Privia Medical Group North Texas

PHYSICIAN: ______________________
BEING SEEN TODAY

LOCATION: ____________ DATE: ____________

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: ____________ Driver's License # ____________ State: ________

Name: ______________________ (LAST) (FIRST) ___ (MI) ___ (SEX) MM DD YY ___/___/___ (DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: ______________________ (MAILING ADDRESS) (APARTMENT) ________ (CITY) ___ (ST) ___ (ZIP) (____) ________ (HOME PHONE)

Alt/Cell Phone: (____)__________ Day Phone: (____)__________ Email: __________

Race__________ Language__________ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Name: or School ______________________

Employer's Address: ______________________ (MAILING ADDRESS) ________ (CITY) ___ (ST) ___ (ZIP)

Occupation: ______________________

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

______________________ (NAME) ________ (RELATIONSHIP) (____) ________ (EMERGENCY CONTACT #)

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other ________ (SPECIFY) Resp. Party SS #: ________

Name: ______________________ (LAST) (FIRST) ___ (MI) ___ (SEX) MM DD YY ___/___/___ (DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: ______________________ (MAILING ADDRESS) (APARTMENT) ________ (CITY) ___ (ST) ___ (ZIP) (____) ________ (HOME PHONE)

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Name: or School ______________________

Employer's Address: ______________________ (MAILING ADDRESS) ________ (CITY) ___ (ST) ___ (ZIP)

Occupation: ______________________ (____) ________ (WORK PHONE) (____) (EXT)

OTHER PATIENT INFORMATION

Spouse's Name: ______________________ Employer: ______________________

___/___/___ (DATE OF BIRTH) Spouse's Work Phone: (____) ________ (______) (EXT) Occupation: ________

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: ______________________ Address: ________ (STREET or P.O. BOX) (____) ________ (PHONE)

Co-Pay Amount: (if applicable) ________ ________ (CITY) ___ (ST) ___ (ZIP)

Primary Care Physician: ______________________

Policy Holder: ______________________ (LAST) (FIRST) ___ (MI) ___ (SEX) ___/___/___ (DATE OF BIRTH) ________ (SS #)

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other________ (SPECIFY)

Employer's Name: ______________________ ________ (INSUREDS ID) ________ (GROUP NAME AND/OR NUMBER)

Address: ______________________ (STREET) ________ (CITY) ___ (ST) ___ (ZIP)

THC99P02

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: ______________________ Address: ______________________ (____) ____________
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) ______________________ ______________________ ______ ______
CITY ST ZIP

Primary Care Physician: ______________________

Policy Holder: ______________________ ______ ______ ___/___/___ ____________
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other ______________________
(SPECIFY)

Employer's Name: ______________________ ______________________ ______________________
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: ______________________ ______________________ ______ ______
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: ______________________ Adj. ____________

Address: ______________________ City: ____________ State ________ Zip ________ Phone ____________

Claim #: ______________________ DOI ______________________

What Employer: ______________________

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident______________Have you reported this injury to your employer? ___Yes ___No When ____________

Describe accident briefly: ______________________

Do you have an attorney representing you? ___Yes ___No Who is the attorney? ______________________

REFERRAL INFORMATION

Who referred you? ______________________ Address: ______________________ Phone: ____________

Family Physician ______________________ Address: ______________________ Phone: ____________

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, Including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

______________________ ____________ ______________________ ____________
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

Patient Name: ______________________________ DOB: ____/____/____

PHARMACY INFORMATION

Preferred Pharmacy: ______________________________ Phone: ____________________

Address: ____

Do you use a mail order pharmacy? If yes, please indicate: ______________________

MEDICATION LIST

Medication Name	Dosage	Frequency

MEDICATION AND FOOD ALLERGIES

Food or Medication	Reaction(s)	Severity

PREVENTATIVE TESTING

Test	Date	Abnormal? Write Y or N
None		
Cardiac Stress Test		
Colonoscopy		
Cologuard		
DEXA Scan/Bone Density Test		
Echocardiogram		
Annual Physical Exam		
Pulmonary Function Test		
Mammogram		
PAP Smear		
Eye Exam		
EKG		
Bloodwork		

Have you had your FLU shot? Y / N If so, when ______/______/______, where? ____________________

Patient Name: ____ DOB: ____/____/_____

MEDICAL HISTORY

CONDITION	YEAR	CONDITION	YEAR
None		Liver Disease	
Allergies		Migraine Headaches	
Anemia		Myocardial Infarction (Heart Attack)	
Angina		Obesity	
Anxiety		Osteoarthritis	
Arthritis		Osteoporosis	
Asthma		Peptic Ulcer Disease	
Atrial Fibrillation		Pneumonia/TB	
Benign Prostatic Hypertrophy		Renal (Kidney) Disease	
Cancer- Type		Seizure Disorder	
Stroke/ TA		Stomach Ulcer	
Coronary Artery Disease/ CHF		Thyroid Disease	
COPD		Other:	
Crohn's Disease			
Dementia/Alzheimer's			
Depression			
Diabetes: Type 1 or Type 2			
Gallbladder Disease			
GERD (Reflux)			
Glaucoma/Cataracts			
Hepatitis C			
Hyperlipidemia (High Cholesterol)			
Hypertension (High Blood Pressure)			
Insomnia			
Irritable Bowel Disease			

SURGICAL HISTORY

Have you had any surgeries? Y / N If yes, please list surgery name and date of surgery below

Surgical Procedure	Date

PATIENT'S 65 YEARS OF AGE AND OLDER

Have you had your Pneumonia shot? Y / N If so, when ____/____/_____, where? ________________________

Have you had your Zostavax shot? Y / N If so, when ____/____/_____, where? ________________________

Have you fallen in the last 12 months? Y / N If so, when ___/___/___ How many times? __________

As a result, from the fall, were you hurt? Y / N If yes, what was your injury? ______________________________

Do you have any Advance Directive? Y / N Power of Attorney ☐ DNR ☐ Living Will ☐

Other: ________________________

Patient Name: ____ DOB: _____/_____/_____

FAMILY HISTORY

Diagnosis	Mother	Father	Brother	Sister	Other
Alive and Well					
Deceased- Age					
No pertinent info known					
Alcoholism					
Alzheimer's Disease					
Asthma					
Blood Disease					
CAD (Heart Attack)					
Cancer- Type:					
CVA (Stroke)					
Depression					
Developmental Delay					
Diabetes					
Hearing Deficiency					
Hyperlipidemia (High Cholesterol)					
Hypertension (High Blood Pressure)					
Irritable Bowel Syndrome					
Learning Disability					
Mental Illness					
Tuberculosis					
Obesity					
Osteoarthritis					
Osteoporosis					
PVD (Peripheral Vascular Disease)					
Renal Disease					
Other					

SOCIAL HISTORY (Circle that which applies)

Tobacco Use Have you ever used tobacco? NO/NEVER YES PAST CURRENTLY

Cigarettes ☐ ______ Packs per day Cigar ☐ Pipe ☐ Chewing Tobacco ☐

Alcohol Use Do you drink alcohol? NO/NEVER YES PAST CURRENTLY

Type of Alcohol: ____________________ How often: __________ Amount: _________ Last Drink: _________

Caffeine Use- Do you drink caffeine? NO/NEVER YES PAST CURRENTLY

Type of Caffeine: Soda Coffee Energy Drinks Caffeine per day: ___________

Exercise Activity- Do you exercise on a regular basis? NO/NEVER YES PAST CURRENTLY

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: ____________________
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ Work Telephone: ____________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: ____________________

I consent and authorize the release of NORMAL test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: ____________________
- ☐ My children: ____________________
- ☐ My parents: ____________________
- ☐ Other: ____________________

I consent and authorize the release of ABNORMAL test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: ____________________
- ☐ My children: ____________________
- ☐ My parents: ____________________
- ☐ Other: ____________________

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

☐ Yes ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

☐ Yes ☐ No

Do you have an advanced directive (Living Will)?

☐ Yes ☐ No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

☐ Yes ☐ No

____ ____________

Patient Signature (Must be an adult 18 yrs or older) Date

____ ____________

Print Name Birthdate

THC99P220
REVISED 09/2016

PRIVIA MEDICAL GROUP NORTH TEXAS

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. ______________________________, with Privia Medical Group North Texas unless revoked by me in writing.

Birth Date # ______________________________

______________________________ ______________________________

Date *Patient/Legal Representative*

THCOBP12

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

NAME: ______________________ DATE: __________ DOB: __________

Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle the answer that pertains to you.

	Never	Sometimes	Frequently	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself; or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself	0	1	2	3
Add columns:				
Total:				

10. If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____
Very difficult _____ Extremely difficult _____