PRECISION
FAMILY MEDICINE

Please print your response to all requested information clearly. If you have any questions, please ask. Thank You.

## PATIENT INFORMATION

Name_____ Home Phone( )_____

Address_____ Office Phone( )_____

City_____ State_____ Zip_____ Date of Birth_____ Age_____

Single____ Married____ Divorced____ Other____ Social Security #_____

Employer_____ Occupation_____

## HOLDER OF INSURANCE POLICY

Name_____ Office Phone( )_____

Home Address_____ City_____ State_____ Zip_____

Employer_____ Occupation_____

Social Security #_____ Date of Birth_____ Age_____

## INSURANCE INFORMATION

Insurance Company_____ Phone( )_____

Address_____ City_____ State_____ Zip_____

Group Number_____ ID Number_____

**CONTACT FOR EMERGENCIES**_____ Relationship_____
(Someone Not Living With You)

Home Telephone( )_____ Office Telephone( )_____

Referred By_____ Relationship_____

I understand it is my full responsibility to keep all insurance(if any) and patient demographic information up to date and correct. I hereby assign all medical and/or surgical benefits to include major benefits to which I am entitled including Medicare, private insurance, PPO plans, and all other health care plans to Precision Family Medicine, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am fully financially responsible for all charges whether or not paid by said insurance. I hereby authorize and assignee to release all information needed to secure the payment.

Signed_____ Date_____

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1428 W. Hebron Parkway, Ste 110 • Carrollton, TX • 75010 • (972) 939-4555• Fax (972) 939-7020

# MEDICAL HISTORY

Date: _____

Name: _____
Last First Middle

Birth Date: _____ Gender: □ Male □ Female Birth Place: _____

Allergies: _____
_____
_____

Current Medications: _____
_____
_____

Current/Chronic Medical Conditions:
_____
_____
_____
_____

Surgeries: _____
_____
_____
_____
_____

What brings you to our office today:
_____
_____

Do you have any special beliefs that would be important for us to know in regards to your medical care?
_____

Tobacco Use: □ None □ Current Use □ Prior Use Year Started _____Year Quit _____ Amount _____

Alcohol Use: □ None □ Occasional use □ Weekly □ Daily # per week _____

Drug Use: □ None □ Yes Type: _____ How often: _____

Drug Supplements (Any vitamins or over the counter drugs taken on a regular basis): _____
_____

Martial Status: □ Single □ Married □ Divorced/Separated □ Widowed □ Other

Do you have Children? Y/N If yes, Children's Name, Age and Year of Birth: _____
_____
_____

Are you currently employed? □ Yes □ No Employer: _____

Name: _____ DOB: _____

Last Pap Smear: _____ Last Mammogram: _____

Last Physical Exam: _____ Last Eye Exam: _____

Last Dental Exam: _____ Birth Control Method: _____

_____ _____

Mother's Full Name Date of Birth Father's Full Name Date of Birth

FAMILY HISTORY: ☐ No knowledge of family medical history

| Relation | Age | Health Issues | If deceased cause and age |
|---|---|---|---|
| | | | |
| Father | | | |
| Mother | | | |
| Brothers/Sisters | | | |
| Children | | | |

Please indicate medical conditions that run in your family. Please indicate also who is affected by these conditions.

| | |
|---|---|
| | Asthma : |
| | Seizures |
| | Cholesterol: |
| | Allergies: |
| | Mental Illness: |
| | Alcoholism: |
| | Lung Dis.: |
| | Diabetes |
| | Ulcers: |
| | Kidney Dis. |
| | Other: |
| | Cancer: |
| | Breast:: |
| | Colon: |
| | Brain: |
| | Lung: |
| | Skin: |
| | Other: |

| | |
|---|---|
| | Headaches: |
| | Liver Disease: |
| | Hypothyroid (Low): |
| | Hyperthyroid (High): |
| | Heart Attacks: |
| | High Blood Pressure: |
| | Stroke: |
| | Arthritis: |
| | Reflux: |
| | Blood Disease |
| | Heart Disease |

How did you hear about us?

_____

_____

_____ _____

Patient Signature Date

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## AUTHORIZATION OF USE/ DISCLOSURE OF PROTECTED INFORMATION

**Appointment reminders:** Typically, appointment reminders are brief non-specific messages that may be left on your voicemail or by text messages that are sent to you cellular phone.

**How would you prefer to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for service provided by Precision Family Medicine. (Check all that apply)**

**Regular mail_____ Appointment cards_____ Phone/voicemail_____ Fax_____ Email_____**

**Cell#_____ Work#_____ Fax#_____ Email _____**

**OK TO LEAVE VOICE MESSAGE**-(CIRCLE ONE) **YES** OR **NO**

**OK TO SEND TEXT MESSAGE AND EMAILS** - (CIRCLE ONE) **YES** OR **NO**

**Other Uses and Disclosures:** Disclosure of your health information or its use for any purposes other than those listed in the "Notice of Privacy Policies and Practices "consent will require your specific authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke will not affect or undo any disclosure prior to your notification date. You have the right to request restrictions on use and disclosure of you health information. **Please list any restrictions below:**

_____

_____

**PERSONS AUTHORIZED TO RECEIVE INFORMATION:**

_____

Name of person/relation/organization Phone #

_____

Name of person/relation/organization Phone #

_____ _____

Print Patient Name Date of Birth of Patient

_____

Signature of Patient Date

_____

Patient Representative Signature/ relationship to patient

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**1428 W. HEBRON PARKWAY, STE 110**
**CARROLLTON, TX 75010**
**972-939-4555 (phone) 972-939-7020 (fax)**

## FINANCIAL POLICY STATEMENT

### IMPORTANT INFORMATION PLEASE READ

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance, FULL PAYMENT IS DUE AT TIME OF SERVICE. For your convenience we accept cash, Master Card, Visa and Discover. Your insurance policy is a contract between you and your insurance company, the doctor is not involved.

**As a courtesy to our patients, we will bill contracted insurance plans directly. Any co-payment and/or co-insurance or deductible is payable at the time of service. Payments not received within thirty (30) days of statement date are considered late. Interest on late payments will accrue at a rate of 1.5% monthly. Past due accounts will result in the account being sent to our collection agency. Patient agrees to pay collection cost at an additional 30% of total balance on each account sent to collections. Any patients sent to collections will be dismissed from the practice until the balance is paid in full. No services will be rendered by this office (appointments or prescription refills) until the balance is paid in full.**

We do charge to fill out disability or insurance forms, example being FMLA leave, and other forms, this fee **does not** apply to filing your claim with your insurance carrier. Payment of $25 is required prior to our filling out the above mentioned forms. For your convenience we accept cash, Master Card, Visa and Discover. **Those forms not properly signed by the patient will not be filled out. Please allow 3 business days for the completion of these forms.**

I have read and understand this financial policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the practice.

_____ _____

Signature of Patient Date

_____

Name of patient (please print)

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## PATIENT WAIVER

### IMPORTANT INFORMATION – PLEASE TAKE TIME TO READ!

To our Patients:

Many insurance companies today do not cover preventive services (annual physicals, immunizations, screening tests, etc.

We do our best to verify your coverage prior to your visit, **but we cannot guarantee payment of benefits by your insurance plan.** This is a contract between you and your insurance company and it is **YOUR** responsibility to know the terms of your plan.

Some (but not all) of the services that may not be covered by insurance are:

Immunizations: Hepatitis B, Influenza, MMR, Pneumovax, Tetanus

Screening Tests: Cholesterol, Diabetes, Thyroid

Office Visits: Well woman exams, and depression

An annual well woman exam or general physical is preventive in nature and consists of a physical exam, Pap test for women, and **refills of birth control prescription medications. These exams are not to be used to treat or discuss any medical problems.** Insurance companies are also very particular that your **annual exam must be scheduled exactly one year from the date of your previous exam. If you schedule your exam too early, it is very likely the insurance will deny payment and you will be responsible for the charges.**

If there is a problem/concern to discuss or treat, then this is not considered a well woman exam or physical and will be billed either as a new or established problem office visit. We are required by insurance company guidelines to submit our bill to your insurance company using accurate information about the type of service you received. **PLEASE DO NOT ASK US TO CHANGE THE CODING OF YOUR VISIT AS THIS IS INSURANCE FRAUD!**

In the event you are referred to a specialist, please keep in mind that the referral is based on quality of care and not insurance acceptance. **It is YOUR responsibility to confirm with the specialist's office to ensure their acceptance of your insurance.**

I understand that I am responsible for full payment to Precision Family Medicine for any services that may not be covered by my insurance plan.

_____ _____

Patient Signature Date