



909 9th Avenue, suite 400 Fort Worth, TX 76104

(P) (817) 725-7880 (F) (877) 953-2256

Patient Information

Patient Name: _____ DOB: _____
Last First M.I.

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phn: _____ Cell Phn: _____ Alt. Phn: _____

SSN: _____ Email: _____

Employer Name: _____ Work Phn: _____

_____ Check here if you have no insurance (Cash Account)

Insurance #1: _____ Insured DOB: _____

Insurance #2: _____ Insured DOB: _____

I, the undersigned, hereby authorize payment directly to Primary Care Associates of Texas for medical services rendered. I understand I am financially responsible for all charges not covered or authorized by my insurance company. I also understand that I am responsible for a fee of \$ 25.00 for not showing up for the scheduled appointment.

Printed Name: _____

Signature: _____ Date: _____

** Please be advised, you will be required to complete this form at your first office visit of each year. The information that you provide is updated yearly and ensures we have accurate information to file a claim on your behalf. Thank you for your assistance with this process.



Acknowledgement of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA,) patients have certain rights to privacy regarding their protected health information. Your protected health information will be used to:

- Conduct, plan, and direct treatment by the physicians employed by Premier Surgical Associates and will be shared in cooperation with healthcare providers who are involved in your care directly or indirectly.
- To obtain payment from third party payers.
- To conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, you agree that you have either received or waived your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Premier Surgical Associates has previously released relying on this consent.

Print Patient Name: _____

Do we have permission to:

- 1. Leave a message at your home regarding appointments and/or treatments?..... ☐ Yes ☐ No
- 2. Leave a message at your place of employment regarding appointments/treatments?..... ☐ Yes ☐ No
- 3. Leave a name and call back number at your home and place of employment?..... ☐ Yes ☐ No
- 4. Mail test results and appointment information to your home address currently on file? ☐ Yes ☐ No
- 5. Email at filed email address regarding appointments and treatments?..... ☐ Yes ☐ No
- 6. Discuss your personal information, including appointments and treatments with someone other than yourself? ☐ Yes ☐ No

Name	Relationship	Contact Number

Patient Signature: _____ **Date:** _____



Authorization to Release Healthcare Information

Autorizacion para Divulgar Informacion Sanitaria

Patient Name/Nombre del Paciente: _____

DOB/Fecha de Nacimiento: _____

SSN/Seguro Social: _____

Previous Name/Nombre Anterior: _____

I request and Authorize/Solicito y Autorizo: _____

(Name of Clinic/Practice/Physician) (Nombre de la Clínica / Práctica / Médico)

To release the medical records of the person named above to:

Para liberar los registros médicos de la persona nombrada arriba a

Name/Nombre: _____

Address/Direccion: _____

City/Ciudad: _____ State/Estado: _____ Zip Code/Código Postal: _____

This request and authorization applies to:

Esta solicitud y autorización se aplica a

____ All healthcare information/ Toda la información de la salud

____ Other/Otro: _____

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus,) sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment.(Entiendo que se requiere mi consentimiento expreso para liberar cualquier información sanitaria relativa a las pruebas, el diagnóstico y / o tratamiento para el VIH (virus del SIDA), enfermedades de transmisión sexual, trastornos psiquiátricos / de salud mental o de drogas y / o alcohol, usted está específicamente autorizadas para liberar toda la información sanitaria relacionada con dicho diagnóstico, pruebas o tratamiento.)

Signature/Firma: _____

Date/Fecha: _____

Relationship if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

Relación si está firmada por alguien que no sea el paciente (padre, tutor legal, representante personal, etc.)



Physician List

Patient Name: _____ DOB: _____

Physician/Specialist Address:

Phone & Fax Number:

Primary Care Physician

Primary Care Physician

Cardiologist

Cardiologist

Pulmonologist

Pulmonologist

Endocrinologist

Endocrinologist

Neurologist

Neurologist

Gastroenterologist

Gastroenterologist

Hematologist

Hematologist

Urologist

Urologist

Other

Other



Medication List

Patients Name: _____ DOB: _____

Pharmacy: _____ Phn: _____

Allergies: _____

[illegible]



Patient Medical History Questionnaire

Name: _____ DOB: _____

Dialysis Days and Times: _____

Please indicate if you have any of the following conditions below:

Cardiology:

- ☐ Hypertension
- ☐ Angina
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Atrial Fibrillation
- ☐ Irregular Heart Beat
- ☐ Heart Murmur
- ☐ Peripheral Vascular Disease
- ☐ Aortic Aneurysm

Pulmonary:

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Pneumonia
- ☐ Pulmonary Hypertension
- ☐ Clot in the lungs
- ☐ Sleep Apnea
- ☐ Lung Cancer

Endocrine:

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Thyroid Issues (high/low)
- ☐ Addison's Disease
- ☐ Cushing's Syndrome
- ☐ Pituitary Adenoma
- ☐ High Cholesterol
- ☐ Obesity

Gastrointestinal:

- ☐ Acid Reflux
- ☐ Ulcer Disease
- ☐ Gall Bladder Disease
- ☐ Vomiting Blood
- ☐ Blood in Stool
- ☐ GI Cancer
- ☐ Diverticulosis
- ☐ Polyps

Liver Disease/Pancreas:

- ☐ Hepatitis (type ____)
- ☐ Cirrhosis
- ☐ Liver Cancer
- ☐ Gallbladder Stones
- ☐ Pancreatitis
- ☐ Pancreatic Cancer

Genitourinary:

- ☐ Recurrent UTI
- ☐ Kidney Stones
- ☐ Chronic Kidney Disease
- ☐ Nephritis
- ☐ Prostate Problem
- ☐ Kidney Cancer
- ☐ Bladder Cancer

Hematology:

- ☐ Anemia
- ☐ Leukemia
- ☐ Bleeding Disorder
- ☐ Blood Clots (legs)
- ☐ Multiple Myeloma
- ☐ Varicose Veins
- ☐ HIV

Neurology:

- ☐ Neuropathy
- ☐ TIA
- ☐ Stroke
- ☐ Migraine
- ☐ Seizure
- ☐ Parkinson's Disease
- ☐ Alzheimer's/ Dementia

Arthritis &

Musculoskeletal:

- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Osteoporosis/Osteopenia
- ☐ Lupus (SLE)
- ☐ Scleroderma
- ☐ Sjogren's Syndrome
- ☐ Fibromyalgia



Patient Medical History Questionnaire

Name: _____ DOB: _____

Surgeries:

	Date/Year	Surgeon Name	Nature of Surgery
1.			
2.			
3.			
4.			
5.			

Hospitalizations:

	Date/Year	Hospital Name	Reason for Hospitalization
1.			
2.			
3.			
4.			
5.			

Procedures:

	Date/Year	Performed By	Result
Upper GI Endoscopy			
Colonoscopy			
Biopsy			
Cardiac Stress Test			
Pap Smear			
Mammogram			



Patient Medical History Questionnaire

Name: _____ DOB: _____

Family History:

Please make a check in the boxes that apply:

	Status: A=Alive D=Deceased	Diabetes	High BP	Heart Disease	Kidney Disease	Stroke	Cancer
Mother	A D						
Father	A D						
Paternal Grandfather	A D						
Paternal Grandmother	A D						
Maternal Grandfather	A D						
Maternal Grandmother	A D						
Brother(s)	A D						
Sister(s)	A D						
Sons(s)	A D						
Daughter(s)	A D						

Social History:

	Current Use	Frequency	If use, When?
Smoking			
Alcohol			
Illicit Drug Use			

Please CIRCLE your answer below:

Married: Y N Living With: Spouse Alone Other: _____

Flu Shot: Y N Date Received: _____

Pneumococcal Vaccine: Y N Date Received: _____