cancel your appointment within 24 hours of your appointment time, or if you no-show for your appointment.
- A $25 service fee will be added for any checks returned for any reason and guarantor will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds.
- Accounts not paid in full within 90 days of a statement date, will be turned over to collections for further processing, and a collection agency processing fee will be added to the outstanding balance.

Please sign below to indicate our understanding and agreement with our financial policies: Signature:

____ Date: ________________________

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for the purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:
Your protected health information may be used and disclosed by your physician, or office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to quality assessments activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see
patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may disclose your protected health information as necessary, to contact you to remind you of your appointment.
We may disclose your protected health information in the following situations without your authorization. These situations are required by law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate to determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has acted in reliance on the use or disclosure indicated in the authorization.

11330 Legacy Drive, Suite
301 Frisco, TX 75033
214-396-9191

Family Medicine Plus

11330 Legacy Dr. Ste 301
Frisco TX 75033
Phone: (214) 396-9191
Fax: 877-730-1002
www.familymedicineplus.com

HIPPA Release Form

Patient Name (Print):____

Date of Birth: ____

Release of Information:

☐ **I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:**

☐ Spouse: ______________________________

☐ Child(ren)______________________________

☐ Other: ______________________________

☐ Information is not to be released to anyone.

I authorize the above-named facility to release the medical information requested above to the person/people listed above, and to include all confidential communicable disease, alcohol/drug abuse treatment, mental health diagnosis/treatment and HIV-related information. Without my express revocation, this consent with automatically expire after the requested information has been supplied.

NOTE: The information requested on this form letter is solicited under Title 38, USC and will authorize the addressee to disclose the information you specify to the above named. The information will be used to assist our medical staff in your examination and treatment. Your disclosure of the information is voluntary. However, your failure to give your consent may result in incomplete information in which to base your treatment.

This release of information will remain in effect until terminated by me in writing.

______________________________________ ______________________

Signature of patient or authorized representative Date

______________________________________ ______________________

Witness Date

Yearly Physicals are provided once per year by most insurance carriers without a copay. Physicals include a comprehensive exam evaluating ears, nose, throat, mouth, thyroid, lymph nodes, heart, lungs, liver, abdomen, pelvis, pulses, reflexes, prostate check (for men over 40), pap smear (for women), and skin check for moles.

Yearly physicals also include a medical history including **review** of medications, medical diagnoses, surgeries, family history and social history. It also includes screening blood test including blood count, electrolytes, blood sugar, kidney/liver function, cholesterol, prostate (for men), urinalysis, and sometimes other test such as Thyroid. These are all screening test for preventative care.

Yearly physicals **DO NOT** include the following:

- Management of medical conditions
- Refilling / Prescribing medications, or supplements to treat acute or chronic medical conditions. • Referrals to specialist. Referrals are considered medical management.
- Sick Visits
- Chronic ailments (example: joint pain/back pain/GERD)

If you desire medical management or a referral to specialist for a medical condition during the physical exam, we will bill your insurance on office visit along with the yearly physical. You **WILL BE** responsible for the applicable co-pay. This is an accepted medical practice, as additional time is spent actively managing medical conditions.

We offer the availability of having both physical and office visit on the same day in order to save you time and having 2 separate appointments. If you would like, we could reschedule the physical to a later date if you need to have a medical appointment first. Please feel free to discuss with a staff member if you have any questions.

I have read and acknowledge the above yearly physical policy.

Signature: ____ Date: ________________

Print Name: ____ DOB: _________________

Family Medicine Plus

11330 Legacy Dr. Ste 301
Frisco TX 75033
Phone: (214) 396-9191
Fax: 877-730-1002
www.familymedicineplus.com

Request for Medical Records

- ☐ **Release to Transfer Care**
- ☐ **Release to Family Medicine Plus**
- ☐ **Release to Outside Provider**
- ☐ **Release to Patient**
- ☐ **STAT Request**
- ☐ **Routine Request**

Office Name:____

Office Phone Number: ____________________ Office Fax Number: __________________

We would appreciate your cooperation in forwarding medical information to assist our medical staff in the examination and/or treatment of the patient named below:

Patient Name (Print):____

Date of Birth:____

Information needed:

- ☐ Discharge Summary
- ☐ Labs (The last 3 sets of labs)
- ☐ Office Notes (The last 2 office visits)
- ☐ Radiology (Everything within the last year)
- ☐ Other:____

I authorize the above-named facility to release the medical information requested above to Family Medicine Plus, and to include all confidential communicable disease, alcohol/drug abuse treatment, mental health diagnosis/treatment and HIV-related information. Without my express revocation, this consent with automatically expire after the requested information has been supplied.

NOTE: The information requested on this form letter is solicited under Title 38, USC and will authorize the addressee to disclose the information you specify to Family Medicine Plus. The information will be used to assist our medical staff in your examination and treatment. Your disclosure of the information is voluntary. However, your failure to give your consent may result in incomplete information in which to base your treatment.

__________________________________ __________________

Signature of patient or authorized representative Date

Please fax the medical information with this cover sheet to the attention of Medical Records to (877) 730-1002.