PRIVIA MEDICAL GROUP | BLAIR Family Medicine, P.A.

Name: _____
First Middle Last

Mailing Address: _____
Street City Zip

Email Address: _____

Primary Phone: _____ **Secondary Phone:** _____

Date of Birth: _____ **Gender:** □ Male | □ Female | □ Other: _____ **SSN:** _____

Emergency Contact Name: _____ **Phone:** _____
Relationship: _____

Marital Status:
- □ Single
- □ Married
- □ Partner
- □ Divorced
- □ Separated
- □ Widowed

Race:
- □ American Indian or Alaska Native
- □ Asian
- □ Native Hawaiian
- □ Black or African American
- □ White
- □ Hispanic
- □ Other Pacific Islander
- □ Other: _____

Ethnicity:
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Language:
- □ English
- □ Spanish
- □ Other: _____

Pronouns:
- □ Traditional (He/Him, She/Her)
- □ Other: _____

Preferred Pharmacy: _____ **City:** _____

Previous Physician(s): _____

Referred By: _____

□ **I do not have insurance**
□ **I have insurance** _____ _____ _____
Insurance Company Group ID Number

Type of Insurnace: □ PPO | □ HMO | □ Other: _____

Responsible Party: _____ Relationship: _____

Insurance Authorization and Assignment:

I authorize Blair Family Medicine, P.A. to release to my insurance company and/or their agents any information necessary to determine benefits payable or related services. I authorize the payment of medical benefits to Blair Family Medicine, P.A. **I understand that I am ultimately responsible for all services whether covered by insurance or not.** I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

_____ _____
Signature Date

PRIVIA MEDICAL GROUP | BLAIR Family Medicine, P.A.

Name: _____

Main reason for today's visit: _____

List all current medications, *including any over-the-counter medications or supplements.*

☐ I do not take any medications.

Name of Medication	Dosage	Times per Day

COVID-19 Vaccination Status: *(tick all boxes that apply)*

☐ 1st Dose | ☐ 2nd Dose | ☐ 1st Booster | ☐ 2nd Booster | ☐ Other: _____ Dates:_____

Last tetanus shot: _____ Date **Last flu shot:** _____ Date **Last pneumonia shot:** _____ Date

List any drug or food allergies or medicines you cannot take.

☐ I have no known drug allergies.
☐ I am allergic to latex.

ROS, PMHx, RHx, SHx completed by patient and reviewed by physician _____ Provider Initials

PRIVIA MEDICAL GROUP | BLAIR Family Medicine, P.A.

Name: _____

Childhood Diseases
- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ _____

Ears, Nose, & Throat
- ☐ Ear Infections
- ☐ Hearing Loss
- ☐ Sinus Infections
- ☐ Sleep Apnea
- ☐ TMJ Dysfunction
- ☐ _____

Digestive
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Hepatitis - Type: A B C
- ☐ Irritable Bowel Syndrome
- ☐ Reflux
- ☐ Gallbladder Disease (stones)
- ☐ _____

Brain/Nervous System
- ☐ Alzheimer's/Dementia
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Headache
- ☐ Migraine
- ☐ _____

Allergies/Immune System
- ☐ AIDS/HIV
- ☐ Autoimmune Disorder
- ☐ Lupus
- ☐ _____

Cancer — **Year**
- ☐ Breast _____
- ☐ Colon _____
- ☐ Lung _____
- ☐ Prostate _____
- ☐ Skin _____
- ☐ _____

Heart
- ☐ Angina (chest pain)
- ☐ Heart Attack _____
- ☐ Hypertension _____
- ☐ Murmur _____
- ☐ Mitral Valve Prolapse _____
- ☐ High Cholesterol
- ☐ High Triglycerides

Bones/Joints
- ☐ Arthritis
  Joints afected? _____
  - ☐ Osteo ☐ Rheumatoid
- ☐ Osteoporosis
- ☐ _____

Mental/Emotional Health
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder (type 1 or 2)
- ☐ Depression
- ☐ Suicide Attempted
- ☐ _____

History of any other condition
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Congenital (Birth) Problems
- ☐ Congenital Malformation
- ☐ Down Syndrome
- ☐ Prematurity _____
- ☐ _____

Lungs
- ☐ Asthma (when diagnosed?)
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Tuberculosis
- ☐ _____

Skin
- ☐ Rosacea
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ _____

Glands/Hormones
- ☐ Diabetes
  - ☐ Type I ☐ Type II
  - ☐ Insulin Requiring?
  - ☐ Grave's Disease
  - ☐ Thyroid Disease
    - ☐ Hyper ☐ Hypo

  Please specify when diagnosed.
  _____

Women - date of your last:
- ☐ Pap Smear/Test: _____
- ☐ Mammogram: _____
- ☐ _____
- ☐ _____

Date of your last colononscopy OR other colon cancer screening (FOBT, FIT, Cologuard): _____

Indicate any major surgeries you have had.

Eyes	☐ Cataract	☐ LASIK		☐ Other
Ears	☐ Ear Tubes			☐ Other
Nose	☐ Rhinoplasty	☐ Septoplasty	☐ Sinus	☐ Other
Mouth/Neck	☐ Tonsil/Adenoid	☐ Thyroid		☐ Other
Heart	☐ Bypass	☐ Pacemaker	☐ Transplant	☐ Other
Lungs/Chest	☐ Esophagus	☐ Lungs		☐ Other
Digestive	☐ Hernia	☐ Gallbladder	☐ Appendectomy	☐ Other
Female/Male	☐ Prostatectomy	☐ C-Section	☐ Hysterectomy	☐ Other
Health	☐ Tubal Ligation	☐ Bladder	☐ Kidney	☐ Other
Other (please describe)				

ROS, FMHx, FHx, SHx completed by patient and reviewed by provider _____

Physician Initials

PRIVIA MEDICAL GROUP | BLAIR Family Medicine, P.A.

Name: _____

Have you ever had any problems with anesthesia? ☐ No ☐ Yes _____
(being put to sleep for surgery) Please describe

Have you ever had a serious injury? ☐ No ☐ Yes _____
Please describe

List any of your BLOOD RELATIVES who have a history of any of the following, and provide their relationship to

☐ **Family history unknown**	**Type**	**Paternal or Maternal & Relationship**
Problems/Complications with Anesthesia		
Heart Problems:		
Hypertension		
Heart Attack		
Stroke		
Lungs		
Bleeding/Clotting Problems		
Diabetes		
Cancer		
Seizures		
Other Major Health Problems		

Current Occupation: _____ ☐ Disabled ☐ Retired ☐ Student

Religion: _____

Tobacco Use: ☐ Never ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew ☐ Vape
Age when started? _____ Average use per day? _____ Age when stopped? _____

Marijuana Use: ☐ Never ☐ Yes ☐ No Method of Use:_____
Age when started? _____ Average use per day? _____ Age when stopped? _____

Alcohol Use: ☐ No ☐ Yes

Types and average number per week? Beer: ___ Wine: ___ Wine Coolers: ___ Mixed/Liquor: ___

Have you ever been dependent on or addicted to any drugs? ☐ No ☐ Yes (please discuss with provider)

ROS, FMHx, FHx, SHx completed by patient and reviewed by provider _____
Provider Initials

PRIVIA MEDICAL GROUP | BLAIR Family Medicine, P.A.

Name: _____

Please list the names of any other providers you see regularly or have seen within the past year.

Specialty	Name	City	Phone	Fax
Primary Care Doctor				
OB/Gyn				
Cardiology				
Neurology				
Orthopedic				
Gastroenterology				
Urology				
Dermatology				

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Annual Wellness Visit

What is an Annual Wellness Visit?

An Annual Wellness Visit is a preventive health check focused on your overall wellness. During this visit, we review your medical history, assess health risks, and create a personalized plan to help you stay healthy and prevent potential issues. As part of your care plan, you will automatically be scheduled for this important visit each year to support your long-term health.

Have you had an Annual Wellness Visit in the last 12 months?

☐ **Yes – If yes, when? _____**

☐ **No**

_____ _____

Name and Date Signature

PRIVIA MEDICAL GROUP | BLAIR Family Medicine, P.A.

CREDIT CARD ON FILE AGREEMENT

We kindly request our patients' guardian/guarantor for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays/co-insurance are still due at the time of service. At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any.

The information will be held securely until your insurance has paid their portion of the claim and notified us of any additional amount owed by the patient. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge. This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please do not hesitate to let us know.

We will NOT accept prepaid cards as a form of card on file.

By signing below, I authorize Blair Family Medicine, P.A. to keep my signature and my credit card information securely on-file in my account. I authorize Blair Family Medicine, P.A. to charge my credit card for any outstanding balances when due.

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Name on Card (Print): _____

Cardholder Relationship to Patient: _____

Credit Card Number: _____ Exp. Date: ___/____

Please fill out information below for any person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: ___/___/_____

Patient Full Name (Print): _____ DOB: ___/___/_____

Patient Full Name (Print): _____ DOB: ___/___/_____

Credit Card Holder's Signature: _____ Date: _____

Authorization for Release of Information

Patient Name: _____

Date of Birth: _____ SSN: _____

Please send the following private health information to my primary care physician:

☐ History & Physical ☐ All Radiology

☐ Most Recent Visit Note ☐ All Cardiovascular tests (EKGs, stress tests, cath reports, etc.)

☐ Most Recent Labs ☐ All Labs

☐ _____

Please release my protected health information FROM the following person(s)/entity:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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

Blair Family Medicine, P.A.
2203 W. Lampasas St. Ste. 101
Ennis, TX 75119

Phone: 972 875 7799
Fax: 972 878 3031

This private health information is being requested for the purpose of sharing with patient's primary care provider. The primary care provider listed will not receive financial or in-kind compensation in exchange for using or disclosing the health information described.

I understand that my medical information may include sensitive health information. Communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses if diagnosed, will be included in my medical record. I further understand that my medical information could indicate that I am undergoing treatment for psychological or psychiatric conditions or substance abuse.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. Initials: _____ Date: _____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand this authorization will expire on ___ / ___ / ___. I understand that I may revoke this authorization at any time by written notification, but if I do, it won't have any effect on any actions taken before the revocation is received. I understand that I may see and copy the information described on this form if I ask for it, and that I may request a copy of this form after I sign it.

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed.

_____ _____

Patient Signature (or parent, guardian, or legal representative) Date