



Pharmacy Name _____

Patient Number _____

Pharmacy Phone Number _____

Referring Physician _____

Allergies _____

Primary Care Physician _____

PATIENT INFORMATION

(PLEASE PRINT AND COMPLETE ALL INFORMATION)

Last Name _____ First Name _____ Middle Name _____

Mailing Address _____ Home Phone _____

City _____ Zip _____ Work Phone _____

Date of Birth _____ Age _____ Sex: M F Cell Phone _____

Email address: _____

Preferred Language: English Spanish Chinese Decline to Answer Other: _____

Race: American Indian/Alaska Native Asian African American Decline to Answer Unknown Nat Hawaiian/Pacific Islander Caucasian

Other: _____ Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to Answer Unknown

Marital Status (circle one): Single/Divorced/Married/Widow/Separated If applicable, please list your spouse's name: _____

Patient's Place of Employment _____

Person responsible for payment _____ Retired? Yes No

Mailing Address of responsible party _____

Are you here because of an auto accident or work related accident? Yes No Do you have medical insurance? Yes No

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S) & ID CARD

PRIMARY Insurance _____ SECONDARY Insurance _____

If you are covered under the policy of a spouse, partner, parent, or legal guardian, please tell us about them:

Name _____ Relationship to Patient _____

Date of Birth _____ Sex: M F

Mailing Address _____ City _____

State _____ Zip _____ Employer _____

Do you have a cancer policy? Yes No (If yes please discuss with our Insurance Office)

PLEASE SEE OTHER SIDE

I understand my doctor's refill policy:

1. Refills must be requested at least 24 hours ahead if I am not seeing the doctor.
2. Refills ARE NOT given at night or on weekends.
3. Refills are provided by my doctor only. I will not ask other physicians for refills.
4. Refills ARE NOT given for lost, stolen, spilled, misplaced or "used up early" medications. NO EMERGENCY REFILLS.

I hereby give my consent to Woodlands Medical Specialists to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. Woodlands Medical Specialists reserves the right to revise its Notice of Privacy Practices at any time.

With the consent, Woodlands Medical Specialists may use the following means to contact me regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance information, billing statements, or any calls pertaining to my clinical care, including laboratory results among others: calling my home or other alternative location and leaving a message on voice mail; emailing my home or other alternative location; sending written mail to my home or other alternative location as long as it is marked "Personal and Confidential."

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

- Home Telephone _____ Work Telephone _____
- Written Communication Other _____

Is it ok to leave a detailed message at the phone number selected above? Yes No

I have the right to request that Woodlands Medical Specialists 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 to Woodlands Medical Specialists use and disclosure of my PHI to carry out TPO.

Woodlands Medical Specialists may disclose PHI to the following individuals:

Name	Relationship	Telephone

I **do / do not (circle one)** authorize the release of information specific to laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions.

Signature of Patient or Legal Guardian

Date



AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

Last Name (please print) _____ **First** _____ **M.I.** _____ **Date of Birth** _____ **Social Security Number** _____

I hereby authorize _____ to disclose the following specific information from my health record from (date) _____ to (date) _____.

Disclose to: (Name) _____ **Phone:** _____ **Fax:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Information to be disclosed (Please initial):

- Entire Health Record _____
- Operative Report _____
- Progress Notes _____
- Consultation Report _____
- Lab Test (please specify) _____
- Biopsy Report _____
- History & Physical _____
- Radiology Films _____
- Mammogram Films _____
- Other (please specify) _____

For the purpose of (circle all that apply): Continuity of care /consultation /personal / insurance/ my request/ other (specify): _____

Disclosure to be: verbal _____ written _____

I understand if I do not authorize the release of my full health record, only a limited health record is provided per patient request. Provider will not require me to sign an authorization as a condition of my further treatment except where the treatment is for the purpose of research or solely for the purpose of creating a health record for disclosure to a third party and I refuse to authorize such disclosures.

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken; forms are available. This authorization will expire 90 days from date of signature and I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. Woodlands Medical Specialist, P.A., and its employee's officers, and health care providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

I understand it may take 7 to 10 business days for this request to be processed. A copying fee of \$1 per page for the first 25 pages then \$.25 per page applies to my request. I further understand that I am entitled to a copy of the authorization.

Signature of Patient: _____ **Date:** _____ **Phone:** _____
Signature of Representative: _____

Witness: _____ **Date:** _____

Please fax records ASAP to _____. Thank you for your cooperation, Woodlands Medical Specialist



FINANCIAL POLICY 2012

I authorize Woodlands Medical Specialists:

1. To obtain all medical information necessary to provide services
2. To receive assignment of benefits from any applicable government funded, privately insured, or employer self-funded health benefit program related to this claim.
3. To request payment and to obtain or release any medical information necessary for reimbursement (payment) under applicable government funded health programs, managed care plans and/or private insurance

I authorize any holder of medical or other information about me, to release to the Social Security Administration, the Centers for Medicare and Medicaid Services, their intermediaries or carriers, or to the billing agent or any other physician or supplier, any information needed for the payment of this claim or related claim.

I understand the fact that having insurance does not release me of my personal responsibility for payment. Further, I understand that, to the extent allowed under federal and state law or contracts with third-party payers, I may be billed or asked to make payment prior to services rendered for co-payments, co-insurance and deductibles due for medical services.

I understand that for non-covered services I will be asked to sign an Advanced Beneficiary Notice prior to services rendered. Further, I understand by signing this notice I acknowledge financial responsible for all services not paid by my insurance carrier.

I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits directly to Woodlands Medical Specialists, P.A.

I understand that Woodlands Medical Specialists will send me 3 bills as a courtesy and if I do not respond to these bills then I could be turned over to an outside collection agency.

The physicians have an ownership interest in Radiology and Radiation Therapy services provided at Woodlands Medical Specialists. I understand that my PET, MRI, CT Scans, and other imaging services ordered by the physicians of our practice, can also be obtained at other facilities in the area I reside. To obtain a list of these centers please see the Front Desk staff.

Signature of Patient or Personal Representative

Date

Date: _____

PATIENT MEDICAL HISTORY

PATIENT'S NAME: _____ DOB: ____/____/____ Age: _____

Weight: ____ BP: _____ Temp: _____ Pulse: ____ Allergies: _____

Past Medical History

Blood clotting	Yes	No	Thyroid Problems	Yes	No
Diabetes	Yes	No	Cancer [Type] _____		
Stroke	Yes	No	Arthritis/Gout	Yes	No
Hepatitis	Yes	No	Venereal Disease	Yes	No
Lupus (SLE)	Yes	No	C.R.E.S.T. Syndrome	Yes	No
Scleroderma	Yes	No	Rheumatoid Arthritis	Yes	No
Ulcerative Colitis	Yes	No	Crohn's Disease	Yes	No
Heart Attack	Yes	No	High Blood Pressure	Yes	No
Glaucoma	Yes	No	Pregnant # Times _____		Delivered _____
High Cholesterol	Yes	No	Congestive Heart Failure	Yes	No
Other: _____					

Previous Surgeries/Hospitalizations:

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Tobacco Usage: YES NO Packs per Day: _____ # of Years: _____ Date Quit: _____
 Alcohol Usage: YES NO Amt: _____ Date Quit: _____
 Drug Usage: YES NO Amt: _____ Date Quit: _____

Marital Status: _____ Occupation: _____

Family History

	Alive	Deceased	Cause of death
1. Father	Alive _____	Deceased _____	_____
2. Mother	Alive _____	Deceased _____	_____
3. Father's Father	Alive _____	Deceased _____	_____
4. Father's Mother	Alive _____	Deceased _____	_____
5. Mother's Father	Alive _____	Deceased _____	_____
6. Mother's Mother	Alive _____	Deceased _____	_____
7. Brothers/Sisters	# Alive _____	# Deceased _____	_____

DATE PHYSICIAN REVIEWED AND/OR AMENDED FORM:

1.	4.	7.
2.	5.	8.
3.	6.	9.

PLEASE COMPLETE BACK →

Review of Systems

Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Wt Loss	Yes	No
Appetite Loss	Yes	No
Headache	Yes	No
Weakness	Yes	No
Loss of Energy	Yes	No

Allergic/Immunologic

Hay Fever	Yes	No
Drug Allergies	Yes	No

Gastrointestinal

Abdominal Pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Indigestion	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Blood from rectum	Yes	No

Cardiovascular

Chest Pain	Yes	No
Leg Pain- walk	Yes	No
Swelling of Lower Extremities	Yes	No

Psychological

Are you generally satisfied with your life?	Yes	No
Do you feel severely depressed?	Yes	No
Have you considered suicide?	Yes	No
Nervousness	Yes	No

Endocrine

Excessive Thirst	Yes	No
Chills	Yes	No
Tiredness	Yes	No

Eyes

Blurred Vision	Yes	No
Double Vision	Yes	No
Pain	Yes	No

Neurological

Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness/tingling	Yes	No
Extremity Weakness	Yes	No
Seizures	Yes	No
Excessive Thirst	Yes	No
Too hot/cold	Yes	No
Tired/ Sluggish	Yes	No

Integumentary

Skin Rash	Yes	No
Boils	Yes	No
Persistent itch	Yes	No
New/changing spots	Yes	No

Respiratory

Wheezing	Yes	No
Short of Breath	Yes	No
Cough	Yes	No

Musculoskeletal

Joint Pain	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No

Ears/Nose/Throat/Mouth

Ear Infection	Yes	No
Sore Throat	Yes	No
Sinus Problems	Yes	No
Hearing Disturb	Yes	No

Genitourinary

Urine Retention	Yes	No
Painful Urination	Yes	No
Urinary Frequency	Yes	No
Blood in Urine	Yes	No
Leaking Urine	Yes	No
Prostate Problems	Yes	No

GYN

Last Normal Menses	_____
Vaginal Discharge	Yes No
Endometriosis	Yes No

Hematologic/Lymphatic

Swollen glands	Yes No
Blood clotting problem	Yes No
Frequent Infections	Yes No

Screening Test History (approx. date of last exam)

Chest X-Ray _____
Mammogram _____
Pelvic exam/PAP smear _____
Colonoscopy/Sigmoidoscopy _____
Prostate Exam/PSA _____

Immunization History (approx. date of last injection)

Flu Vaccine _____
Pneumonia Vaccine _____
Tetanus Shot _____
Hepatitis Vaccine _____

Have you ever been exposed to (please circle): Asbestos/ Chemicals/Ionizing Radiation?

