PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: Ungs
BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM/DD/YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (___) _____ Day Phone: (___) _____ Email: _____

Race _____ Language _____ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (___) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM/DD/YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (___) _____ (___)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ Spouse's Work Phone: (___) _____ (_____) Occupation: _____
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (___) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ ___ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ _____ _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____ Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accord-ingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

PATIENT HISTORY

NAME:_____ DOB:_____ DATE:_____

AGE:_____ SEX: M / F HEIGHT:_____ WEIGHT:_____

List doctors you currently see._____

_____

_____

PATIENT PHARMACY INFO
NAME_____
ADDRESS_____
PHONE_____

*REASON FOR VISIT:_____

LIST DRUG ALLERGIES:_____
ARE YOU ALLERGIC TO LATEX? YES NO IODINE? YES NO

SURGERIES

_____ _____

_____ _____

_____ _____

PRESCRIPTIONS & OVER THE COUNTER MEDICATIONS

_____ _____

_____ _____

_____ _____

_____ _____

HAVE YOU HAD?	YES	NO		YES	NO
HIGH BLOOD PRESSURE	_____	_____	ASTHMA	_____	_____
HEART ATTACK	_____	_____	HEPATITIS (TYPE_____)	_____	_____
STROKE	_____	_____	HIV/AIDS	_____	_____
SEIZURE	_____	_____	BLEEDING TENDENCY	_____	_____
DIABETES	_____	_____	THYROID CONDITION	_____	_____
CANCER (TYPE_____)	_____	_____	KIDNEY DISORDER (DIALYSIS)	_____	_____
REFLUX	_____	_____	DEPRESSION	_____	_____
ARTHRITIS	_____	_____	ANXIETY	_____	_____

TOBACCO
_____NEVER
_____FORMER, age/year quit_____
_____CURRENT
Cigarettes per day_____
Chewing_____
Cigars/Pipe_____

ALCOHOL
_____NEVER
_____FORMER, age/year quit_____
_____CURRENT
Amount_____

Family History-List any diseases that run in your family (please be specific to which family member.)
Example: Maternal grandmother-Cancer, breast Father-High blood pressure, diabetes

_____

_____

_____

Patient Signature:_____

NAME:_____ DOB:_____ DR; CRUDUP

CONSTITUTIONAL

	YES	NO
CHILLS		
FATIGUE		
FEVER		
NIGHTS SWEATS		
WEIGHT GAIN		
WEIGHT LOSS		

HEENT

	YES	NO
EAR PAIN		
NASAL DRAINAGE		
SINUS PRESSURE		
SORE THROAT		

RESPIRATORY

	YES	NO
CHRONIC COUGH		
TB EXPOSURE		
SHORTNESS OF BREATH		
WHEEZING		

CARDIO VASCULAR

	YES	NO
CHEST PAIN		
CALF PAIN W/WALKING		
LEG OR ANKLE SWELLING		
PALPITATIONS		
DEEP VEIN THROMBOSIS		
PULMONARY EMBOLUS		

NEUROLOGICAL

	YES	NO
DIZZINESS		
HAND/FOOT NUMBNESS		
HAND/FOOT WEAKNESS		
SEIZURES		

METABOLIC/ENDOCRINE

	YES	NO
COLD INTOLERANCE		
HEAT INTOLERANCE		
POLYDIPSIA/excessive thirst		

HEMATOLGIC/LYMPHATIC

	YES	NO
EASY BLEEDING		
EASY BRUISING		
CIRRHOSIS OF LIVER		

***COLONOSCOPY?_____

GASTROINTESTINAL

	YES	NO
ABDOMINAL PAIN		
BLOOD IN STOOL		
CHANGE IN STOOLS		
CONSTIPATION		
DIARRHEA		
HEARTBURN		
NAUSEA		
VOMITING		

GENITOURINARY

	YES	NO
DYSRURIA/painful urination		
HEMATURIA/blood in urine		
POLYURIA/excessive urine		
URINARY FREQUENCY		
URINARY RETENTION		
SLOW STREAM		

MUSKULOSKELETAL

	YES	NO
CHRONIC BACK PAIN		
JOINT PAIN		
JOINT SWELLING/ARTHRITIS		
MUSCLE WEAKNESS		
NECK PAIN		

PSYCHIATRIC

	YES	NO
ANXIETY		
DEPRESSION		
INSOMNIA		

INTEGUMENTARY/BREAST/SKIN

	YES	NO
BREAST DISCHARGE		
BREAST LUMP		
MOLE CHANGES		
RASH		
SKIN LESIONS		

REPRODUCTIVE (WOMEN ONLY)

	YES	NO
VAGINAL DICHARGE		
ABNORMAL PAP		

***MAMMOGRAM?_____

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ○ OK to leave a message with detailed information
  - ○ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ○ OK to leave message with detailed information
  - ○ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of **NORMAL** test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of **ABNORMAL** test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- ☐ Yes
- ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- ☐ Yes
- ☐ No

ADVANCED DIRECTIVE

Do you have an advanced directive (Living Will)?

- ☐ Yes
- ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority