PATIENT FACE SHEET

DATE:_____

NAME:_____SSN:_____/_____/_____
(LAST) (MI) (FIRST)

HOME ADDRESS:_____APT/STE:_____

CITY_____STATE:_____ZIP:_____

(HOME): (_____)_____-_____CELL:(_____)_____-_____ OFF:(_____)_____-_____

DATE OF BIRTH:_____/_____/_____GENDER: M F

MARITAL STATUS:_____EMAIL:_____@_____

EMERGENCY CONTACT

NAME:_____DATE OF BIRTH:_____/_____/_____
(LAST) (FIRST)

TELEPHONE # (_____)_____-_____RELATIONSHIP:_____

CAN THIS PERSON MAKE MEDICAL DECISIONS FOR YOU? YES NO

INSURED INFORMATION

NAME:_____DATE OF BIRTH:_____/_____/_____

EMPLOYER:_____

CITY_____STATE:_____ZIP:_____

RELATIONSHIP TO PATIENT:_____INSURED SSN:_____/_____/_____

INSURANCE INFORMATION

NAME:_____

ID #:_____GROUP:_____

CLAIM ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE:_____-_____-_____ FAX:_____-_____-_____

I HAVE BEEN PROVIDED A COPY OF THE OFFICE PROCEDURES:_____
(INITIALS)

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarraiges	# of Abortions	# of Living

Last Pap Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Name _____ Gender _____ Age _____ Date of Appointment: _____

Review of Systems

General
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth – Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain
- ☐ Weight Loss

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Marital Problems
- ☐ Panic Attacks
- ☐ Trouble Concentrating
- ☐ Suicide –Thoughts/Attempts

Skin
- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Chills
- ☐ Dry / Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

Gastrointestinal
- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

Neurological
- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

ENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

Respiratory
- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Musculoskeletal
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

Men Only
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penile Discharge
- ☐ Sore on Penis

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge

Other Symptoms

_____

_____

_____

Health Exams & Procedures

Please check and date the last time you had each exam or procedure performed.

	Month & Year		Month & Year
☐ Cholesterol Test	_____	☐ MRI	_____
☐ Colonoscopy	_____	☐ Physical Exam	_____
☐ CT/CAT Scan	_____	☐ Cardiac Stress Test	_____
☐ EKG	_____	☐ Ultra Sound	_____
☐ Echocardiogram	_____		

Immunizations

Please check and date all immunizations you have had.

	Month & Year		Month & Year
☐ Hepatitis A	_____	☐ MMR (Measles, Mumps, Rubella)	_____
☐ Hepatitis B (Series of 3)	_____	☐ Pneumonia	_____
☐ HPV Vaccine	_____	☐ Polio	_____
☐ Influenza (Flu Shot)	_____	☐ Tetanus	_____
☐ Meningitis	_____		

PATIENT MEDICATION LIST

NAME:_____ DATE OF BIRTH:_____

*(Please include **all** medication including herbal medication, supplements and all over-the-counter medications as well as inhalers, eye drops, ear drops etc.)*

MEDICATION	DOSE	FREQUENCY

*ALLERGIES:*_____

*PHARMACY NAME:*_____

*ADDRESS:*_____

*PHONE:*_____*FAX:*_____

REFILL PREFERENCE: *30 DAYS* *90 DAYS*

himc HEALING
Internal Medicine Clinic

HEALING
Internal Medicine Clinic

Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize Healing Internal Medicine Clinic to release patient healthcare information, compiled from the medical records pertaining to my service,in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payer, including but not limited to my insurance plan.

I hereby authorize payment of insurance benefits under the terms of my policy directly to Healing Internal Medicine Clinic for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan. I agree that it is my responsibility to change my PCP to Dr. Adeel Afzal with my HMO if applicable before I can be seen.

Patient Initials_____ **Date:**_____/_____/_____

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by Healing Internal Medicine Clinic, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles,co-insurance and non-covered charges. Payment in full is due at time of services are rendered or payment arrangements are to be made before your appointment.

Patient Initials_____ **Date:**_____/_____/_____

Consent to Medical Treatment by Physician

I, or authorized/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services,which may include routine diagnostic procedures and such medical treatment as the physician,his assistants consider to be necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at Healing Internal Medicine Clinic or Dr. Adeel Afzal

Patient Initials_____ **Date:**_____/_____/_____

Release of Patient Healthcare Information.

I hereby authorize Healing Internal Medicine Clinic to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the sole purpose of providing current continuum of care including, but not limited to fax,mail or electronic submission.

Patient Initials_____ **Date:**_____/_____/_____

The above authorization are valid unless you specify otherwise or revoke them in writing.

Do you have an advanced directive(living will)? _____Yes _____No
If Yes, please bring a copy into our office for our files.
If No and you would like information on an Advance Directive, please speak with our front office.

PATIENT NAME:_____DATE:_____

HEALING
Internal Medicine Clinic

ATTENTION ALL PATIENTS

1. COPAYS are due at the time of your visit, every time. Please confirm amount of copay with your insurance and make necessary arrangements. If your insurance requires you to have Dr. Afzal listed as your PCP and you do not, your insurance might not pay for the services provided to you and you will be responsible for any charges.

2. Please notify Front Office staff of any changes in your address or insurance. Please call your PHARMACY for any refill requests. Ask them to fax over the refill request for approval. Any phone calls or messages for refill requests after 4 PM will not be answered until after clinic the following day. Any calls after 4 PM on Friday will not be answered until Monday after clinic. Please allow up to five (5) business days for your refill requests to be completed. It is patient's responsibility to request refills in timely fashion so as to not run out of medication. All messages left for the nurse or at the main voice mail will be returned in 24-48 hours and on the first working day after a weekend or national holiday. Please DO NOT ever leave any messages of URGENT or EMERGENT nature on the voice mail.

3. Please allow 72 hours for all referrals and authorizations to be processed.

4. All patients under the age of 18 years of age will need to be accompanied by a parent or legal guardian. Parent or legal guardian must be present through the entire duration of the appointment. If a parent or legal guardian is unavailable to accompany the patient, then a MEDICAL TREATMENT AUTHORIZATION form must be completed giving another adult permission to accompany the patient.

5. If you are going to be more than thirty minutes late for your scheduled appointment, please let us know as early as possible. You will be rescheduled. Also, If you are not going to be able to keep your appointment, please give at least a 24 hour notice. After 2 NO SHOW appointments, a $25.00 charge will be added to your account.

6. We generally do not accept Checks, If we do accept a check from you and it becomes a Non-Sufficient Funds, we charge $50.00 as Non-Sufficient Funds fee.

ADDITIONAL CHARGES THAT YOUR INSURANCE DOES NOT COVER

(Forms can take up to 5 business days to be completed)

- Missed Appointment: $25.00 (less than 24 hrs Notice)
- Handicap Placard Medical Form Completion: $35.00
- Lab Reports: $1.00 per page
- Lost Notes/Prescriptions/Requisitions: $15.00
  (not all Prescriptions will be reissued)
- Copy Medical Records: First 20 pages: $25.00 Each additional page: 25 cents
- Disability Form: $50.00
- FMLA Form: $50.00

_____ I agree that I have reviewed the above notice and agree to proceed with my care at
(patient initial) Healing Internal Medicine Clinic.

PATIENT NAME:_____DATE:_____

HEALING
Internal Medicine Clinic

Please list the individuals Dr. Adeel Afzal or other employees of the clinic are allowed to discuss your medical information with. That may include otherwise privileged information including, but not limited to your Psychiatric history and/or history of sexually transmitted diseases or treatment.

Please leave blank if you are not sure.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Do you consent to Dr. Adeel Afzal or Staff leaving test result information on your voice mail?

YES NO

Do you consent to Dr. Adeel Afzal or Staff sending test result information as a text message?

YES NO

(If yes, please write you text message capable cell phone number:_____)

Do you consent to Dr. Adeel Afzal or Staff releasing medical information to any specialist that we refer you to or you are currently under treatment of?

YES NO

Please list all specialists that you are currently being treated by:

Physician:_____Specialty:_____Phone:_____

Physician:_____Specialty:_____Phone:_____

Physician:_____Specialty:_____Phone:_____

Physician:_____Specialty:_____Phone:_____

Physician:_____Specialty:_____Phone:_____

PATIENT NAME:_____DATE:_____