HEALTH HISTORY
Confidential

Patient Name______________________ Today's Date ____________

Age________ Birthdate ____________ Date of last physical examination ____________

What is your reason for visit? ______________________

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ____________

Date of last Pap Smear ____________

Have you had a mammogram? ____________

Are you pregnant? ____________

Number of children ____________

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

____

____

____

____

____

Pharmacy Name ____________ Phone ____________

ALLERGIES To medications or substances

____

____

____

____

____

(Vers.M2SSS04)

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All information is strictly confidential

FAMILY HISTORY
Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

Check	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. ____________________

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

SERIOUS ILLNESS/INJURIES

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS
Check (✓) which substances you use and describe how much you use.

Check	Substance	Description
	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

Check	Concern
	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

______________________________ Signature of Patient, Parent, Guardian or Personal Representative

______________________________ Date

______________________________ Please print name of Patient, Parent, Guardian or Personal Representative

______________________________ Relationship to Patient

______________________________ Reviewed By

______________________________ Date

Frisco Primary Care, P.A.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name:	First:	MI:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one): Single / Married / Divorced / Widow / Other

Date of Birth:	Sex: ❑ M ❑ F	Social Security Number:	Race: ❑ American Indian ❑ Asian ❑ Black / African American ❑ Hispanic ❑ White ❑ Other

Mailing Address:	City / State / Zip Code:	E-Mail Address:

Primary Phone:	Alternate Phone:	❑ OK to leave message with detailed information ❑ Leave message with call back information only ❑ OK to mail written communication to my address
Occupation:	Employer:	Work Phone:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Location ❑ Yellow Pages / Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance Carrier:	ID / Policy Number:	Group Number:	Primary Policy Holder Name:

Relationship to Patient? ❑ Self ❑ Spouse ❑ Parent ❑ Other ________________ Co-Pay / Deductible:

Secondary Insurance Carrier:	ID / Policy Number:	Group Number:	Primary Policy Holder Name:

Relationship to Patient? ❑ Self ❑ Spouse ❑ Parent ❑ Other ________________

EMERGENCY CONTACTS

Name of relative or friend:	Relationship to patient:	Phone Number:
Name of relative or friend:	Relationship to patient:	Phone Number:

PHARMACY INFORMATION

Pharmacy Name:

Address / Intersection: Phone Number:

AUTHORIZATION / CONSENT

The above information is correct to the best of my knowledge. I authorize Frisco Primary Care, P.A. to:

- File an insurance claim(s) on my behalf based on the information I provided and I will receive an Explanation of Benefits (EOB) from my insurance carrier(s) that will detail any payments, deductions, and adjustments per my individual insurance plan's guidelines.
- Request my insurance benefits be paid directly to Frisco Primary Care, P.A. for services rendered at this location.
- Release any information to my insurance company that is required to process my medical claims.
- View my prescription history from external sources.

I certify that I am an adult with appropriate decision making capacity and hereby provide consent for medical treatment by Frisco Primary Care, P.A.

Patient signature: **Date:**

Frisco Primary Care, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain protected health information. I understand Frisco Primary Care, P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy to me in writing.

Persons Authorized to Receive Information:

The following names are of people I authorize to have access to my protected health information. I give permission for Frisco Primary Care, P.A. to share my protected health information with:

_____________________________________ ______________________________
Name Relationship

_____________________________________ ______________________________
Name Relationship

_____________________________________ ______________________________
Name Relationship

I authorize the person(s) listed above to receive information about appointments, treatments, and/or other information pertinent to my healthcare and relationship with Frisco Primary Care, P.A.

______ I do NOT authorize any information to be disclosed to any other parties other than those outlined in the Notice of Privacy Practices.

Information Release to Other Healthcare Professionals:

I authorize Frisco Primary Care, P.A. to release any pertinent medical information to other healthcare professionals directly involved in my medical care. This includes lab results, radiology reports, physician notes, prescription information, treatment plans, etc.

Expiration Date of Authorization:

This authorization does not expire unless revoked or terminated by the patient or patient's legal representative in writing.

Signatures:

_____________________________________ ______________________________
Signature of Patient or Legal Representative Date

_____________________________________ ______________________________
Printed Name of Patient or Legal Representative Witness Signature

Frisco Primary Care, P.A.
Controlled Substance Agreement

The purpose of this Agreement is to prevent confusion about certain prescription medications that are controlled substances that you may be prescribed for pain or other illness management. This Agreement is to help both you and your doctor follow the state and federal laws on controlled substances. Controlled substances include medication such as narcotic pain relievers, stimulants, anxiety medications, ADHD / ADD medications, and sleeping medications. These medications are controlled and regulated by the Department of Public Safety based upon their medicinal value, harmfulness, and potential for abuse or addiction.

Effective January 1, 2013, the Texas Department of Public Safety has implemented an online registry that requires any physician prescribing a controlled substance to check the prescription history of a patient. This online portal allows the doctor to view the prescription history of the patient to determine which (if any) controlled substances they have received in the past 12 months. This portal allows us to view the prescribing doctor's name, pharmacy name, date filled, etc. This is a mandatory state policy and does not require us to obtain written permission or signed consent from the patient.

I understand that this Agreement is important to the trust and confidence necessary in a doctor/patient relationship. I understand my doctor's goal is to provide safe and optimal medical care to the patient and he / she may be unable to do so if I intentionally withhold medical information crucial to my care. I understand that my doctor agrees to treat me based on my compliance with this Agreement. My doctor can refer me to a Pain Management specialist, psychiatric specialist, or other specialist if he/she deems it necessary.

I understand that if I violate this Agreement in any way, my doctor will stop prescribing these medications and can discontinue providing ongoing medical care to me. I agree to follow the guidelines listed below:

- I understand that my doctor will not prescribe controlled substances without a recent evaluation of my medical condition, which may include x-rays or other tests my doctor orders.
- I will not use any illegal substances, including marijuana, cocaine, or other non-prescribed illegally obtained substances. I also agree to random drug screenings during the course of my care.
- I will not share, sell, or trade my medicine with anyone.
- I will not obtain controlled medications, including pain medicines, stimulants, or anti-anxiety medicines ***from any other doctor.*** If I require emergency care or hospitalization, it is my responsibility to notify my doctor immediately of any duplicate medications prescribed. Failure to report this information is a direct violation of the Agreement.
- I will protect my medicine from getting lost or stolen. Lost or stolen medicines will not be replaced without an official police report of the theft.
- I will notify my doctor at least 3 business days in advance of running out of my medication to allow adequate time for the doctor to approve the medication refill.
- I will not request early refills on any of the controlled substances prescribed to me.
- I will not request refills of controlled substances on weekends or holidays.
- I will take this medication only as directed by my doctor and will not take more than what he / she has recommended.
- I will only use one pharmacy to fill these medications and I will provide this pharmacy information to my doctor.

I understand that, in order to continue to receive my prescription, my doctor will require me to attend follow-up office visits as frequently as he / she deems necessary to monitor the medication I am on.
The doctor may terminate our relationship at any time if he/she has cause to believe that I am not complying with the terms of this Agreement, or believes that I have made a misrepresentation or false statements concerning my symptoms or my compliance with the terms of this Agreement.

By signing below, I agree to the terms and conditions of this Agreement.

________________________________ ____________________

Patient Signature Date

FRISCO PRIMARY CARE, P.A.
FINANCIAL POLICY

NAME: ______________________________ **DATE OF BIRTH:** ______________

Thank you for choosing Frisco Primary Care, P.A. as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.** If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. **It is ultimately your responsibility to know and understand the types of services covered and reimbursements provided by your insurance company.**
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for any services not covered by your insurance company.**
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company.
- **Co-payments, coinsurance, and/or deductibles are due at the time of service.** We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.
- **Patients without insurance coverage are required to pay the balance in full at the time of service.**
- We do not file claims to any Workers Compensation programs or on claims for automobile-related accidents.
- It is your responsibility to provide us with your most current billing information. Please provide your most current billing address, all available telephone numbers, and any other important contact information. If your address or contact information changes, please contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, please contact our billing office within 30-days after receipt of the initial statement at (214) 842-6449.
- **We accept cash, credit cards, debit cards, and most Health Savings Account cards as forms of payment.**
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be referred to a professional collection agency for further collection activity.**
- If you are not able to pay the balance due in full, please contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency.
- **If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Frisco Primary Care, P.A.** Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

I have read and understand this Financial Policy.

______________________________ ______________

Patient Signature **Date**