1. Health & Neck Questions		
Headache	Y	N
Hay Fever	Y	N
Recent change in eyesight	Y	N
Hearing problem	Y	N
Cataract	Y	N
2. Chest & Lung Questions		
Chronic cough	Y	N
Asthma	Y	N
Blood clot in lungs (Pulmonary Embolus)	Y	N
Tuberculosis	Y	N
Shortness of breath that limits activity	Y	N
Decrease in exercise or work activity	Y	N
3. Heart Questions		
Heart Attack	Y	N
Heart Catherization	Y	N
Chest pain, tightness, pressure	Y	N
Irregular heart beats, palpitations	Y	N
Shortness of breath or cough while laying down	Y	N
Swelling of feet or ankles	Y	N
Urination more than one during the night	Y	N
Pain in legs while walking	Y	N
4. Stomach & Intestine Questions		
Nausea or vomiting	Y	N
Indigestion or Heart burn	Y	N
Food sticking after it is swallowed	Y	N
Abdominal pain or bloating	Y	N
Stomach or Duodenal Ulcer	Y	N
Jaundice, Hepatitis, or liver trouble	Y	N
Gallstones	Y	N
Diarrhea or Constipation	Y	N
Change in bowel habits	Y	N
Mucus or blood in stool	Y	N
Black "Tar Like: Stools	Y	N
Spastic Colon	Y	N
Diverticulitis	Y	N
5. Genitourinary Questions		
Burning sensation during urination	Y	N
Leaking of urine	Y	N
Kidney Stones	Y	N
Trouble starting urinary stream	Y	N
6. For Men Only		
Tender or swollen testicle	Y	N
Problem with erection	Y	N
7. For Women Only		
Breast Biopsy (Removal of breast mass or lump)	Y	N
Lump in Breast	Y	N
Bleeding or discharge from nipples	Y	N
Family History or Breast Cancer	Y	N
Hysterectomy	Y	N
8. Muscle & Bone Questions		
Chronic neck or back pain	Y	N
Pain, or Stiffness in joints	Y	N
Leg cramps at night	Y	N
Rheumatoid arthritis	Y	N
Gout	Y	N
9.Neurologic Questions		
Weakness, paralysis of on arm and/or leg	Y	N
Numbness, tingling of one arm and/or leg	Y	N
Dizziness and/ or light-headedness	Y	N
Fainting and/or seizures	Y	N

10. General Questions		
Diabetes	Y	N
Hypertension	Y	N
Thyroid trouble	Y	N
Anemia	Y	N
Cancer	Y	N
Weight Loss	Y	N
Weight Gain	Y	N
Chronic skin rash	Y	N
11. Family History		
Diabetes	Y	N
Hypertension	Y	N
Thyroid trouble	Y	N
Anemia	Y	N
Cancer	Y	N
Heart Disease (MI, Stroke)	Y	N
12. How are you feeling		
Having trouble sleeping?	Y	N
Having trouble staying asleep?	Y	N
Feel chronically tired?	Y	N
Are you tense, nervous, or anxious?	Y	N
Feel depressed, or down at in the slumps?	Y	N
Having trouble remembering or concentrating?	Y	N
Have you been treated by a psychiatrist?	Y	N
13. Social		
Do you wear seatbelts?	Y	N
Do you exercise?	Y	N
How often?		
Do you smoke?	Y	N
How much daily?		
Do you drink alcohol?	Y	N
How much daily?		
How much weekly?		
Socially only	Y	N
What is your current occupation?		
Have you recently traveled outside of the country?		
Where to?		
Is your mother living? Yes or No Age:		
Is your father living? Yes or No Age:		
Number of living sisters:		
Number of deceased?		
Cause(s) of death?		
Number of living brothers:		
Number of deceased?		
Cause(s) of death?		
Number of living children:		
Number of deceased?		
Cause(s) of death?		
Name :		
DOB:		

List current medications with dosage and frequencies:

1. ______________________ 7. ______________________
2. ______________________ 8. ______________________
3. ______________________ 9. ______________________
4. ______________________ 10. ______________________
5. ______________________ 11. ______________________
6. ______________________ 12. ______________________

List surgeries and/or hospitalizations you have had:

- ______________________ **Year:** ______
- ______________________ **Year:** ______
- ______________________ **Year:** ______
- ______________________ **Year:** ______

Date of your last:

Chest X-ray: ______________________

EKG: ______________________

Mammogram: ______________________

Pap Smear: ______________________

Colonoscopy: ______________________

TB Test: ______________________

Hearing Screening: ______________________

Do you currently have hearing loss or ringing in your ears? ______________________

List any allergies to medicines:

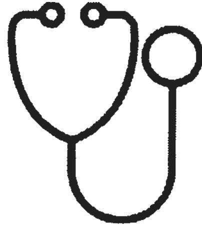
- ______________________ **Type of reaction:** ______
- ______________________ **Type of reaction:** ______
- ______________________ **Type of reaction:** ______
- ______________________ **Type of reaction:** ______

Current Pharmacy: ______________________

Location/Phone Number: ______________________ (   )   -

Physician Signature: ______________________ **Date:** ______

Patient's Name: ______________________ **D.O.B.** ______



Arlington Family Health Pavillion

Family Doctors

Arlington, Texas

All co pays and balances are due at the time of services are rendered unless prior arrangements have been made with the office manager. Parents completing the following forms for their children, please make sure that you provide us with the correct information that is needed to contact the legal guardian. We will not get in the middle of divorce legalities and any issues regarding balances and payments or past due balances.

Personal Information:

Patients Name: Last:_______________ First:_______________ MI:____

Gender: ☐ Male ☐ Female

SS#:_______________ D.O.B_______________ DL#:_______________

Address:_______________ Apt#:_______________

City:_______________ State:_______________ Zip:_______________

Please Check Contact Preference (Contact preference will allow physicians/staff to leave a detailed message.)

☐ Home Phone:_______________

☐ Cell Phone:_______________ ☐ Consent for text messages

☐ Email:_______________

Employed:

☐ Yes ☐ No ☐ Retired ☐ Full Time Student

Place of Employment:_______________

Martial Status:

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Spouse Name:_______________ D.O.B:_______________ SS#:_______________

Spouses Employer:_______________

Emergency Contact:

Name:_______________ Relationship:_______________ Phone Number:_______________

Race/Ethnicity:

☐Asian ☐American Indian/Alaskan Native ☐Black or African American

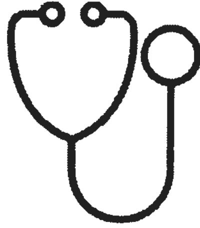
☐Caucasian/White ☐Hawaiian Native ☐Hispanic/Latino

☐Other ☐Do not wish to answer

Language:

Primary:_______________ Secondary:_______________

Signature:_______________ D.O.B:_______________ Date:_______________



Arlington Family Health Pavillion
Family Doctors

Arlington, Texas

Insurance Information:

Are you the primary insured? ☐ Yes ☐ No ☐ No Insurance *(Skip to page 3)*

If your answer was NO, please provide primary's information below:

Primary Insured's Name:______________________________ ☐ Male ☐ Female

Date of Birth:__________ SS#:______________ DL#:______________

Place of Employment:____________________ Relationship:______________

Insurance Company:______________________________________

ID#:________________________ Group#:______________________

If you have secondary insurance and you are not the primary insured please fill out the following:

Primary Insured's Name:______________________________ ☐ Male ☐ Female

Date of Birth:__________ SS#:______________ DL#:______________

Place of Employment:____________________ Relationship:______________

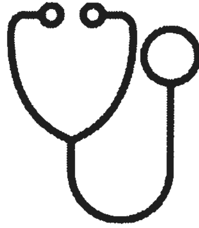
Insurance Company:______________________________________

ID#:________________________ Group#:______________________

The privacy rule requires Health Care Providers to take reasonable means to limit the use of disclosure of and request for personal health information (PHI). We will do all in our means to accomplish the intended purpose. These provisions do not apply to notes or disclosures made in pursuant to an authorized request by an individual. Health Care entities must keep record of PHI disclosures provided below. Uses and disclosures may be permitted without prior consent in case of an emergency.

I authorize the release of medical records or financial information necessary to process any claims. I authorize my insurance company if applicable to make payments to AFHP for medical treatment. I also agree that the filling out of any medical claim with insurance company is not guarantee of payment. If my claim is denied, I will be responsible for the balance. There is a filing deadline for every insurance company. Please be aware that if you do not bring a current insurance card within 60 days of your visit you will be responsible for the balance due.

Signature:________________________ D.O.B:______________ Date:______________



Arlington Family Health Pavillion

Family Doctors

Arlington, Texas

Authorization & Consent of Medical Information

HIPAA requires a list of all individuals to whom you are granting access to your medical information. This form will allow authorized individuals to receive information regarding appointments, test results, account status and any other information regarding treatment or services provided by our facility.

I allow the following individuals to have access to my medical records:

1.______________________________ 2.______________________________

3.______________________________ 4.______________________________

Would you like us to notify you if any outside source (i.e., life insurance, auto insurance, health insurance companies), is requesting information on your behalf without a signed consent? Please note that if you check "**NO**" we will not notify you **UNLESS** a signed authorization is not present.

□ Yes, please notify me.
□ No, do not notify me.

Signature:______________________________ D.O.B:____________________ Date:____________________

CONSENT TO TREATMENT OF A MINOR
(To be filled out by parent or guardian of a minor)

I hereby give my permission for Arlington Family Health Pavilion and its physicians, nurse practitioners, and other associates to examine and treat my child whose name is listed below:

Patient's Name ______________________________ Date of Birth______________

In addition, if I cannot be contacted, or I am unable to attend the appointment, I hereby give my permission to the following individuals or institutions to consent to medical treatment of the above-named child:

1. **Name of Individual**______________________________**Relationship**______________

Phone Number ______________________________

2. **Name of Individual**______________________________**Relationship**______________

Phone Number ______________________________

Parent or Guardian Printed Name ______________________________Relationship:______________

Parent or Guardian Signature ______________________________Date______________

Medication List

Patient Name:____

Date of Birth:____

Medication Name	Strength	Frequency (Directions)

Arlington Family Health Pavilion
707 N. Fielder Rd, Suite A
Arlington, TX 76012
Office: 817-277-2671
Fax: 817-460-3004

Authorization for Release/Disclose Protected Health Information

Patient Name: ______________________ D.O.B ____/____/____

Address: ______________________

City ______________________ State ________ Zip ____________

Home: ____________________ Cell: ____________________

Date Records Requested: ____/____/____

I, authorize Arlington Family Health Pavilion to request or send my medical records from the following doctor:

(Please check one) ☐ **Send to** ☐ **Request from**

Doctor's Name: ______________________

Address: ______________________ City ______________ State ______ Zip __________

Phone: ______________________ Fax: ______________________

Information Being Requested: Please describe the information that you would like to be released or obtained. (*Please include inclusive dates and/or specific type of records*)

____

____

____

Instructions: ******If more than 75 pages please send on disc. ******

Review Procedures:
Your request to inspect or copy your protected health information will be reviewed by our privacy official, who will determine if the information requested may be available to you. We may be legally prohibited from making certain information available to you or your representative, including:

- Psychotherapy notes
- Information related to legal proceedings
- Information that federal or state laws prevent us from disclosing
- Information related to medical research in which you have agreed to participate
- Information whose disclosure may result in harm or injury to you or to another person
- Information obtained under a promise of confidentiality

Attach this request to records when faxing back records.

Fax: 817-460-3004

Within the limitations of the law, we will make every effort to accommodate your request. We will:

- Complete our review of your request and either arrange for you to inspect your records within **30 days** of your request
- Provide you with a written explanation of any request that we review that decision if we deny your request, in whole or in part, you may request that we review that decision.

Patient Acknowledgment

- I understand that the records used and disclosed pursuant to this authorization may include information relating to: Genetic counseling, human immunodeficiency virus (HIV) or acquired Immunodeficiency Syndrome (AIDS) treatment, history of drug or alcohol abuse, mental, behavioral health or psychiatric care, and/or other sensitive information.

- I understand that I may revoke this authorization in writing at any time except to the extent that Arlington Family Research Center has relied on this authorization. The written revocation should be addressed to the Records Department, unless otherwise revokes, I understand that the date or event which this authorization expires 180 days from the date of signature. A photo copy of this authorization is considered as valid as the original.

- I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under the Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient, and therefore, may be subject to re-disclosure by the recipient.

- I understand that according to Chapter 159 of the Texas Occupational Code Section 159.005 and HIPAA, a re-disclosure could be made from records received from another health care provider involved in my care or treatment.

Patient Signature

____

Name of Patient (Print) Signature of Patient Date

____

Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form) Relationship of Representative