PRIMED CARE

502 North Valley Parkway, Suite 1
Lewisville, Texas 75067

Name:_____Date of Birth: _____SS#:_____

Gender:_____ Race:_____ Ethnicity:_____ Preferred Language:_____

Home #: (____)_____Cell #: (____)_____ Email:_____

Address: _____City:_____Zip:_____

Employer: _____Position: _____

May we leave a message at home or work in reference to appointments?_____

Whom may we thank for referring you?_____

Pharmacy: _____Phone #: _____

Dentist: _____Phone #: _____

Emergency contact: _____Phone #: _____

Nearest friend not living with you: _____Phone #: _____

Who is responsible for this bill? _____

I agree and understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and completed the above information. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Please list all relatives/friends who may have access to your medical file, or who we may call on your behalf. Also please list at a number were we are able to LEAVE A MESSAGE with RESULTS. _____-_____.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

Sign: _____ Date: _____

PRI-MED CARE

502 North Valley Parkway, Suite 1
Lewisville, Texas 75067

Patient History

Name:_____ Date of Birth:_____

Pharmacy Name and Number:_____

List all current medications and doses:_____

_____

_____

Do you have any allergies?_____

_____

When was your last flu shot?_____ Pneumonia shot?_____

Medical History

	Yes	No	Date
Diabetes			
Hypertension			
Stroke			
Heart Attack			
Irregular Heart Beat			
Leg Cramps			
Joint Problems			
Swelling			
Echocardiogram			
Cardiac Catheter			
Gall bladder			
Balloon Angioplasty			
Heart Surgery			
Pacemaker			
Flexible Sigmoidoscopy/Colonoscopy			
Mammogram			
Pap Smear			
Bone Density			

Do you have any other medical problems not listed above?

_____

Risk Factors

Have you ever had your cholesterol checked?____Yes_____No. If yes, what was it? _____
Do you smoke? _____Yes_____No. If yes, _____ packs per day, for _____ years.
Is there any history of heart disease in your family? _____ Yes _____ No. If yes, please list family member and condition:

_____

_____

PRI-MED CARE

502 N. VALLEY PKWY, STE. 1
LEWISVILLE, TX 75067

CONSENT STATEMENTS

Name:_____ DOB:_____

FOR INJECTIONS:
I hereby authorize the physicians and/or nursing staff of Pri-Med Care to perform injection(s). I have no known allergies to the medicine/s I am receiving. I was notified of the complications, which include, but are not limited to bleeding, infection, and no pain relief.

_____ _____
Signature Date

FOR PROCEDURES:
I hereby authorize the physicians and/or nursing staff of Pri-Med Care to perform procedure(s) (lesions, I&D, and/or laceration). I was notified of the complications, which include, but are not limited to bleeding, infection, and no pain relief.

_____ _____
Signature Date

FOR DIAGNOSTIC EXAMS:
I hereby authorize the physicians and/or technicians of Pri-Med Care to perform Ultrasounds, Echocardiograms, Dopplers, U/S Guided Injections, ANS and ABIs. I am not pregnant/nor is there any possibility that I am pregnant at this time. I was notified of any complications that may arise with these diagnostic exams.

_____ _____
Signature Date

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502 N. VALLEY PKWY, STE. 1
LEWISVILLE, TX 75067

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payments from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have takes action relying on this consent.

Patient name:_____

Signature:_____

Relationship to the Patient:_____

Date: _____

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Please be advised that there is a $ 25.00 charge for all appointments that are considered "NO SHOW". Pri-Med Care does require 24 hours advance notice to cancel an appointment.

Sign: _____ Date: _____

PRI-MED CARE +

502 N. VALLEY PKWY, STE. 1
LEWISVILLE, TX 75067

Patient:_____ Claim Group:_____

Employer:_____ SS # / ID #:_____

I hereby instruct and direct _____ Insurance Company to pay by check, made out to and mailed to:

PRI-MED CARE +
502 N. VALLEY PKWY, STE. 1
LEWISVILLE, TX 75067

If my current policy prohibits direct payment to the doctor, I hereby instruct and direct you to make out check to me and mail it as follows:

502 N. VALLEY PKWY, STE. 1
LEWISVILLE, TX 75067

For the professional and medical expense benefit allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. **THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date this _____ day of _____, _____
Day Month Year

_____
Signature of Policyholder