Carl A. Davis, M.D.
613 Russell Boulevard
Nacogdoches, Texas 75965

## PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name | First Name | Middle | Social Security No.

Date of Birth | Age | Male or Female (Please circle one) | Marital Status: M S W D (Please circle one)

Home Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Contact Preference: (Please Check One) Home Work Cell Mail | Email Address

Referred By: | Phone #:

## EMERGENCY CONTACT INFORMATION

Name | Phone No. | Alt. Phone | Relationship

## PATIENT EMPLOYER INFORMATION

Employer Name | Phone | Fax

Address | City | State | Zip

## GUARANTOR / POLICY HOLDER INFORMATION

Last Name | First Name | Middle | Social Security No.

Date of Birth | Patient's Relationship to Policy Holder | Home Phone | Cell Phone

Employer Name | Phone | Fax

Employer Address | City | State | Zip

## INSURANCE INFORMATION

| | | | | |
|---|---|---|---|---|
| Primary Insurance | Name of Primary Insurance | ID/Policy Number | Group Number | Customer Service No. |
| Secondary Insurance | Name of Secondary Insurance | ID/Policy Number | Group Number | Customer Service No. |
| Work Comp Insurance | Name of WC Insurance | Claim # | Adjuster Name | Adjuster Phone No. |

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 30 DAYS. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

Signature: _____ Date: _____

# Health History Intake Form

Please take the time to fill out this form as completely as possible. This will help us get a comprehensive health history and expedite your clinic evaluation time.

Form Completed by (If other than patient): _____

Patient Name: _____ Date: _____

## MEDICAL AND PREVENTATIVE HEALTH

Former Primary Care Physician: _____

Name of Specialist(s) that you see: _____

_____

**Date of Last Exam/Procedure**

Prostate Exam _____ Pelvic/Pap Smear _____

MammoGram _____ Tuberculosis skin test _____

Tetanus shot _____ Pneumonia Vaccine _____

Complete Physical _____ CT/MRI scan _____

**Allergies:** List medication(s) you are allergic to and reaction(s) you have

_____

**Current Medications:** List all medications, including over-the-counter and homeopathic/natural remedies, with dosages. _____

_____

_____

_____

**List all Surgeries, Hospitalizations, and Serious Accidents:** Include year/Place treated

_____

_____

## Family Health History

| Relation | Age if Living | Age at Death | Major Health Problems | Cause of Death |
|---|---|---|---|---|
| FATHER | | | | |
| MOTHER | | | | |
| SIBLINGS | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Questions for Women:**

Age Periods Began: _____

How Often: _____

Last Menstrual Period: _____

Birth Control: Yes or No

Sexually Active Yes or No

**Pregnancies:**

Total Number: _____ Full Term: _____ Premature: _____

Miscarriages: _____ Abortions: _____ Tubal Pregnancies: _____

Complications: _____

**Social/Dietary Habits**

How many meals do you eat each day? ____ How much coffee/tea do you drink a day? _____

How much alcohol do you drink? _____ Current Weight _____

Have you ever smoked/vaped? _____ How much do you smoke/vape? _____

How long have you smoked/vaped? _____

Are you ready to quit smoking/vaping? _____

Other tobacco use _____

How often do you exercise? _____

**Past Medical History:**
**Please check any that you have had or now have:**

- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Cancer: type _____
- ☐ Stomach/intestinal ulcers
- ☐ Parkinson's disease
- ☐ High Cholesterol
- ☐ Diverticulosis
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Thyroid Problems
- ☐ Stroke
- ☐ Glaucoma
- ☐ Pancreatitis
- ☐ Irregular heart rhythm
- ☐ High blood pressure
- ☐ Migraine Headaches
- ☐ Kidney failure
- ☐ Sexually transmitted diseases
- ☐ Seizures
- ☐ Cataracts
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Angina
- ☐ Gall stones
- ☐ Hernias
- ☐ Arthritis or Gout
- ☐ Asthma/ emphysema
- ☐ Mental illness
- ☐ Kidney stones
- ☐ Blood Clots/ Phlebitis

Name: Date:

## Review of Systems Questionnaire

Rate each of the following symptoms based on your health profile for the past 30 days.

### Point Scale

0= Do not suffer at all
1= Occasionally have it, not severe
2= Suffer frequently, not severe
3= Suffer occassionally, severe
4= Suffer Frequently

**Constitutional**

| | |
|---|---|
| Weight Change | 0 1 2 3 4 |
| Loss of appetite | 0 1 2 3 4 |
| Fever | 0 1 2 3 4 |
| Weakness | 0 1 2 3 4 |
| Night Sweats | 0 1 2 3 4 |
| Fatigue | 0 1 2 3 4 |

**Dermatology**

| | |
|---|---|
| Suspicicous lesions/moles | 0 1 2 3 4 |
| Lumps | 0 1 2 3 4 |
| Hives | 0 1 2 3 4 |
| Rash | 0 1 2 3 4 |
| Itching/Picking/Scratching | 0 1 2 3 4 |
| Hair loss | 0 1 2 3 4 |
| Dry/Sensitive skin | 0 1 2 3 4 |

**ENT**

| | |
|---|---|
| Nose Bleeds | 0 1 2 3 4 |
| Nasal Congestion | 0 1 2 3 4 |
| Room Spinning Vertigo | 0 1 2 3 4 |
| Change in voice | 0 1 2 3 4 |
| Sore throat | 0 1 2 3 4 |
| Difficulty swallowing/ chewing | 0 1 2 3 4 |

**Respiratory**

| | |
|---|---|
| Shortness of Breath | 0 1 2 3 4 |
| Wheezing | 0 1 2 3 4 |
| Coughing | 0 1 2 3 4 |

**Gastroenterology**

| | |
|---|---|
| Blood in stool | 0 1 2 3 4 |
| Diarrhea | 0 1 2 3 4 |
| Nausea/Vomiting | 0 1 2 3 4 |
| Constipation | 0 1 2 3 4 |
| Abdominal Pain | 0 1 2 3 4 |

**Genitourinary Female**

| | |
|---|---|
| Premenstrual Syndrome | 0 1 2 3 4 |
| Irregular periods | 0 1 2 3 4 |
| Dysmenorrheal | 0 1 2 3 4 |
| Breast tenderness/changes/lumps | 0 1 2 3 4 |
| Vaginal itching | 0 1 2 3 4 |
| Intermenstrual bleeding | 0 1 2 3 4 |
| Pelvic pain | 0 1 2 3 4 |
| Abnormal discharge | 0 1 2 3 4 |
| Irregular periods | 0 1 2 3 4 |

**Opthamology**

| | |
|---|---|
| Eye irritation/reddness | 0 1 2 3 4 |
| Drainage from eyes | 0 1 2 3 4 |
| Blurring of vision | 0 1 2 3 4 |
| Glaucoma | Yes or No |

**Hematology**

| | |
|---|---|
| Easy bruising/bleeding | 0 1 2 3 4 |
| Jaundice | 0 1 2 3 4 |

**Endocrinology**

| | |
|---|---|
| Hot Flashes | 0 1 2 3 4 |
| Heat/Cold intolerance | 0 1 2 3 4 |
| Excessive Thirst | 0 1 2 3 4 |
| Excessive sweating | 0 1 2 3 4 |
| Excessive urination | 0 1 2 3 4 |
| Brittle Nails | 0 1 2 3 4 |

**Allergy**

| | |
|---|---|
| Runny/stuffy Nose | 0 1 2 3 4 |
| Scratchy throat | 0 1 2 3 4 |
| Itchy eyes | 0 1 2 3 4 |
| Sneezing | 0 1 2 3 4 |
| Ear Fullness | 0 1 2 3 4 |

**Psychology**

| | |
|---|---|
| Depression | 0 1 2 3 4 |
| High stress | 0 1 2 3 4 |
| Mood Swings | 0 1 2 3 4 |
| Suicidal ideation | 0 1 2 3 4 |
| Attention/focus | 0 1 2 3 4 |

**Neurology**

| | |
|---|---|
| Headache | 0 1 2 3 4 |
| Tingling/numbness | 0 1 2 3 4 |
| Seizures | 0 1 2 3 4 |
| Dizziness | 0 1 2 3 4 |
| Focal Weakness | 0 1 2 3 4 |

**Urology**

| | |
|---|---|
| Difficulty urinating | 0 1 2 3 4 |
| Blood in urine | 0 1 2 3 4 |
| Urinary urgency | 0 1 2 3 4 |
| Urinary incontinence | 0 1 2 3 4 |

**Cardiology**

| | |
|---|---|
| Palpitations | 0 1 2 3 4 |
| Chest Pains | 0 1 2 3 4 |
| High Blood Pressure | 0 1 2 3 4 |

**Musculoskeletal**

| | |
|---|---|
| Joint Stiffness | 0 1 2 3 4 |
| Leg cramps/muscle aches | 0 1 2 3 4 |
| Joint pain/swelling | 0 1 2 3 4 |
| Neck/Back pain | 0 1 2 3 4 |

**Carl A. Davis, MD**
**613 Russell BLVD.**
**Nacogdoches, Texas 75965**
**Office # (936) 305-4155**
**Fax # (936) 305-4156**

**Late Arrival for Appointment:** Patients arriving more than 15 minutes late for a scheduled appointment will be subject to possible rescheduling. We will ask Dr. Davis if there is available time to work your appointment into the schedule. If your appointment is worked in, please be aware that other patients who arrive after you may get called back for their scheduled appointments. If Dr. Davis does not have any available time, your appointment will be rescheduled. (_____) initial

**Cancellation / No Show:** Patient appointments that are not cancelled **AT LEAST** 24 hours prior to the scheduled appointment time will be subject to a fee of $25.00. This charge cannot be billed to insurance. We will bill directly to the patient! A patient is considered a no show 15 minutes from the time of their appointment. Charges will be at Dr. Davis's discretion. Continuous no-shows could result in dismissal from the practice.
(_____) initial

**Phone Message:** Our phones are answered the hours of 8:00 am - 12:00 pm and 1:00 pm – 5:00 pm Monday through Thursday, and 8:00 am – 12:00 pm on Friday. All messages will be returned with a phone call within 24 hours of leaving the message. If Dr. Davis is in the office, a return call should be expected the same day. **Please do not repeatedly call the office. Leave one message per 24-hour period.** (_____) initial

**Forms Fee:** Patients that require our office to fill out paperwork will be subject to a fee that will be collected before the paperwork is released. The fee is based on the amount of paperwork that will be at Dr. Davis's discretion. Please allow 48 hours (about 2 days) for forms to be completed, excluding weekends. Forms **will not** be filled out during your appointment time.
(_____) initial

**Rescheduling Appointments due to Provider Emergencies:** Our office will contact the patient if Dr. Davis must be out of the office, running late, or has an emergency. We will do everything possible to accommodate your schedules as much as our schedule will allow. (_____) initial

**Time of Service Collections:** All co-pays, coinsurance, deductibles, past due balances, and/or fee for service are due at the time of visit. When you receive your appointment reminder call, you will be notified of any outstanding balances due, and arrangements will have to be made or your appointment will be cancelled and rescheduled.
Please understand that Dr. Davis is not in network with some insurances, you will be informed prior to your visit if this applies to you. (_____) initial

**Medication/Controlled Drug Policy:** Controlled drug policy is attached. Please thoroughly review the policy. I give the office of Dr. Davis to query all medications prescribed to me from an online database. (_____) initial

**Patient communication consent:** We may need to contact you regarding your medical care such as appointments, test results, referrals, or for any other reason. Please initial if you consent to being contacted via secure email, phone (home or cell) and patient portal.
You may authorize (2) family members that we can speak to regarding your medical care or financial matters. (_____) initial

Name:_____

Phone:_____

Relationship:_____

Name:_____

Phone:_____

Relationship:_____

**Notice of Privacy Practices:** I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I have been given the opportunity to ask questions if I do not understand. I understand that I am entitled to receive a copy of this document, and that it also will be scanned in my chart. (_____) initial

**Patient Signature:** _____

**Date of Birth:** _____

**Today's Date:** _____