Primary Doc
Primary Care Clinic

Patient Information

First Name:_____MI:____Last Name:_____
Sex: Male___Female___ Marital Status: S__M__D__W__ DOB:_____
Race (check all that apply): Native American___ Alaskan Native___ Asian___
Native Hawaiian___ African American___ Caucasian___ Hispanic___
Other_____
Social Security #: _____/_____/_____
Street Address:_____
City:_____ State:_____ Zip:_____
Phone#:_____Alt Phone #:_____
Employer:_____Empoyer's Phone #:_____
Preferred Email address:_____
How did you hear about us?_____

Insurance Carrier:_____
Policy Holder Name:_____Relationship:_____
Policy Holder DOB:_____

Guarantor's Information if other than patient or if patient is a minor:
Name:_____Relation to patient:_____
Phone #:_____

Emergency contact information:
Name:_____Relation to patient:_____
Phone number:_____

Please list any designated person other than yourself who may receive information about your personal medical records:
Name:_____Relation to patient:_____
Phone number:_____

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Please list your pharmacy:
Pharmacy Name:_____
Address:_____
Phone #:_____

Please read and initial and then sign below:

If you need to cancel or reschedule your appointment, please call our office within 24 hours prior to your appointment time if at all possible._____Initial

If you do not show up for your appointment without prior notice, you will be charged $25._____Initial

I am aware that my services may be provided by a Nurse Practitioner. These services may include: obtaining history and performing an exam, ordering and performing procedures, prescribing medication, developing a treatment plan and monitoring said plan.
I have read the above and hereby consent to the services of a NP for my healthcare needs._____Initial

I authorize Primary Doc to file claims and collect payments for said claims on my behalf to my insurance carrier and to provide medical records if requested._____Initial

Printed Name:_____ Date:_____
Signature:_____ DOB:_____

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Patient Medical Information

Patient Name:_____ Date:_____

Please list **ALL** medications including their strength and frequency or provide a list:

Medication Name	Strength	Frequency

Please list any **drug allergies**:

_____

_____

_____

Please list any **surgery or hospitalizations** in your past:

_____

_____

_____

Do you **smoke**? Y___N___ If so, how long? _____How often?_____
Do you **drink alcoholic beverages**? Y___N___ If so, how often?_____
Do you **exercise** at least 3 days per week? Y___N___
Are you **sexually active**? Y___N___
Do you **drink caffeine**? Y___N___ If so, what and how often?_____
Do you have **children**? Y___N___ If so, how many____and what age(s)_____

Please indicate which of your blood **relatives** has any of the following diseases or health problems:

Disease/Health Problem:	Relative:(mom, dad, siblings, grandparents, children)
Cancer	
High Blood Pressure	
Kidney Disease	
Stroke	
Arthritis	
Diabetes	
Mental/Emotional Problems	
Tuberculosis	
Other:	

Please check yes or no if **you** have had significant problems in the areas below:

Yes	No	Problem	Yes	No	Problem
		Allergies, Hay Fever, Asthma			Diabetes
		Thyroid			Skin Problems
		Anemia/ Abnormal Bleeding			SOB, Coughing, Wheezing
		Heart Problems			Liver Disease
		Circulation Problems			Stomach Problems
		High Blood Pressure			Kidney Disease
		Chest Pain			Urination Problems
		Female Organs			Male Organs
		Joint Pain/ Stiffness			Phlebitis
		Depression			Nerves, Difficulty Sleeping
		Psychiatric			Fainting or Convulsions
		Stroke			Other Illness or Problems

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HIPAA Privacy

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize the office of Krista Gresham, NP to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of this practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time-to-time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

This practice may disclose your protected health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Printed Name:_____ Date:_____
Signature:_____
Relation to patient if minor or guarantor:_____

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Patient Controlled Substance & Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management, anxiety and/or sleep disorders. This will help you comply with the law regarding controlled pharmaceuticals.

- I agree that refills of my prescriptions for any controlled substance medication (for pain, anxiety, or sleep) will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.
- I will inform my physician of any medications I am taking prescribed by any other physician.
- I will bring all controlled medications to my office visits that are prescribed to me by another physician.
- I will not use any controlled medications, including cocaine, etc.
- I agree to use my medication prescribed by my physician.
- I will not share, sell, or trade my medications with anyone.
- I agree to use _____ pharmacy, located at _____ _____ with the phone number of_____.

I authorize the provider and pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled substances. I understand if I break this agreement my provider will not provide any controlled medication prescriptions.

I agree to follow the guideline above. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be provided at my request.

Date:_____

Patient Name:_____ Signature:_____

Witness Name:_____ Signature:_____

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Medical Records Request

Patient Name:_____ DOB:_____
Last 4 of SSN #:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone #:_____

Doctor's Name, Hospital, or Applicable Facility to release records:

_____

Address:_____
City:_____ State:_____ Zip:_____
Phone #:_____ Fax#:_____
Please release patient records including office notes, radiology reports, and lab results to: Primary Doc
1615 West Church St., Suite A
Livingston, Tx. 77351
P. (936)-286-4767 F. (936)-873-8753

By signing this form I authorize the persons or entities listed above to release my medical records.

_____ _____
Patient Signature Date