PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____ 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. Accordingly, 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

TEXAS HEALTH CARE

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. _____, with Texas Health Care unless revoked by me in writing.

Social Security # _____

_____ _____

Date *Patient/Legal Representative*

TRCOBP12

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

Texas Health Care

Christopher M. Ripperda, MD

LAST NAME: _____ FIRST NAME: _____ AGE: _____

Date of Appointment: _____ Date of Birth: _____ Race: _____

Referring Physician: _____ Other Referral: _____

Chief Complaint (why you came to see the doctor today): _____

_____

_____

PELVIC ORGAN SYMPTOMS:

BLADDER CONTROL PROBLEMS:

Do you have problems with accidental loss of urine or urinary urgency/frequency? Yes No

IF YOU ANSWERED YES CONTINUE IF NO SKIP TO NEXT SECTION

How many months or years have you had bladder problems? _____Months _____ Years

Do you use pads to absorb lost urine? Yes No If yes, how many pads do you wear in a day? _____

About how many trips do you make to the bathroom during the day? _____

About how many times do you wake at night to go to the bathroom? _____

Do you ever wet the bed while asleep? Yes No

Are there times when you cannot make it to the bathroom in time? Yes No

Does the sound, sight or feel of running water cause you to lose urine? Yes No

Which best describes urine loss: *check all that apply*

_____ I lose urine during coughing, sneezing, running or lifting

_____ I lose urine with changes in posture, standing or walking

_____ I lose urine continuously such that I am constantly wet

_____ I have sudden,urgent needs without the ability to make it to the bathroom

Have you seen a physician for complaints of urine loss? Yes No If yes, who _____

Have you taken medication to prevent urine loss? Yes No If yes, what medication _____

How many glasses of liquid do you consume daily? _____

How many drinks containing caffeine (coffee, tea, soda) do you consume daily? _____

BLADDER EMPTYING PROBLEMS:

Do you have problems with urinating or emptying your bladder completely? Yes No

IF YOU ANSWERED YES CONTINUE, IF NO SKIP TO NEXT SECTION

How long have you had bladder emptying problems? _____Months _____Years

Do you notice any dribbling of urine when you stand after passing urine? Yes No

Do you usually have difficulty starting your urine stream? Yes No

Do you have to assume abnormal positions to urinate? Yes No

Do you have to strain to empty your bladder? Yes No

Is your urine flow: Strong Weak Dribbling Intermittent

Do you feel as if your bladder is empty after passing urine? Yes No

PROLAPSE/VAGINAL SUPPORT PROBLEMS:

Do you have a feeling of fullness or pressure, bulge or protrusion of any vaginal tissue? Yes No

IF YOU ANSWERED YES CONTINUE, IF NO SKIP TO NEXT SECTION

Do you notice a bulge? Yes No

How long have you had a protrusion or bulge? _____Months _____Years

Are your symptoms worse at the end of the day or after standing for prolonged periods? Yes No

Do you push the protrusion back to help with a bowel movement or to empty your bladder? Yes No

Have you ever used a pessary (a plastic support device) for this problem? Yes No

BOWEL SYMPTOMS:

Do you have problems with your bowels (bowel incontinence or difficulty emptying your bowels)? Yes No

IF YOU ANSWERED YES CONTINUE, IF NO SKIP TO NEXT SECTION

How long have you had bowel symptoms? _____Months _____Years

Do you have accidental loss of solid stool? Yes No

Do you have accidental loss of liquid stool? Yes No

Do you have accidental loss of gas? Yes No

How long have you had accidental loss or stool or gas? _____Months _____Years

How many episodes per week? _____

Do you wear protective pads for this problem? Yes No If yes, how many pads a day _____

Do you have constipation? Yes No Diarrhea? Yes No Bloating? Yes No

Do you have a frequent desire to have a bowel movement? Yes No

Do you feel that your bowels are never completely empty? Yes No

Do you ever place your fingers in your vagina between the vagina and rectum to help with a bowel movement? Yes No

Have you seen a physician for bowel symptoms? Yes No If yes, who _____

SEXUAL HISTORY:

Are you sexually active? Yes No

If not sexually active, are barriers to sexual activity due to:

Prolapse (vaginal bulging) Yes No

Incontinence Yes No

Pain Yes No

PELVIC PAIN:

Do you have pain in your pelvic area? Yes No

IF YOU ANSWERED YES CONTINUE, IF NO SKIP TO NEXT SECTION

Where is your pain? ____Pelvic Area ____Vagina ____Rectum ____Lower Abdomen

How long have you had pelvic pain? _____Months _____Years

Is your pain relieved by bladder emptying? Yes No

Do you have pain with urination? Yes No

Does anything relieve the pain? Yes No If yes, what _____

Do you see a pain specialist? Yes No If yes, who _____

GYN HISTORY:

Of Pregnancies _____ # of Deliveries _____ # of Miscarriages_____

Pregnancy	**Delivered Y/N**	**Miscarriage or Abortion Y/N**	**Route of Delivery (Vag/C-Section)**	**Weight**	**Living (Y/N)**

MEDICAL HISTORY: (check all that apply)

___Abnormal Pap
___Anesthetic Complications
___Asthma
___Auto Immune Disorder
___Breast Cancer
___Cancer
___Depression
___Diabetes
___Endometrial Cancer
___Heart Disease
___Hepatitis
___Hypertension
___Kidney Disease
___Mental/Physical Abuse
___Postpartum Depression
___ Psychiatric Disorder
___Seizures
___Sexual Abuse
___Sexual Dysfunction
___Thyroid Disease
___Uterine Abnormality

If Heart Problems, please specify: _____

Cardiologist Name: _____

If Cancer, please specify: _____

Other: _____

Do you see any other specialist, if so, please provide name and speciality: _____

_____

SURGICAL HISTORY:

Hysterectomy Date: _____ Reason: ___Prolapse ___Fibroids ___Bleeding ___Endometriosis
Incision: ___Vaginal ___Abdominal ___Laparoscopic Assisted

Bladder Repair Date:_____ Reason: ___Prolapse ___Leakage
Incision: ___Vaginal ___Abdominal

___Breast Surgery ___C-section ___Vulvar Surgery ___Hysteroscopy
___Cryosurgery ___Myomectomy ___Endometrial Ablation ___Vaginal Surgery
___Tubal Ligation ___Laparascopy/Laparotomy ___D&C

List any other surgeries below with dates:

_____ _____
_____ _____
_____ _____

Drug Allergies:

___No Known Drug Allergies

Name: Reaction Name Reaction

_____ _____
_____ _____
_____ _____

CURRENT PRESCRIPTION MEDICATIONS:

NAME: DOSE: PURPOSE/INDICATION:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY:

Marital Status ___Single ___Married ___Divorced ___Widowed ___Seperated
Alcohol Use ___Never ___Rarely ___Occasionally ___Daily
Tobacco Use ___Never ___Current___Packs per day for ___years
___Quit *If so when?*_____How long did you smoke_____
Drug Use ___Never ___Recreational ___Daily
_____Type

Occupation: _____
Does your occupation require heavy lifting? (<25lbs) Yes No

FAMILY HISTORY: *Check all that apply and indicate relationship of relative*

___Cancer (*specify site*)_____
___Heart Disease_____
___Hypertension_____
___Reactions to Anesthesia_____
___Bleeding Disorder_____
___Diabetes_____
___Stroke_____
___Other_____

REVIEW OF SYMPTOMS: *(circle all that apply)*

Fever
Chills
Weight Loss
Fatigue
Sweating
Weakness
Rash
Itching
Headaches
Hearing Loss
Ringing of Ears
Ear Pain
Ear Discharge
Nosebleeds
Congestions
Noisy Breathing
Sore Throat
Blurred Vision
Double Vision
Light Sensitivity
Eye Pain
Eye Discharge
Eye Redness
Chest Pain
Palpitations
Difficulty Breathing
Leg Pain
Leg Swelling
Cough
Coughing up Blood
Productive Cough
Shortness of breath
Wheezing
Exercise Intolerance
Heartburn
Nausea
Vomiting
Abdominal Pain
Diarrhea
Constipation
Blood in Stool
Urgency
Frequency
Blood in Urine
Flank Pain
Muscle Pain
Neck Pain
Back Pain
Joint Pain
Falls
Easily bruises/bleed
Environmental Allergies
Excessive Thirst
Dizziness
Tingling
Tremors
Sensory Change
Speech Change
Seizures
Loss of Consciousness
Depression
Suicidal Thoughts
Substance Abuse
Hallucinations
Anxiety
Insomnia
Memory Loss

Other Symptoms:

_____
_____

_____ _____
Patient or Guardian's Signature Date

Name:_____Date of Birth:_____Date:_____

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual daily activities. Answer every questions by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

---

1. In general, could you say your health is: ___Excellent ___Very Good____Good____Fair____Poor

---

The following questions are about activities you might do during a typical day. Does your health **now** limit you in these activities? If so, how much?

2. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf?

_____Limited a lot _____Limited a little _____No limits at all

3. Climbing several flights of stairs

_____Limited a lot _____Limited a little _____No limits at all

---

During the past **4 weeks** have you had any of the following problems with your work or regular daily activities as a result of your physical health?

4. Accomplished less than you would like Yes No
5. Were limited in the kind of work or other activities Yes No

---

During the past **4 weeks** have you had any of the following problems with your work or regular daily activities as a result of any emotional problems? (such as feeling depressed or anxious)

6. Accomplished less than you would like Yes No
7. Didn't do work or other activities as carefully as usual Yes No

---

During the past **4 weeks**, how much did pain interfere with your normal work (including both work outside the home and or housework)

_____Not at all _____Limited a little _____Moderately _____Quite a bit _____Extremely

---

During the past **4 weeks**

8. Have you felt calm and peaceful?

____All of the time _____Most of the Time _____Some of the Time_____All of the Time_____None of the Time

10. Did you have a lot of energy?

____All of the time _____Most of the Time _____Some of the Time_____All of the Time_____None of the Time

11. Have you felt down-hearted and blue?

____All of the time _____Most of the Time _____Some of the Time_____All of the Time_____None of the Time

---

During the past **4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities? (visiting friends, relatives, etc)

____All of the time _____Most of the Time _____Some of the Time_____All of the Time_____None of the Time

Thank you for taking the time to answer these questions, they will help me in providing you the best and most accurate care!

Texas Health Care

Christopher M. Ripperda, MD
1250 8th Ave. Suite 330
Fort Worth, Texas 76104
Phone 817-923-5559

Physician Ownership Disclosure Form

During the course of your physician/patient relationship with Dr. Christopher Ripperda, M.D. you may be advised to undergo surgery or additional treatment as part of your care. The physician wants to make you aware of their investment interest in the following facility.

Baylor Surgicare

Should you prefer to seek treatment at another facility in which your physician does not have an investment in, this office can assist you in selecting an alternative facility and scheduling your surgery or treatment. The physician also operates at Baylor All Saints, Texas Health Harris Southwest, and at Glen Rose Medical Center as your physician feels these facilities provide excellent care. Your choice of facilities may be limited by your health plan and you may want to consult your health insurer or employer prior to making an alternate selection.

If you wish to have your surgery or treatment performed at another facility other that the above mentioned, be assured your choice of facility will in no way diminish the quality of care that you receive from the surgical facility the physician has an investment in.

Acknowledgement: (I/We) have read this "Physician ownership disclosure" form, and (I/we) understand by signing this form that the physician has disclosed his/her direct financial interest in the facility he has referred.

Patient Name _____ **Date** _____

Patient DOB: _____

Patient/Parent/Patient Delegate Signature

_____