Health First

PRIMARY CARE OF SOUTHERN TEXAS

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 bring them in or email them to **Backoffice@stxprimarycare.com**

Name : _____

DOB: _____

Items to bring to your appointment:

1.) New patient forms (if not emailed)
2.) Insurance card
3.) Form of Identification
4.) Medication list
5.) Any Recent Imaging reports

Office Information: Primary Care Of Southern Texas
27160 US 290 Ste 207
Cypress Tx 77433
Phone: 713-673-8774
Fax: 855-576-4146

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.

Health First PRIMARY CARE OF SOUTHERN TEXAS

PATIENT DEMOGRAPHICS

Patient Name: _____

Last First Mi

Birth Date: ___/___/____ Gender: ☐ Female ☐ Male

Home Address: _____

Cell #: ____-_____-_____ Home #: ____-_____-_____

Email Address: _____

Preferred Language: _____

Emergency Contact Information:

Name: _____ Phone: _____-_____-_____

Release Of Medical Information:
(Medical Information mayb be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____

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Preferred Pharmacy : _____ **Phone #:** _____

Allergies 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		

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Past Surgical History:

Operations (Include Biopsy)	Year		

Past Hospitalizations (non-surgical):

Reason for Admission	Year	

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:	☐	☐	☐	☐	☐

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Social History:

Smoking: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoker

Alcohol use: ☐ Yes ☐ No

☐ Heavy Drinker (1-5 drinks/Day ☐ Occasional Drinker

Recreational Drug Use: ☐ Yes ☐ No

☐ Heavy Use (daily to weekly) ☐ Occasional User

List of recreational drugs used: _____

Periodic Examinations: (please check exam and state when)

☐ Pap Smear: _____

☐ Mammogram: _____

☐ Colonoscopy Exam: _____

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Current Medications:

List ALL medications that you are currently taking that are prescribed by a medical provider

Medications	Dose	How Often	

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Specialist Contact List

Please include the name of every specialist you currently see, along with their specialty and contact information

Office name	Physicians Name	Office Phone Number

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

Directive to Physicians and Family or Surrogates (Living Will)

Advance Directives Act (see §166.033, Health and Safety Code)

Instructions for completing this document:

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

Directive

I, _____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

- ○ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR
- ○ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (This Selection Does Not Apply To Hospice Care.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

- ○ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR
- ○ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (This Selection Does Not Apply To Hospice Care.)

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

_____

_____

_____

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do **not** have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make health care or treatment decisions with my physician compatible with my personal values:

1. _____

2. _____

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed _____ Date _____

City, County, State of Residence _____

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as **Witness 1** may not be a person designated to make a health care or treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 _____ Witness 2 _____

Health First PRIMARY CARE OF SOUTHERN TEXAS

Purpose:
Primary Care of Southern Texas uses Artificial Intelligence (AI) tools integrated within **eClinicalWorks (eCW)** to help healthcare providers improve documentation accuracy, communication, and overall quality of care. This form explains how AI may be used and requests your permission.

Use of AI:
AI may assist with:

- Charting and note summaries
- Clinical decision support
- Scheduling or patient reminders
- Quality improvement using de-identified data

Privacy:
Your health information remains protected under **HIPAA** and all applicable privacy laws. The AI systems within eClinicalWorks meet federal healthcare security standards. Only authorized staff may review, edit, or approve AI-generated information.

Limitations:
AI does **not replace medical professionals.** All medical decisions, diagnoses, and treatments are made or confirmed by licensed providers.

Your Rights:

- Participation is **voluntary**.
- You may **withdraw consent** at any time without affecting your care.
- You may ask questions about AI use at any time.

Consent Statement:
I have read and understood this form. I consent to the use of AI tools within eClinicalWorks as part of my care at Primary Care of Southern Texas.

Patient Name: _____ **DOB:** _____

Patient/Guardian Signature: _____ **Date:** _____