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NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION				
Last Name		First Name		MI
Social Security Number		Date of Birth		Gender
Occupation		Marital Status		
Mailing Address		City	State	Zip
Phone Number	E-Mail Address		Preferred Method of Contact ☐ Phone (call or text) ☐ E-Mail	
EMERGENCY CONTACT				
First & Last Name		Relationship	Phone Number	
PREFERRED PHARMACY				
Preferred Pharmacy		Phone Number		
ACCESS TO INFORMATION				
☐ I do NOT permit purePEDIATRICS to share my health information with any individuals aside from myself.				
First & Last Name		Relationship	Phone Number	
INSURANCE INFORMATION				
Primary Insurance Carrier		Insurance Address		
Subscriber Name		Group Number	Policy Number	
Secondary Insurance Carrier		Insurance Address		
Subscriber Name		Group Number	Policy Number	

I consent to treatment as necessary, including whichever medications, performance of tests, conduct of laboratory, or other studies that may be used by the attending doctor, nurse practitioner, nurse or qualified designate of purePEDIATRICS. I acknowledge and understand that I am ultimately responsible for all charges and services rendered.

Signature: ______________________________ Date: ______________

Patient Name: ____________________________

Date of Birth: ____________________________

MEDICAL HISTORY QUESTIONNAIRE

Current Medications

☐ No current medications

*Please include prescription and over the counter medications in addition to all vitamins and herbal supplements.

DRUG NAME	DOSAGE & INSTRUCTIONS	REASON

Allergies

☐ No known drug allergies

*Please include medication, food, and environmental allergies.

DRUG/ALLERGEN NAME	REACTION/COMMENTS

Patient Name: ______________________________

Date of Birth: ______________________________

MEDICAL HISTORY QUESTIONNAIRE

Past Medical History

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood transfusion
- ☐ Cancer
- ☐ COPD
- ☐ Clotting disorder
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Nerve/muscle disease
- ☐ Osteoporosis
- ☐ Peripheral artery disease
- ☐ Prostate problem
- ☐ Psychiatric illness
- ☐ Seizure disorder
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Sexually transmitted infection
- ☐ Substance abuse
- ☐ Tuberculosis
- ☐ Other: ____________________
- ☐ Other: ____________________

Surgical History

- ☐ Appendectomy
- ☐ Bladder surgery
- ☐ Brain surgery
- ☐ Breast surgery
- ☐ Cardiac surgery
- ☐ C-section
- ☐ Colon surgery
- ☐ Eye surgery
- ☐ Gallbladder surgery
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint surgery
- ☐ Lung surgery
- ☐ Prostate surgery
- ☐ Small intestine surgery
- ☐ Spine surgery
- ☐ Tonsillectomy
- ☐ Thyroid surgery
- ☐ Tubal ligation
- ☐ Vasectomy
- ☐ Vascular surgery
- ☐ Weight reduction surgery
- ☐ Other: ____________________
- ☐ Other: ____________________

Social History

Do you drink alcohol?

- ☐ No
- ☐ Yes, how many drinks per week? ______________________________

Do you use tobacco?

- ☐ No
- ☐ In the past, how many years ago did you quit? ______________________________
- ☐ Yes, what form? ____________________ How much? ____________________ For how long? ____________________

Do you, or have you ever used recreational drugs?

- ☐ No
- ☐ Yes, describe: ______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

MEDICAL HISTORY QUESTIONNAIRE

Family History

*Place an (X) in applicable space (include comments such as age diagnosed and type of cancer below)

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sibling	Sibling	Other
Autoimmune Condition									
Cancer									
Diabetes									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Liver Disease									
Thyroid Disease									
Other									

Comments: ____

Patient Name: ______________________________

Date of Birth: ______________________________

Notice of Privacy Practices

purePEDIATRICS may use and disclose health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. The Health Insurance and Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This document contains a condensed version of our policies. This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.
The following are the policies we have adopted, in brief:

1. Treatment: We are permitted to use and disclose your medical information to those involved in your treatment.
2. Payment: We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you.
3. Health care operations: We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.
4. Disclosures that can be made without your authorization: There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization. The following are situations where we may disclose your medical information without your authorization:
   - Public Health, Abuse or Neglect, and Health Oversight
   - Legal Proceedings and Law Enforcement
   - Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
   - Those instances required by law
5. Your rights under federal law: The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights. Those rights are as follows:
   - You may request that we restrict how your protected medical information is used. We, however, do not need to agree to this restriction.
   - You may request that we send your protected health information by alternative means or to an alternative location.
   - You may inspect and/or copy your health information within a designated record set; request must be in writing. There are limitations regarding the information you may inspect or copy. Texas law requires us to release this information within 15 days or your written request received by our office. We will inform you if access has been denied or limited. HIPAA permits us to charge a reasonable cost-based fee for such information.
   - You may request an amendment of your medical information, however, we are not required to do so.
   - You may request an accounting of certain disclosures that are for means other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative.
   - Appointment Reminders, Treatment Alternatives, and Other Benefits: we may contact you by telephone, mail, email to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Signature: ______________________________ Date: ______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

Telemedicine Consent

1. I understand that my health care provider may use telemedicine consultations.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit since I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
5. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
6. I understand that billing will occur from my practitioner and payment is due at the time services are rendered.
7. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions about telemedicine. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Signature: ____ Date: ______________________

Financial Responsibility

Charges for services provided by Family Nurse Practitioner for adult patients (not included in monthly membership fee).

1. Telemedicine visit: $50 for first 10 minutes, then $25 for every 5 minutes thereafter
2. Office visit: $100
3. House call (during office hours): $150
4. House call (after hours*/weekends): $225
5. OhMD encounter with prescription: $25

*Office hours are Monday to Friday 9:00am to 5:00pm – after hours includes all visits before 9:00am or after 5:00pm

Patients of purePEDIATRICS have the right of patient confidentiality on all medical information and test results. All information shall be held in confidence and shall not be disclosed to any person, except upon the expressed consent of the patient or by the guidelines of his/her medical insurance. All reports will only be given to patient unless otherwise noted below.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescription. I also authorize payment of medical benefits to the physician. I understand that purePEDIATRICS does not accept insurance, and I am responsible for payment at the time services are due.

Signature: ____ Date: ______________________