HEALING
Internal Medicine Clinic

Chart Number: _____ Patient Name: _____ Today's Date: _____

**Reason for Visit:**

_____

**Past Medical History: (Please Check)**

| | | | | |
|---|---|---|---|---|
| ☐ HIV/AIDS | ☐Anemia | ☐Anxiety | ☐Arthritis | ☐ Asthma |
| ☐ Diabetes | ☐Depression | ☐ Epilepsy | ☐ Gout | ☐ Heart Disease |
| ☐ High Blood Pressure | ☐ Migraines | ☐ High Cholesterol | ☐ Osteoporosis | ☐ Joint Disorder |
| ☐ Kidney Disorder | ☐ Liver Disorder | ☐Lung Disease | ☐ Autoimmune Disease | ☐ Stroke |
| ☐ Stomach Ulcers | ☐ Substance Abuse | ☐ Thyroid Disorder | ☐ Cancer | ☐ Venereal Disease |
| ☐ Back Pain | ☐ Hepatitis | ☐ Pneumonia | ☐ Skin Disorder | ☐ Ear Problems |

Other: _____

**Surgical History:** _____

**Family History:** _____

**Colonoscopy:** ☐ Yes ☐ No. When? _____, Eye Exam: ☐ Yes ☐ No. When? _____

**Females Only:** Mammogram: ☐ Yes ☐ No. Last time? _____ Pap Smear: ☐ Yes ☐ No Last time? _____

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed

Are you Sexually Active? ☐ Yes ☐ No # of partners in past year? _____

Profession: _____

Do you wish to be checked for STDs? ☐ Yes ☐ No

Living Situation: ☐ With Family ☐ Alone ☐ Other: _____

Has anyone in your home ever physically or verbally hurt you ☐Yes ☐No

Sexual Preference: ☐ Male ☐ Female ☐ Both

Do You Smoke: ☐Never ☐ Current ☐ Previous

Years Smoked: _____, Cigarettes/Day: _____

Chewing Tobacco: ☐ Never ☐ Current ☐ Previous Pouches/Day_____

Alcohol: ☐ Less than one drink per week ☐ More than one drink per week

Drinks per Day_____ Type: _____

Illegal Drugs: ☐Yes ☐No What Type? ☐ Snorted ☐ Smoked ☐ Injected

Prescription Drug Addiction: ☐ Yes ☐ No If yes, What Drug? _____

**REVIEW OF SYSTEMS**

**GENERAL**
☐ FATIGUE
☐ FEVER
☐ NIGHT SWEATS
☐ WEIGHT LOSS

**HEENT**
☐ SORE THROAT
☐ PAINFULL SWALLOWING
☐ CHOCKING
☐HOARSENESS
☐ RINGING IN EARS

**WOMEN ONLY**
☐ BLEEDING BETWEEN PERIODS
☐ MENSTRUAL PAIN
☐ EXCESSIVE MENSTRUAL BLEED
☐ HOT FLASHES
☐ PAINFULL INTERCOURSE
☐VAGINAL DISCHARGE
☐ NIPPLE DISCHARGE
HAVE OU EVER HAD?
ABNORMAL PAP SMEAR; ☐YES ☐ NO
UTERINE FIBROID: ☐YES ☐NO
OVARIAN MASSES: ☐ YES ☐NO
BREAST MASS: ☐YES ☐ NO
NUMBER OF PREGNANCIES: _____
LIVE BIRTHS: _____

**NEUROLOGICAL**
☐ VISION LOSS
☐ BLURRING OF VISION
☐ DOUBLE VISION
☐ HEADACHES
☐ HEARRING LOSS
☐ SINUS PAIN
☐ EAR PAIN
☐ TREMORS
☐ SEIZURES
☐ WEAKNESS

**ENDOCRINE**
☐ EXCESSIVE THIRST
☐ WEIGHT GAIN
☐ HAIR LOSS
☐ COLD INTOLERANCE
☐ HEAT- INTOLERANCE

**SKIN**
☐ ACNE
☐ ECZEMA
☐ NON-HEALING SKIN

**MUSCULOSKELETAL**
☐ ANKLE SWELLING
☐ LEG PAIN/ACHE
☐ VERICOSE VEINS

**GASTROINTESTINAL**
☐ ABDOMINAL PAIN
☐ CONSTIPATION
☐ DIARRHEA
☐ NAUSEA
☐ VOMITING
☐ HEMORRHOIDS
☐ BLOOD IN STOOL

**HEMATOLOGY**
☐ EASY BLEEDING
☐ EASY BRUISING

**CARDIOVASCULAR**
☐ CHEST PAIN
☐ PALPITATIONS
☐ ANKLE SWELLING

**UROLOGICAL**
☐ EXCESSIVE URINATION
☐ WEAK STREAM OF URINE
☐ FEELING OF INCOMPLETE EMPTYING OF BLADDER
☐ NIGHT TIME URINATION PROBLEM

**ALLERGIES**
☐ SEASONAL
☐ ENVIRONMENTAL
☐ FOOD

**COGNITIVE**
☐ MEMORY IMPAIRMENT

**SLEEP**
☐ TROUBLE FALLING ASLEEP
☐ TROUBLE STAYING ASLEEP
☐ NIGHT TERRORS
☐ EXCESSIVE SLEEPINESS

**PSYCHIATRIC**
☐ ANXIETY
☐ DEPRESSION
☐ HOPELESSNESS
☐ PANIC ATTACKS
☐ FLASHBACKS
☐ SUICIDAL THOUGHTS
☐ HOMICIDAL THOUGHTS

**RESPIRATORY**
☐ COUGH WITH PLEGM
☐ COUTH WITH BLOOD
☐ SHORTNESS OF BREATH
☐ CHEST PAIN WHEN BREATHING
☐ WHEEZING

Other:_____

# 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.)*

| Medicine | Dose (Strength) | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

ALLERGIES: _____

PHARMACY NAME: _____

ADDRESS: _____

PHONE: _____FAX: _____

REFILL PREFERENCE: 30 DAYS 90 DAYS

**Assignment of Benefits**

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 Primary Care Provider to Dr. Adeel Afzal 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 health benefit plan or personnel of this 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 is 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.

# 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 2 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 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 Nonsufficient 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 hours' 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.

## People you allow us to discuss test results, lab results and medical history.

**(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: _____