Name: (Last, First, MI)	Age:	Sex: M F	Birth Date:
Street Address:	City:	Zip	SS#
Mailing Address:	City:	Zip:	
Home & Cell Phone:	Email Address:		
Employer:	Address:	Work Phone:	
Email Address:	Occupation:	Referred by:	

SPOUSE OR LEGAL GUARDIAN

Name: (Last, First, MI)	Legal Guardian: Yes No	Birth Date:	
Street Address:	City:	Zip:	
Home & Cell Phone:	Work Phone:	Email Address	SS#:
Employer:	Address:	Email Address:	

In Case of Emergency (Friend or Relative not listed above. ONE MUST BE LOCAL)

Name (1): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:
Name (2): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:

INSURANCE INFORMATION (A copy of ALL Insurance cards is required for filing purposes.)

Primary Insurance:		Name of Insuree & SS#:
Group #:	Insuree's DOB:	Insurance ID#
Secondary Insurance:		Name of Insured & SS#:
Group #:	Insuree's DOB:	Other Insurances (cont on back):
Medicare? Yes or No	Medicare #	SS#

Optional: **Decline** ☐

Married Status: ☐ Single ☐ Married ☐ Divorced **Language:** ☐English ☐Spanish Other_______________

Race: ☐White/ Hispanic ☐ African American ☐ Asian ☐Native American ☐ Other ___________

Ethnicity: ☐White American ☐ Hispanic/ Latino ☐African American ☐ Native American ☐Indian American ☐ Chinese American ☐Other ___________________

Assignment of Benefits

I authorize Midland Health/Premier Physicians to release any medical information that may be necessary to process medical/surgical claims for myself or my dependents. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health plans to issue payments on my behalf to Midland Health/Premier Physicians. I understand that I am responsible for amounts not covered by insurance, unless covered by contracted employer agreement. This order will remain in effect until revoked by me in writing.

____________________ ____

DATE SIGNATURE of PATIENT (or Parent/Legal Guardian if Patient is a minor)

MIDLAND **HEALTH**

PATIENT HISTORY FORM

Last Name: ______________________________ First Name: ______________________________ M.I. ______
Date of Birth: _______________________ Age: ____________

Height ________ Weight ________ Dominant hand ☐ Right ☐ Left ☐ Ambidextrous

MAIN PROBLEM / REASON FOR THIS APPOINTMENT: ____
____

Date of injury or date problem began ____

Was this an on the job injury? ☐ No ☐ Yes Employer notified? ☐ No ☐ Yes

Is the injury/problem due to an auto accident? ☐ No ☐ Yes At fault? ☐ No ☐ Yes
Insurance/attorney? ____
Have you had prior treatment for this injury? ☐ No ☐ Yes By whom? ____
If yes, please describe treatment ____

PHARMACY: ____ **Location:** _________________________________

Current Medications – please list prescribing doctor **Dose** **Times/Day**

Current Medications – please list prescribing doctor	Dose	Times/Day
____	_________________________	________________
____	_________________________	________________
____	_________________________	________________
____	_________________________	________________
____	_________________________	________________
____	_________________________	________________

Please list any Herbs, Vitamins, or any Supplements you take: ____
____

ALLERGIES:
☐ No Known Allergies Medications Allergies: ____
Food Allergies: ___________________________________ Environmental Allergies: ________________________________
Have you ever had an allergy to Latex? ☐ No ☐ Yes IV contrast ☐ No ☐ Yes Topical Iodine ☐ No ☐ Yes
Do you have an allergy to metal? ☐ No ☐ Yes If yes, what kind of metal? ______________________________________

SOCIAL HISTORY / PREVIOUS HEALTH CARE: Circle/mark those that apply

Marital status:	Education:	Living Arrangement:	Tobacco Products:	Diet/Exercise:
Single Married Divorced Separated Widowed	Grade School High School College Professional /Technical Other: _______________	Alone Spouse/Parents/Children # of children _________ Roommate Significant other Other: ______________	Dip/Chew ☐ No ☐ Yes How much? ________ Smoking ☐ No ☐ Yes How much? _________ Year quit? __________ Second-hand	Want to lose / gain weight Eats regular, daily meals Exercise Type ____________ ☐Rarely ☐ Never ☐ Daily ☐Weekly ☐Monthly Caffeine Coffee/Tea _____ cups/day Soft Drinks _____ oz./day

Employed (occupation ____) ☐ Work in home ☐ Student ☐ Retired
Chemical Exposures: ____

Last Name: ______________________________________ First Name: ____

SOCIAL HISTORY / PREVIOUS HEALTH CARE continued: Circle/mark those that apply

Is there any possibility of being pregnant? ☐ No ☐ Yes ☐ NA (If yes, please tell X-ray Tech prior to any x-rays)

Recreational drugs? ☐ No ☐ Yes, what? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Methamphetamine ☐ Other: _____________

Do you have a history of mental or psychological problems? ☐ No ☐ Yes, Describe: ____

Major stressors in last six months: ☐ No ☐ Yes Money Job Marriage Children Home Life Health Physical Abuse Mental Abuse

Immunizations Received: Hepatitis A Hepatitis B DTP Haemophilus Influenza B Pneumococci Polio MMR Varicella Meningococcal Influenza (flu shot) BCG Small Pox Gamma Globulin Other _______________

Approximate Date of: Last Tetanus Shot: ____________________ Last Antibiotic: __________________________________

Last Complete Physical: Date _____________________________ Findings: ____

List any out of town places you have visited or any contact with animals, including pets in the past six months: ___________

____

SURCIAL/HOSPITAL/ILLNESS HISTORY:

Have you ever had general anesthesia? ☐ Yes ☐ No Any problems? Describe ____________________________________

OPERATIONS	DATE	OTHER HOSPITALIZATIONS/ILLNESSES	DATE
Women only: Hysterectomy? N or Y Ovaries? N or Y			

PERSONAL AND FAMILY HISTORY (Check those that apply)

Mother: Living ☐ No ☐ Yes Current age, or age at time of death? ___________________

Father: Living ☐ No ☐ Yes Current age, or age at time of death? ____________________

SYSTEMS ILLNESS OR DISEASE (Check those that apply)	Self	Mother	Father	Grand-Parents	Sister/ Brother	Children
Aids / HIV						
Alcohol Abuse						
Allergies or Hay Fever						
Alzheimer's						
Anemia						
Arthritis: ☐ Degenerative ☐ Rheumatoid						
Back Pain: ☐ Neck ☐ Thoracic (middle) ☐ Lumbar (Lower)						
Black Outs						
Bleeding Disorder : ☐ Blood Clots (DVT) ☐ Hemophilia ☐ Phlebitis						
☐ History of Bruising Easily ☐ History of Bleeding Easily						
Bowel Problems: ☐ Constipation ☐ Diarrhea ☐ Bloody Stool						
Breathing Problems: ☐ Asthma ☐ Chronic Cough ☐ COPD						
☐ Emphysema ☐ Pneumonia ☐ Pulmonary Embolus (PE)						
☐ Shortness of Breath (SOB) ☐ Sleep Apnea						
Cancer: ☐ Bladder ☐ Bone ☐ Brain ☐ Breast ☐ Lung ☐ Prostate						
☐ Skin ☐ Other ____________________________						
Cardiovascular-Heart Problems: ☐ Angina ☐ Chest Pain						
Congestive Heart Failure (CHF)						
Heart Attack (MI)						
☐ Pace Maker ☐ Stents						
☐ Irregular Heart Beat ☐ Murmur						
Swelling in ☐ Legs ☐ Feet						
Chills						

Last Name: ____ First Name: ________________________________

ILLNESS OR DISEASE Continued... (Check those that apply)	**Self**	**Mother**	**Father**	**Grand-Parents**	**Sister/ Brother**	**Children**
Colds: ☐ Frequent ☐ Chronic						
Coughing: ☐ Frequent ☐ Chronic ☐ Bloody						
Depression						
Diabetes: ☐ Type I ☐ Type II						
Dizziness or Fainting Spells						
Epilepsy						
Ears: ☐ Chronic Infections ☐ Deaf ☐ Hard of Hearing						
Eyes: ☐ Blindness ☐ Blurred Vision ☐ Double Vision ☐ Glaucoma						
Fever/Temp: __________						
Gallbladder Problems						
Gout						
Fibromyalgia						
Hardening of the Arteries						
Head: ☐ Headaches ☐ Migraines						
Hepatitis Type ☐ A ☐ B ☐ C						
Hernia						
High Blood Pressure (HTN)						
Kidney/Urinary Problems: ☐ Frequent Bladder Infections						
☐ Kidney Disease (ESRD) ☐ Kidney Stones ☐ Problems Urinating						
Liver Disease: ☐Cirrhosis ☐ Jaundice						
Neuropathy:						
Weakness in: ☐Arms ☐Hands ☐Legs ☐Feet						
Numbness in: ☐Arms ☐Hands ☐Legs ☐Feet						
Tingling in : ☐Arms ☐Hands ☐Legs ☐Feet						
Loss of Sensation: ☐Arms ☐Hands ☐Legs ☐Feet						
Nose Bleeds						
Osteoporosis						
Rheumatic Fever						
Scarlet Fever						
Seizures						
Sexually Transmitted Disease: ☐ Chlamydia ☐ Gonorrhea ☐ Herpes						
☐ HIV ☐Syphilis						
Skin Problems						
Sleeping Problems						
Stomach: ☐ Ulcers ☐ Ulcerative Colitis ☐ Gastric Reflux (GERD)						
☐ Irritable Bowel Syndrome (IBS)						
Stroke						
Suicide or Attempted Suicide						
Swollen or Painful Joints						
Throat						
Thyroid Problems						
Tuberculosis						
Weight Loss, How much? _____________						
Weight Gain, How much? ____________						

Additional information that the provider should know: ____

____

____

Authorization Form For Release of Protected Health Information

We are required by law and regulations to protect the privacy of your medical information. Without this form signed by patient, or **an agent given medical power of attorney, your private health information and/or treatments will not be disclosed.**

By signing this form, I authorize you to use and disclose the protected health information described below.

The health information you may release subject to this authorization is as follows:

☐ Medical ☐ Financial ☐ Other: ___________________________

Release my protected health information to the following person(s)/entity:

Name: ____________________________Relation ___________________ Phone: ________________

Name: _________________________ Relation __________________ Phone: _______________

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Privacy Officer Midland Health/Premier Physicians 4214 Andrews Hwy, Ste.240 Midland, TX 79703

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. **The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.**

______________________________________ ___________________ ___________

Signature of Patient Date of Birth Date

______________________________________ ______________________________________

Signature of Personal Representative Relationship to patient (or other authority)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **Midland Health** to use and disclose health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Midland Health has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Consent to Treatment. I voluntarily consent to receive medical and health care services provided by Midland Health/Premier Physicians, employees and such associates, assistants, and other health care providers. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only.

I acknowledge that Midland Health/Premier Physicians may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.
Please mark if you agree to accept artificial messages by:

Phone Calls □ Yes □ No **Text Messages □ Yes□ No** **Emails □ Yes □ No**

How to contact our Privacy Officer: PREMIER PHYSICIANS/MIDLAND HEALTH 4214 Andrews Hwy, Ste 240 Midland, TX 79703 Attention: Privacy Officer Telephone:(432) 686-6600 Facsimile: (432) 682-2284

Acknowledgement and Consent

I have received the Notice of Privacy Practices for MIDLAND HEALTH/PREMIER PHYSICIANS. MIDLAND HEALTH/PREMIER is authorized to use and disclose health information about patient listed below for treatment, payment and healthcare operations purpose consistent with its Notice of Privacy Practice.

____ ____________________
Signature of patient Date
(or patient's personal representative)

____ ________________________
Name of Personal Representative Relationship to patient
(or other authority)