GRAPEVINE INTERNAL MEDICINE CENTRE

PATIENT INFORMATION

Welcome To Our Office

DATE_____

PATIENT'S NAME (PLEASE PRINT)	S.S.#	MARITAL STATUS					SEX		BIRTH DATE	AGE
		S	M	W	D	SEP	M	F		
STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY, STATE & ZIP								HOME PHONE	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)								CELL PHONE	
EMPLOYERS STREET ADDRESS	CITY, STATE & ZIP								WORK PHONE	
EMAIL ADDRESS	DRUG ALLERGIES IF ANY									
SPOUSE OR PARENT'S NAME	S.S.#								BIRTH DATE	
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)								HOME PHONE	
EMPLOYER'S STREET ADDRESS	CITY, STATE & ZIP								CELL PHONE	
SPOUSE'S STREET ADDRESS, IF DIFFERENT THAN ABOVE	CITY, STATE & ZIP								WORK PHONE	

GUARANTOR NAME	RELATION TO PATIENT	HOME PHONE
STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY, STATE & ZIP	CELL PHONE

EMERGENCY CONTACT	RELATIONSHIP	PHONE
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? INCLUDE NAME OF PHYSICIAN AND FAMILY MEMBER.		
REFERRED BY	STREET ADDRESS, CITY, STATE & ZIP	DAYTIME PHONE

PRIMARY INSURANCE			POLICY ID#
PATIENT RELATIONSHIP TO INSURED			
POLICY HOLDER NAME:			
DATE OF BIRTH	SEX	HOME PHONE	CELL PHONE

SECONDARY INSURANCE			POLICY ID#
PATIENT RELATIONSHIP TO INSURED			
POLICY HOLDER NAME:			
DATE OF BIRTH	SEX	HOME PHONE	CELL PHONE

GRAPEVINE INTERNAL MEDICINE CENTRE

FINANCIAL AGREEMENT

Patients WITH Health Insurance: Due to the many new options in Health Insurance plans it is patients' responsibility to call their insurance company to verify that we are in network with your plan before being seen in our office. Although we can accept most major insurance plans, there are now several new options under those plans that have restricted networks. If your insurance won't cover a visit due to changes in their plan coverage, it is patient responsibility to pay for services. Many health insurance plans require you to pay a copay and we are contractually required to collect this copayment at the time of service. The remaining balance of the charges for your services will be billed to your insurance plan. If you are unable to pay your copayment at the time of service, you may be asked to reschedule your appointment for a future time. If you have an existing balance, you are required to either pay this balance or make financial arrangements with us to pay the balance before you can be seen. Financial arrangements can be made by calling the Billing Specialist at (817) 481-8661. If your account is more than 120 days overdue, you may be referred to collections. If your account has been referred to collections, you must make payment arrangements before we can schedule an appointment.

MEDICARE PAYMENTS: (Patient's Certification, Authorization to Release Information, and Payment Request) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Patients who DO NOT have Health Insurance: For those who do not have health insurance, payment for services rendered is required at the time of service. If you are unable to pay at the time of service, please ask to speak to our Billing Specialist.

Office of Inspector General (OIG): If our office has a contract with your insurance carrier, we are required by law to collect all co-pays, deductibles and co-insurances. Our office will not waive your co-pay deductible and/or co-insurance as this will breach our contract with your insurance carrier. All co-pays, deductible and/or co-insurance and self-pay monies will be due at the time of visit and will be billed to you after receiving the explanation of benefits (EOB) from your insurance and is due immediately or at your next visit. Any remaining balance from previous visits will be due at your next visit or when you receive your statement, whichever comes first. Please be advised that our providers are NOT allowed to discuss your financial account. Please direct your questions to our billing department.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I also authorize Grapevine Medicine Centre the release of and to receive any information pertinent to my case to and from my insurance carrier. I understand that if my insurance company denies coverage and/or payment of services provided to me, I assume financial responsibility and will pay for all such charges in full.

_____ _____

Patient / Personal Representative Signature **Date**

_____

Printed Name / Relationship to Patient

GRAPEVINE INTERNAL MEDICINE CENTRE

Patient Name: _____ **Date of Birth:** _____/_____/_____

Informed Consent for Treatment

I the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Grapevine Internal Medicine Centre on an office visit/outpatient visit basis. This consent includes my consent for all medical services rendered under the general or specific instruction of a provider; including treatment by a mid-level provider, and other health care providers or the designees under the direction of a physician, as deeded reasonable and necessary.

Telehealth

- Telehealth allows physicians to use computers to connect with patients using secure video conferencing technology to provide safe, more efficient use of medical resources, improve healthcare coordination, minimize patient travel costs and keeps care local.
- I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
- All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

Privacy Notice Acknowledgement

- I have received a copy of the Notice of Privacy Practices as required under the Health Insurance Portability and Accountability Act (HIPAA).
- I acknowledge receipt of a written statement regarding my rights and responsibilities as a patient, which tells me how to register any complaint I might have.
- I understand that if I have questions or complaints, I may contact the Privacy Officer/Office Manager at 1-817-481-8661 or via email at Janr@gvimc.com.
- I understand that if I allow anyone to accompany me throughout my visit while I receive treatment and my personal health information is discussed, this will constitute an implied consent regarding the disclosure of my personal health information in the presence of the individual.

Accidental Exposure of Healthcare Worker

I understand and acknowledge that if any person is exposed to my blood or other bodily fluid, the facility may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

The undersigned certifies that she/he is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

_____ _____

Patient / Personal Representative Signature **Date**

_____

Printed Name / Relationship to Patient

Medical Information Release Form

(HIPAA Release Form)

Name:_____ **Date of Birth:** _____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed:_____ Date: _____/_____/_____

Witness:_____ Date: _____/_____/_____

Grapevine
INTERNAL MEDICINE CENTRE
1604 Lancaster Dr.
Grapevine, Texas 76051
817-481-8661 817-488-9792 (fax)

Name Date

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

Where were you getting your care before? _____

In the past **2 weeks**, have you been bothered by: Little interest or pleasure in doing things? ☐ **No** ☐ **Yes**
Feeling down, depressed or hopeless? ☐ **No** ☐ **Yes**

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
___ Unexplained weight loss / gain
___ Unexplained fatigue / weakness
___ Fall asleep during day when sitting
___ Fever, chills
___ **No problems**

Skin
___ New or change in mole
___ Rash / itching
___ **No problems**

Breast
___ Breast lump / pain / nipple discharge
___ **No problems**

Ears/Nose/Throat
___ Nosebleeds, trouble swallowing
___ Frequent sore throat, hoarseness
___ Hearing loss / ringing in ears
___ **No problems**

Eyes
___ Change in vision / eye pain / redness
___ **No problems**

Cardiovascular
___ Chest pain / discomfort
___ Palpitations (fast or irregular heartbeat)
___ **No problems**

Respiratory
___ Cough / wheeze
___ Loud snoring / altered breathing during sleep
___ Short of breath with exertion
___ **No problems**

Gastrointestinal
___ Heartburn / reflux / indigestion
___ Blood or change in bowel movement
___ Constipation
___ **No problems**

Genitourinary
___ Leaking urine
___ Blood in urine
___ Nighttime urination or increased frequency
___ Discharge, penis or vagina
___ Concern with sexual function
___ **No problems**

Musculoskeletal
___ Neck pain
___ Back pain
___ Muscle / joint pain _____
___ **No problems**

Endocrine
___ Heat or cold sensitivity
___ **No problems**

Hematologic/Lymphatic
___ Swollen glands
___ Easy bruising
___ **No problems**

Neurological
___ Headache
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness / tingling
___ Unsteady gait
___ Frequent falls
___ **No problems**

Allergic/Immune
___ Hay fever / allergies
___ Frequent infections
___ **No problems**

Psychiatric
___ Anxiety / stress / irritability
___ Sleep problem
___ Lack of concentration
___ **No problems**

Women only
___ Pre-menstrual symptoms (bloating cramps, irritability)
___ Problem with menstrual periods
___ Hot flashes / night sweats
___ **No problems**

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ☐

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot or illness _____ Pneumovax (pneumonia) _____

Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

☐ **TAKE NO MEDICATIONS**

Medication Dose (e.g. mg/pill) How many times per day?

_____

_____

_____

Allergies or intolerance to medications (include type of reaction): _____

_____ ☐ **NONE**

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)	Date _____	Abnormal?	☐ No	☐ Yes
Sigmoidoscopy or Colonoscopy (circle one)	Date _____	Polyp?	☐ No	☐ Yes
Women only:				
Mammogram	Date _____	Abnormal?	☐ No	☐ Yes
Pap Smear	Date _____	Abnormal?	☐ No	☐ Yes
Bone Density Test	Date _____	Abnormal?	☐ No	☐ Yes

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions? ☐ **NONE**

Condition	*Code*	*Current*	*Past*	*Comments*
Alcohol / Drug abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder / Kidney Problems				
Blood Clot (leg)	453.40			
Blood Clot (lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulosis	562.10			
Emphysema	492.8			
Fractures (broken bones)				Where?
Gallbladder Disease	574.20			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			
Glaucoma	365.9			

PERSONAL MEDICAL HISTORY Continued: Condition	Code	Current	Past	Comments
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Gynecological Conditions (Other)				
Heart Attack	410.90			
Hepatitis – Type A	070.1			
Hepatitis – Type B	070.30			
Hepatitis – Type C	070.51			
Hepatitis – Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease / Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive) / Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (list)				
Other (list)				

SURGICAL HISTORY – Please check off any procedure or surgeries. List any abnormal finding or complications. ☐ NONE

Surgical Procedure	Code	Yes	Year	Comments
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal

SURGICAL HISTORY Continued: *Surgical Procedure*	*Code*	*Yes*	*Year*	*Comments*
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation ("Tubal")				
Ovary Removal				Circle: Right Left Both
Vasectomy				
Sigmoidscopy				
Sinus Surgery				
Other (list)				

Adopted – Yes No (Please Circle) If yes and you do not know your family history skip this section and continue to page 5 (Other Health Issues)

FAMILY HISTORY – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

OTHER HEALTH ISSUES:

Tobacco Use
Smoke cigarettes: ☐ Never ☐ No ☐ Yes
(If you never smoked please go to alcohol use question now)

Quit date: _____ How many years did you smoke? _____

Approximately how many packs a day did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use
Do you drink alcohol? ☐ No ☐ Yes
# of drinks/week: _____ ☐ Beer ☐ Wine ☐ Liquor

Drug Use
Do you use marijuana or recreational drugs? ☐ No ☐ Yes
Have you ever used needles to inject drugs? ☐ No ☐ Yes

Sexual Activity
Sexually involved currently: ☐ No ☐ Yes
Sexual partner(s) is/are/have been: ☐ male ☐ female
Birth control method (circle below all that apply): ☐ None needed
Condom, pill, diaphragm, vasectomy, other _____

Exercise: Do you exercise regularly? ☐ Yes ☐ No
What kind of exercise? _____

_____

How long (minutes)? _____ How often? _____

Diet: How would you rate your diet? ☐ Good ☐ Fair ☐ Poor
Would you like advice on your diet? ☐ No ☐ Yes

Safety: Do you use a bike helmet? ☐ No bike ☐ Yes ☐ No
Do you use seatbelts consistently? ☐ Yes ☐ No
Does your home have a working smoke detector? ☐ Yes ☐ No

If you have guns in your home, are they locked up?
☐ Not applicable ☐ Yes ☐ No
Is violence at home a concern for you? ☐ No ☐ Yes

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?
(Circle above all that apply) ☐ Yes ☐ No

SOCIAL HISTORY:

Occupation (or prior occupation): _____ retired/unemployed/leave of absence/disabled (circle one)

Employer: _____ Years of education or highest degree: _____

Marital status (circle one): single, partner, married, divorced, widowed, other: _____

Spouse/partner's name: _____ Number of children: _____ Ages if under 18 years: _____

Number of grandchildren: _____ Number of great grandchildren: _____

Who lives at home with you? _____

Leisure activities, group involvement, religion, volunteer work, recent travel: _____

_____

_____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

Thank-you for taking the time to fill this out.

CURRENT MEDICATION LIST

PATIENT NAME:_____DOB:_____

DATE:_____

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11._____

12._____

13._____

14._____

15._____

PHARMACY INFORMATION

NAME:_____

PHONE#:_____

PLEASE LIST ALL MEDICATIONS WITH STRENGTH AND DOSAGE. THIS NEEDS TO BE UPDATED AT EVERY VISIT TO ENSURE EXCELLENT MEDICAL CARE, FACILITATE TIMELY REFILLS, PRIOR AUTHORIZATIONS, AND REFERRALS.

1604 Lancaster Drive
Grapevine, Texas 76051

Ph: 817-481-8661
Fax: 817-488-9792

GRAPEVINE INTERNAL MEDICINE CENTRE

Allergy History

Patient: _____ **DOB:** _____

Contact number: _____ **Date:** _____

Email: _____

Check Conditions Affecting Symptoms

1) During which months do symptoms occur?

☐ All Months

☐ January	☐ March	☐ May	☐ July	☐ September	☐ November
☐ February	☐ April	☐ June	☐ August	☐ October	☐ December

2) Are your symptoms worse?

☐ Morning	☐ Afternoon	☐ Evening	☐ Night
☐ At home	☐ At work/School	☐ Other location:_____	

3) Are symptoms?

☐ Constant ☐ Erratic ☐ Rare

4) Do symptoms interfere with your activities?

☐ Not at all ☐ A little ☐ Moderately ☐ All the time

5) Family History:

☐ Asthma	☐ Eczema	☐ Sinus problems	☐ Migraines
☐ Hay Fever	☐ Ulcer	☐ Nervous Disorder	☐ Colitis

☐ Other:_____

6) Please rate your symptoms 1 – 5 (#1 is low degree of symptom, #5 is high degree of symptom)

	CIRCLE THE NUMBER				
Eyes (itchy, watery or swelling)	1	2	3	4	5
Ears (itchy, draining or congested)	1	2	3	4	5
Nose (runny or congested)	1	2	3	4	5
Headaches (allergy related)	1	2	3	4	5
Cough (allergy related)	1	2	3	4	5
Sneezing	1	2	3	4	5

7) Are you currently being treated for allergies? Yes No

8) Are you interested in being allergy tested? Yes No

Signature : _____ **Date:** _____

Circle your provider: ***Dr. Trotter*** ***Dr. Page*** ***Dr. Ferris*** ***Dr. Gordon***