Bedford Family Medicine
New Patient Medical History Form

Today's Date: _____

NAME: _____ **SEX:** _____ **DOB:** _____ **AGE:** _____

MARITAL STATUS: _____ **OCCUPATION & PLACE OF EMPLOYMENT:** _____

EMAIL ADDRESS: _____

REASON FOR VISIT TODAY: _____

Pharmacy Name _____ **Phone#:** _____ **Address:** _____

ALLERGIES (Include medications, foods, x-ray dyes and list type of reaction) or ❑ **NONE KNOWN**

1.	3.
2.	4.

CURRENT MEDICATIONS (Include prescriptions, over the counter, and herbal supplements. Attach extra sheet if necessary) or ❑ **NONE**
(List Name of mediation, dose and how often taken)

1.	4.
2.	5.
3.	6.

MEDICAL PROBLEMS (list your long-term medical problems. Attach extra sheet if necessary)

PREVIOUS HOSPITALIZATIONS (Include all non-surgical hospitalizations, Attach extra sheet if necessary) or ❑ **NONE**

Reason for hospital stay	Date (approx.)	Hospital or City if known
1.		
2.		

SURGERIES (include all surgery in your lifetime. Attach extra sheet if necessary) or ❑ **NONE**

Type of surgery	Date (approx.)	Hospital or City if known
1.		
2.		

OB/GYN HISTORY: No. of Pregnancies: _____ No. of Deliveries: _____ Last Menstrual Cycle: _____

TOBACCO, ALCOHOL AND DRUG HISTORY

Are you an active cigarette smoker? ❑ Yes ❑ No Have you ever been a cigarette smoker? ❑ Yes ❑ No,
If yes, I smoke/smoked an average of _____packs/day for _____years. I quit in _____ (year)
Do you use other tobacco products? ❑ Yes ❑ No If yes, please specifiy_____
Have you ever been diagnosed with alcoholism? ❑ Yes ❑ No
Do you currently drink alcohol regularly? ❑ Yes ❑ No If yes, approx. how many drinks/week (beer, wine, or liquor) _____
Have you ever used intravenous/Illicit drugs? ❑ Yes ❑ No If yes, please specify _____

FAMILY HISTORY

	Age	Health problems	Cause of death/age at death
Father			
Mother			
Brother(s)			
Sister(s)			
Children			

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Today's Date: _____

NAME:_____ **DOB:**_____

Please check "X" on the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?).

General	Fatigue / Tired	Yes No
	Fever / Chills	Yes No
	Headaches	Yes No
	Weight loss	Yes No
	Weight gain	Yes No
	Insomnia	Yes No
	Other	_____
Eyes	Blurred vision	Yes No
	Double vision	Yes No
	Other	_____
Allergic, Head, Ears, Nose, throat	Runny Nose	Yes No
	Itchy eyes	Yes No
	Sore throat	Yes No
	Hoarseness	Yes No
	Ear pain	Yes No
	Hearing issues	Yes No
	Other	_____
Neuro	Tremors	Yes No
	Dizzy spells	Yes No
	Numbness	Yes No
	Tingling	Yes No
	Weakness	Yes No
	Memory Loss	Yes No
	Other	_____
Gastro-Intestinal	Abdominal pain	Yes No
	Nausea	Yes No
	Vomiting	Yes No
	Diarrhea	Yes No
	Heartburn	Yes No
	Trouble swallowing	Yes No
	Hemorrhoids	Yes No
	Rectal bleeding	Yes No
	other	_____
Cardio-Vascular (heart)	Chest pain	Yes No
	Varicose veins	Yes No
	Palpitations	Yes No
	Edema/swelling	Yes No
	Fainting	Yes No
	other	_____
Respiratory	Cough	Yes No
	Shortness of breath	Yes No
	Use of inhalers	Yes No
	Wheezing	Yes No
	Other	_____

Males Only	Blood in urine	Yes No
	Erectile issue	Yes No
	Foul odor of urine	Yes No
	Pain in testicles	Yes No
	Trouble urinating	Yes No
	Other	_____
Females Only	Breast discomfort	Yes No
	Irregular bleeding	Yes No
	Painful intercourse	Yes No
	Trouble urinating	Yes No
	Vaginal discharge	Yes No
	Other	_____
Musculo-Skeletal	Back pain	Yes No
	Joint pain	Yes No
	Muscle pain	Yes No
	Swelling	Yes No
	Other	_____
Skin Hair Nails	Bruising	Yes No
	Hair loss	Yes No
	Nail problems	Yes No
	Rash	Yes No
	Other	_____
Mental health	Anxiety	Yes No
	Depression	Yes No
	Trouble sleeping	Yes No
	Concentration issues	Yes No
	History of abuse	Yes No
	Mood swings	Yes No
	Stress	Yes No
	Other	Yes No

Recent Tests / Health Maintenance (month/year)

Bone Density: _____
Colonoscopy:_____
Diabetic Foot Exam: _____
Eye Exam: _____
Mammogram:_____
PAP Smear: _____
Physical: _____
PSA: _____
EKG: _____
Chest X-ray: _____
Tetanus Shot: _____
Pneumonia Shot: _____

Bedford Family Medicine, P.A.

1701 Forest Ridge Drive Bedford, TX 76022 (817) 545-7700

Non-Parental Authorization for Consent to Treat a Minor

I, _____, parent/legal guardian of the child listed below do hereby give my authorization and consent for the below named adult(s) to consent for the medical or surgical treatment of my child. I hereby authorize and grant that the below named adult(s) has/have permission from the parents of legal guardian to obtain medical treatment or sign for surgical procedures deemed necessary for the health and well-being of my child.

_____ _____ _____
Signature Relationship to child Date

Child:_____ Date of Birth: _____

Authorized Person(s):

_____ _____
Name Relationship to child

_____ _____
Name Relationship to child

_____ _____
Name Relationship to child

_____ _____
Name Relationship to child

I understand that while this authorization may be rescinded at any time, it is my responsibility to communicate any changes to this consent in writing to **Bedford Family Medicine, P.A.**

This authorization expires one year after the date it is signed and must be renewed yearly.

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

Do you have an advanced directive (Living Will)?

☐ Yes ☐ No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

☐ Yes ☐ No

_____

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

_____

Print Name Birthdate

PRIVIA MEDICAL GROUP NORTH TEXAS

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 Privia Medical Group North Texas Unless revoked by me in writing.

Patient Name:_____ Date of Birth: _____

Patient/Legal Representative Signature: _____

Date: _____

THCOBP12

PRIVIA
MEDICAL GROUP

Preventive Medical Visit Patient Information

Dear Patient,

You are seeing your provider for a preventive medical visit. This is a comprehensive, preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures. Insurance carriers may or may not provide coverage for screening laboratory and diagnostic studies; rules are carrier specific. Preventive medical visits are exempt from copayments.

However, if an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform key components of a problem-oriented evaluation and management service, then a separate office visit code may be charged. The use of this additional code will require a copayment if one is charged by your insurance plan.

If you have any questions, we advise you to contact your insurance carrier directly to discuss your coverage for these services.

Sincerely,

Privia Medical Group

I certify that I have read and understand the differences between preventive and problem-oriented visits, and agree to pay the associated copay should the nature of my visit change.

➔ **Signature**: _____ **Date**: _____

To be signed by parent or legal guardian if patient is a minor under the age of 18, or a mentally incompetent patient.

➔ **Printed Name**: _____

Bedford Family Medicine, P.A.

Medication Prescription Guidelines

The healthcare providers are happy to help you with your medical needs. That includes supplying needed medication for our patients. Refill guidelines are:

- If you need a refill on your medication, **call your pharmacy at least 3 days prior to your refill** and tell them which medication you need refilled. They in turn will forward the request on your behalf or call us with all of the information we need to be able to refill the medicine. (If you call us first, we will ask you to call the pharmacy.)
- **We do not refill medication after business hours or on the weekends.** Please make sure that you contact your pharmacy before you run out of medication to allow time for the refill to be processed. All refills are authorized by the physician, so we must have enough time to contact them for authorization.

I have read and understand the above policy on medication refills.

Print Name of Patient: _____ DOB: _____

Signature:_____Date:_____

FMLA/Short Term Disability paperwork

If an employer is requiring forms to be completed by the physicians/Nurse Practitioner a fee of $30.00 will be charged to your account and must be paid prior to completion, in most cases an office visit will be required as well. It can take a Physician or the Nurse Practitioner up to 5 business days to complete the forms. It's the patients responsible to make sure their employer/HR department receives their forms by the due date.

I have read and understand the above information on FMLA forms.

Print Name of Patient: _____DOB: _____

Signature:_____Date:_____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

Child's Date of Birth / / ***Children under 18 years only.**

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian or managing conservator: _____
Printed Name

_____ _____
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See **http://www.dshs.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 05/18/2012

TEXAS Department of State Health Services

***PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and **affirm** that consent has been granted.*
DO NOT fax to ImmTrac. Retain this form in your client's record.