NEW PATIENT PAPERWORK

Today's Date _____ **Today's Visit Reason** _____

First Name _____ **Last Name** _____

Home Address _____

City _____ **State** _____ **Zip Code** _____

Cell # _____ **Email** _____

Date of Birth _____ **Marital Status** Divorced Married Single Widow

Sex Female Male **Occupation** _____

Referred By _____

Spouse's Name _____ **Spouse's Date of Birth** _____

Cell # _____ **Alternate #** _____

Emergency Contact Name _____

Emergency Contact Relationship _____ Cell# _____

Other Patient Information-Circle all that are applicable

Race Africa American Asian Asian Indian Native American Pacific Islander White Declined Other _____

Ethnicity Hispanic/Latino Non-Hispanic/Latino Declined Other _____

Patient's Preffered Language _____

Insurance Information

Primary Insurance Policy _____

Name of Insurance Holder _____ **DOB** _____

Group # _____ **Policy #** _____

Employer Name _____

Secondary Insurance Policy _____

Name of Insurance Holder _____ **DOB** _____

Group # _____ **Policy #** _____

GENERAL CONSENT FORM

Today's Date _____

Patient's Name _____ **Date of Birth** _____

Read every section on this form and initial after each statement that you understand and agree to the information.

Assignment of Benefits: I authorize Advanced Family Medical Care, ("AFMC") to submit claims on my behalf directly to my health insurance carrier. This means that AFMC will collect payment for all supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid by the insurance company. I authorize you to release any information necessary to my insurance company, regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient's Initials _____

Consent for Treatment: I consent for AFMC to administer and/or order treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives.

Patient's Initials _____

Electronic Prescription: I understand AFMC utilizes electronic prescribing and will not be giving me a paper prescription at any time. If my pharmacy does not offer electronic prescribing, I understand that AFMC will fax the prescriptions. I understand that Dr. Khan does not write prescriptions for controlled medications on a regular basis, however, if he does write one he will first check my prescription history with the Texas Prescription Monitoring Program, online. Dependent upon my history of controlled prescriptions, or information that is obtained via the pharmacy, AFMC reserves the right to cancel a controlled substance prescription.

Patient's Initials _____

Patient Portal: I understand AFMC utilizes electronic records that are accessible via the Patient Portal and the Healow app. I understand that all of my lab results will be available on the patient portal and will not be printed in the office except in extenuating circumstances. I understand that I can communicate with the staff, pay my bill, access my records, or request an appointment via my patient portal.

Email _____ **Patient's Initials** _____

Phone Calls: By providing contact information, I authorize AFMC, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home or cell phone; leave voice or text messages; and use pre-recorded/artificial/voice messages in connection with any communication to me.

Patient's Initials _____

GENERAL CONSENT FORM-CONTINUED

Today's Date _____

Patient's Name _____ **Date of Birth** _____

Involvement of Others in Care: I authorize AFMC and it's staff to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone Number

☐ I **DO NOT** wish to add any additional contact person to discuss my/the patient's needs.

How May We Contact You By Phone and Leave a Message About Your Care?

Main Phone # _____

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

Other Phone# _____

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

Patient Financial Policy

I acknowledge the receipt of the "Patient Financial Policy." **Patient's Initials** _____

Notice of Privacy Practices

I acknowledge the receipt of the "Notice of Privacy Practices."

Patient's Initials _____

Patient Photograph

I consent to have my/the patient's picture taken by the AFMC staff for identification purposes only. **Patient's Initials** _____

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative and Relationship if not the patient

MEDICAL HISTORY FORM

Today's Date _____

Patient's Name _____ **Date of Birth** _____

PHARMACY (List the pharmacy most frequently used for prescriptions. We will only have one pharmacy on file at a time and we will only send the pharmacy listed.)

Name: _____ Phone # _____

Address _____ City _____

MEDICAL HISTORY-Past or Present (Please list all conditions that you have had or currently have. You can attach an additional sheet if needed)

Condition	Date Diagnosed	Treatment	Date Resolved

List ALL other medical providers (Primary Care, Specialists, and others) you are currently seeing or have seen in the past. Format Name, Specialty, year seen. (i.e. Dr. Tom Johnson-Cardiologist-2020 etc):

_____

_____

ALLERGIES (include medication, foods, x-ray dyes)		**No Known Allergies** ☐
Name of allergen (i.e. Lisinopril)	Type of reaction (i.e. rash)	Date started

CURRENT MEDICATIONS (Attach an extra sheet if needed)				**None** ☐
Name of medication (i.e. Metformin)	Dose (i.e. 500 mgs)	How often taken (i.e. Twice a day)	Reason for taking/Current Diagnosis (i.e.	Name of Doctor prescribing

Advanced Family Medical Care

MEDICAL HISTORY FORM-CONTINUED

Today's Date _____

Patient's Name _____ **Date of Birth** _____

PREVIOUS HOSPITALIZATIONS (include all non surgical hospitalizations. Attach an extra sheet if needed) **None** ☐

Reasons for hospital stay	Date (approximate)	Hospital Name

SURGERIES (include all surgeries or procedures in your lifetime. Attach an extra sheet if needed) **None** ☐

Surgery or Procedure	Date (approximate)	Hospital or Surgeon Name

FAMILY HISTORY (List all family history. Attach an extra sheet if needed) **None** ☐

Relative	Significant Medical Problem	Age at Diagnosis	Current Age (or age when deceased)
Father			
Mother			
Children			
Brother			
Sister			
Grandfather	Maternal Paternal		
Grandmother	Maternal Paternal		
Aunts			
Uncles			

OB/GYN HISTORY # of Pregnancies _____ # of Deliveries _____ Last Menstrual Cycle _____

TOBACCO HISTORY

Are you an active cigarette smoker? Yes ☐ No ☐

Have you ever been a cigarette smoker? Yes ☐ No ☐

If yes, I smoked an average of: _____ packs a day for _____ years.

What year did you quit smoking. _____

Do you use other tobacco products? Yes ☐ No ☐

If yes, please specify what you use:

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? Yes ☐ No ☐

Do you currently drink alcohol regularly? Yes ☐ No ☐

If yes, approximately how many drinks per week (beer, wine, or liquor)

Have you ever used intravenous drugs? Yes ☐ No ☐

Have you ever used any drugs? Yes ☐ No ☐

If yes, what type of drugs have you used and when? _____

Advanced Family Medical Care

MEDICAL HISTORY FORM-CONTINUED

Today's Date _____

Patient's Name _____ **Date of Birth** _____

Please check the box next to all the conditions that apply currently or in the past.

Past	Present	Condition
General Health		
☐	☐	Change in appetite
☐	☐	Fatigue
☐	☐	Fever/Chills
☐	☐	Weight Gain
☐	☐	Weight Loss
Eyes		
☐	☐	Blurred Vision
☐	☐	Cataracts
☐	☐	Double Vision
☐	☐	Glaucoma
Head, Ears, Nose, Throat		
☐	☐	Hay Fever (pollen allergy)
☐	☐	Hearing Loss
☐	☐	Hoarseness
☐	☐	Lumps/Swelling in Neck
☐	☐	Sinusitis/sinus problems
☐	☐	Sore Throat
☐	☐	Trouble Swallowing
Cardiovascular (Heart)		
☐	☐	Chest Pain
☐	☐	Heart Murmur
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Irregular Heart Beat
Respiratory		
☐	☐	Asthma
☐	☐	Cough
☐	☐	Ephysema/COPD
☐	☐	Pneumonia
☐	☐	Shortness of Breath
☐	☐	TB
Skin, Hair, Lymph Nodes		
☐	☐	Acne
☐	☐	Bruising
☐	☐	Eczema
☐	☐	Hair Loss
☐	☐	Lymph Node Swelling
☐	☐	Rash
☐	☐	Skin Changes
☐	☐	Other

Past	Present	Condition
Gastrointestinal		
☐	☐	Abdominal Pain
☐	☐	Blood in Stool
☐	☐	Colon Polyps
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Diverticulitis
☐	☐	Heartburn
☐	☐	Hemorrhoids
☐	☐	Hepatitis
☐	☐	Hernia
☐	☐	Irritable Bowel Syndrome
☐	☐	Jaundice
☐	☐	Liver Disease
☐	☐	Nausea
☐	☐	Ulcers
☐	☐	Vomiting
Genital and Reproductive		
☐	☐	Genital Wart/HPV
☐	☐	Infertility
☐	☐	STDs
		Females Only
☐	☐	Irregular Bleeding
☐	☐	Painful Intercourse
☐	☐	Vaginal Discharge
		Males Only
☐	☐	Difficulty Achieving an Erection
☐	☐	Pain in Testicles
☐	☐	Prostate Enlargement (BPH)
Mental Health		
☐	☐	ADD/ADHD
☐	☐	Alcohol/Drug Problem
☐	☐	Anxiety/Panic Attacks
☐	☐	Depression
☐	☐	Eating Disorder
☐	☐	History of Physical/Mental Abuse
☐	☐	Insomnia
☐	☐	Mood Swings
☐	☐	Stress
☐	☐	Suicidal
☐	☐	Other

MEDICAL HISTORY FORM-CONTINUED

Today's Date _____

Patient's Name _____ **Date of Birth** _____

Please check the box next to all the conditions that apply currently or in the past.

Past	Present	Condition
Urinary		
☐	☐	Frequent Urination
☐	☐	Incontinence (loss of urine control)
☐	☐	Kidney Disease
☐	☐	Slow Urine Stream
☐	☐	Trouble Urinating
Musculoskeletal		
☐	☐	Back Pain
☐	☐	Joint Pain
☐	☐	Muscle Pain
☐	☐	Arthritis
☐	☐	Gout
☐	☐	Muscle Aches
Neuro		
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Headache
☐	☐	Memory Loss
☐	☐	Numbness
☐	☐	Seizures/Epilepsy
☐	☐	Stroke
☐	☐	Weakness
☐	☐	Other
Hem-One and Immunology		
☐	☐	AIDS/HIV
☐	☐	Anemia
☐	☐	Blood Clots
☐	☐	Cancer
☐	☐	Easy Bleeding
☐	☐	Easy Bruising
☐	☐	Sickle Cell Anemia
☐	☐	Transfusion
Breast		
☐	☐	Abnormal Mammogram
☐	☐	Breast Biopsies
☐	☐	Breast Lumps
Endocrine		
☐	☐	Diabetes
☐	☐	Thyroid Disorders

Tests/Immunization	Date
Eye Exam	
Pulmonary Function Test	
Echocardiogram/EKG	
Cardiac Stress Test	
Mammogram	
Bone Density Test/Dexa Scan	
Diabetic Foot Exam	
Colonoscopy/ColoGuard/FIT card	
PAP Smear/Well Woman's Exam	
Influenza/Flu Vaccine	
Pneumonia Vaccine(s)	
Tetanus Vaccine	
COVID-1	
COVID-2	
COVID Booster	
Last Physical	