PRIMARY CARE OF
SOUTHERN TEXAS

To: PRIMARY CARE OF SOUTHERN TEXAS From: _____

Fax: (713) 673-8044 Phone: _____

Thank you for choosing PRIMARY CARE OF SOUTHERN TEXAS. In an effort to expedite your check-in process as a new patient, please complete the new patient forms before your appointment and either fax or bring them with you to your appointment.

Items to bring to your appointment:

1). New Patient Forms

2). Insurance Card(s)

3). Any and all recent X-rays and MRI's

4). Medications

Office Information:

PRIMARY CARE OF SOUTHERN TEXAS
27160 US-290, Cypress, TX
77429, United States
Ph: (713) 673-8774 Fax: (713) 673-8044

Thank you for choosing PRIMARY CARE OF SOUTHERN TEXAS. If you have any questions please feel free to contact our office staff. We look forward to seeing you.

☐ New Patient ☐ Updated Information

PRIMARY CARE OF SOUTHERN TEXAS

Patient Demographics

Patient Name:_____ Birth Date:_____/_____/_____
LAST FIRST MI

Social Security No:_____-_____-_____ Gender: ☐ Male ☐ Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #:_____-_____-_____Cell #:_____-_____-_____ Work #:_____-_____-_____

E-Mail Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language: _____

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone:_____-_____-_____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company:_____Insured's Name:_____

Policy #:_____Group #:_____Insured's Date of Birth: _____

Secondary Insurance

Secondary Company:_____Insured's Name:_____

Policy #:_____Group #:_____Insured's Date of Birth: _____

Self-Pay Agreement

I agree to pay for medical services rendered from PRIMARY CARE OF SOUTHERN TEXAS PLLC.
I understand that payment must be made prior to establishing as a new patient.

Patient Signature:_____Date: _____

New Patient Health Questionnaire

NAME: _____ Birth Date:_____/____/_____ Age: _____
LAST FIRST MI

Preferred Pharmacy:_____Phone #: _____

Allergies / Sensitivity to Medications:_____

Chief Complaint for Visit: _____

Current Symptoms: (Please check all that apply.)

☐ Headaches	☐ Hoarseness	☐ Bowel Problems
☐ Vision Problems	☐ Throat Problems	☐ Bladder Problems
☐ Nasal Congestion	☐ Swallowing problems	☐ Sexual Difficulties
☐ Runny Nose	☐ Dizziness	☐ Weakness
☐ Ear Problems	☐ Breathing Problems	☐ Numbness
☐ Chest Pain	☐ Stomach Problems	☐ Weight Changes

Past Medical History: (Please check all that apply.)

☐ Deafness/Decreased Hearing	☐ Epilepsy / Seizures	☐ Diabetes Mellitus
☐ Heart Problems	☐ Mental Illness	☐ Hemorrhoids
☐ Heart Attack	☐ Nervous Breakdown	☐ Stomach / Bowel Problems
☐ High Blood Pressure	☐ Mental Retardation	☐ Ulcers
☐ Blood Transfusion	☐ Cancer	☐ Migraines
☐ Anemia	☐ Stroke	☐ Arthritis
☐ Bleeding Disorder	☐ Blindness	☐ Hepatitis
☐ High Cholesterol	☐ Glaucoma	☐ Liver Problems
☐ Lung Problems	☐ Sinus Infection	☐ Gout
☐ Asthma	☐ Urine Infection	☐ Broken Bones
☐ Pneumonia	☐ Kidney Disease	☐ Joint Dislocation
☐ Rheumatic Fever	☐ Kidney Stone	☐ Birth Defects
☐ Scarlet Fever	☐ Thyroid Problems	☐ Amputations
☐ Tuberculosis	☐ Venereal Disease	☐ HIV
☐ Allergies		

New Patient Health Questionnaire

NAME: _____ Birth Date:_____/____/_____ Age: _____
LAST FIRST MI

Past Surgical History

Operations (Include Biopsy)	Year	Surgeon	Reason for Surgery

Past Hospitalizations (non-Surgical)

Hospital	Year	Reason for Admission

Family Medical History: (Please check all that Apply.)

Conditions	Father	Mother	Brother(s)	Sister(s)	Children
Diabetes:	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐
Cancer/Type:	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐
Glaucoma:	☐	☐	☐	☐	☐
Anemia:	☐	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

Immunizations:

Description	Last Known Date
PNEUMONIA	/ /
TETANUS	/ /
FLU	/ /
OTHER:	/ /

New Patient Health Questionnaire

NAME: _____ Birth Date:_____/____/_____ Age: _____
LAST FIRST MI

Social History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employment: ☐ Employed ☐ Unemployed ☐ Retired Occupation:_____.

Living Situation: ☐ Lives alone ☐ Lives with family ☐ Lives with others

Smoking: ☐ Current Smoker, everyday ☐ Current Smoker, some days ☐ Former Smoker
☐ Never Smoker ☐_____packs/day ☐_____years smoked

Alcohol Use: ☐ YES ☐ NO
☐ Heavy drinker (1-5 drinks/day) ☐ Moderate Drinker (1-5 drinks/week)
☐ Occasional Drinker

Recreational Drug Use:
☐ YES ☐ NO
☐ Heavy User (daily to weekly) ☐ Moderate User (monthly) ☐ Occasional User

List recreational drugs used:_____.

Periodic Examinations:

(Please Check Exam and State when.)

☐ Pap Smear:	/ /	☐ Mammogram:	/ /
☐ Rectal Exam:	/ /	☐ Chest X-Ray:	/ /
☐ EKG:	/ /	☐ Test for Blood in Stool:	/ /
☐ Blood Work:	/ /	☐ Colonoscopy Exam:	/ /

FOR WOMEN ONLY:

Last Menstrual Cycle:		Method of Birth Control:	
Number of Pregnancies:	Live Births:	Miscarriages:	Abortions:
Age of Menopause: _____	Natural or Surgical (Please Circle One)		

New Patient Health Questionnaire

NAME: _____ Birth Date:_____/____/_____ Age: _____

Current Medications:

List ALL medication that you are currently taking including Non-Prescriptions Medication & Herbal remedies.
(Please DO NOT Substitute a List. Please write meds below)

Medications	Dose	How Often	Approximately Start Date (Month/Year)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of PRIMARY CARE OF SOUTHERN TEXAS and affiliatedproviders may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name

_____

Print Name Legal Guardian

_____

Date

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of PRIMARY CARE OF SOUTHERN TEXAS. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical and surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that PRIMARY CARE OF SOUTHERN TEXAS and affiliated providers reserve the right to terminate the physician/patientrelationship for non-compliance with any of the above policies.

_____ _____ _____

Patient Name (Please Print) Date Patient Signature