PrimeCareMDs

Date: _____

Patient Name: _____ DOB : _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Insurance: _____

Pharmacy / Location: _____

Email: _____

Emergency Contact Name/ Phone Number/ Relationship to Patient:

_____

Prescription Retrieval History

I, _____, give Prime Care MDs permission to retrieve my prescription history at any time needed.

_____

Patient Signature / Date

_____

Relationship to Patient

Notice to all Patients of PrimeCare MDs

This office and its staff strive to provide our patients professional care in a timely manner.

Please understand that while we do accept walk in patients without appointments those patients will be seen after patients with appointments have been taken care of.

You may notice patients arriving after you and being called in prior to you, this is due to the fact we take patients by appointment time not by the order of signing in, and patients are roomed according to appointment and non-appointment in different rooms. WE do our best to stick to the schedule; however, an unexpected emergency may cause disruptions from time to time. Please understand your needs will be met as soon as possible.

To ensure a shorter wait time at our office, please call ahead to schedule an appointment.

If you are a patient on maintenance medications, please do not wait until you run out of your medication to schedule an appointment. Schedule your appointment a few days ahead of running out of the medication.

If you are in need of a referral to another physician due to insurance guidelines, please note you will need to see your primary care physician then allow at least 2 days after that visit for the referral to be completed. Do not go to the specialist and call us from there for a referral as you will not be able to get one and will then be responsible for that visit.

We look forward to taking care of your medical needs both today and in the future.

Thank you for entrusting us with your care!

PATIENT INTRODUCTION *PrimeCare MDs 2655 West Baker, Baytown, Tx.*

1. PATIENT INFORMATION (PLEASE PRINT) **DATE:_____**

Last Name:	First Name:	MI:
Date of Birth:	Sex: ☐ female ☐ male	Social Security Number:
Home Address:	City State	Zip
Home Phone:	Business Phone:	Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced
Employer:	Occupation:	
Whom May We Contact In Case Of Emergency/Relation & Phone No:		
Cell Phone Number:	Email:	

2. PERSON RESPONSIBLE FOR PAYMENT

Last Name:	First Name:	MI:
Social Security Number:	Date of Birth:	Drivers's License Number:
Home Address:	City State	Zip
Home Phone/Cell Phone:	Business Phone:	Relationship To Patient: ☐Spouse ☐Parent ☐Child ☐Employer
Employer:	Occupation:	

3. INSURANCE INFORMATION (please give receptionist copy of card[s])

Primary Insurance Company Name:	Insured's Name:	
INSURED'S RELATIONSHIP TO PATIENT:		
Address For Claims:		
Insured's Social Security Number:	Insured's Date of Birth:	Policy Number:
Group Number:	Deductible Amount $:	Copay Amount $:
Secondary Insurance Company Name:	Insured's Name:	
Address For Claims:		
Insured's Social Security Number:	Insured's Date of Birth:	Policy Number:
Group Number:	Deductible Amount $:	Copay Amount $:

IMPORTANT INSURANCE INFORMATION

To Our Valued Patient:

Providing quality medical care for our patients is our primary concern. In order to accommodate the needs and requests of our patients, PrimeCare MDs are enrolled in numerous insurance programs.

It is extremely difficult for our office to keep track of all the stipulations and requirements of each patient's individual plan. Each plan has its own stipulations and requirements regarding how often specific services may be provided, and more importantly, what part of services covered benefits, where those services may be performed, what part of the services covered are paid by the plan or the member (i.e. diagnostic testing, specialist referrals, prescriptions, immunizations, etc.) **Even within the same insurance plan the stipulations and requirements vary depending upon what type of contract your employer negotiates for your group.**

As we are very willing to provide care within insurance guidelines to the best of our abilities, we feel it is an important practice for you to familiarize yourself with your plan requirements and suggest that you bring the information to your visit (i.e. deductibles, co-pays, covered prescriptions, in-network diagnostic facilities and/ or hospital, etc.) by calling your benefits coordinator at your place of employment or your insurance carrier.

With your cooperation and assistance, together we will be able to concentrate on your medical needs.

Thank you in advance for your cooperation.

PrimeCare MDs

PATIENT INITIAL AND ACKNOWLEDGEMENT

_____

PrimeCareMDs

2655 West Baker Rd.

Baytown, Texas 77521

Tel: (281) 425-9205

Fax: (281) 422-9408

Authorization for release of medical information

Patient Name: _____DOB:_____

Address:_____

City:_____ State: _____ Zip: _____

Social Security:_____ Home Phone:_____

I hereby request Facility/Physician

_____

_____

To furnish a copy of the medical records of the above named patient

For the period of:

Month/Yr_____ to Month/Yr _____

TO: PrimeCare MDs

2655 West Baker Rd

Baytown, Texas 77521

I authorize the release of all information, including information regarding HIV testing, substance abuse and psychological disorders that may be included in my medical records. I hereby release your physician and employees from liability following this authorization and release. The release will expire at the end of the Ninety (90) days from signature.

Signature: _____ Date: _____

Patient or parent-guardian

PrimeCareMDs

2655 W. Baker Rd.,
Baytown, TX 77521

Acknowledgement of Receipt of Notice of Private Practices

I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Signed _____ Date _____

Relationship if not signed by patient _____

INTERNAL USE ONLY

If patient/ parents/ representatives refuse to sign acknowledgment please document date and time notice was presented to patient.

Presented on (date and time) _____

By (name and title) _____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable for the care of the patient named below including, but not restricted to drugs , medications, lab tests, or other studies, which may be used, by the physician or his/her qualified designate.

I accept full responsibility for the payment of such services and agree to pay my bill in full AT THE TIME OF SERVICES unless other arrangements are made. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. PrimeCare MDs will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay with in a reasonable period of time.

I authorize PrimeCare MDs to release information as required to my insurance (including my employer of my employer's worker's compensation carrier) for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/ or mental health issues. I also authorize PrimeCare MDs to bill my insurance and receive payment directly from them for services rendered.

This authorization shall remain valid for a period of two (2) years or until such as I revoke it in writing. A photocopy of a faxed copy of this authorization shall be deemed as valid as the original.

Patient: _____

Signed: _____

Relationship to Patient: _____

PRIME CARE MDs
ADULT HEALTH HISTORY AND PATIENT CHECK LIST

Patient Name _____

Patient Number _____

Date of Birth _____

Physician _____

ALLERGIES TO MEDICINES
(Describe allergy or reaction to any medicines)

Today's Date: _____ Main reason for today's visit: _____

Date(s) of last physical exam: _____

PAST MEDICAL HISTORY Check ☑ conditions you have or have had.

CONDITION	YES	YEAR	CONDITION	YES	YEAR	CONDITION	YES	YEAR
Alcoholism			Gall Bladder Disease			Malaria		
Anemia			Glaucoma			Measles		
Anorexia			Goiter			Migraine Headaches		
Appendicitis			Gonorrhea			Mumps		
Arthritis			Gout			Pneumonia		
Asthma			Heart Disease			Polio		
Bleeding Disorder			Heart Murmur			Prostate Problems		
Breast Lump			Hemorrhoids			Psychiatric Care		
Bronchitis			Hepatitis			Rheumatic Fever		
Bulimia			Hernia			Skin Disease		
Cancer Type:			Herpes			Stomach Ulcers		
Cataracts			High Blood Pressure			Stroke		
Chicken Pox			High Cholesterol			Syphilis		
Depression			HIV Positive			TB Skin Test (Positive)		
Diabetes			Kidney Disease			Tuberculosis		
Emphysema			Liver Disease/Jaundice			Thyroid Disease		
Epilepsy or Seizures			Low Back Pain					

ILLNESSES, INJURIES, & OPERATIONS
(Do not list those checked above.)

TYPE	YEAR	TYPE	YEAR

MEDICATIONS (includes over the counter), VITAMINS, HERBS/OTHER THERAPIES	Dose	Times per day

IMMUNIZATIONS (Check those received)

☑	VACCINE	YEAR

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

PATIENT NAME _____ OCCUPATION _____

FAMILY HISTORY (Fill in the health information about your family)

Relative	Age	Health Status	Age of Death	Illness
Mother				
Father				
Brothers				
Sisters				

Check ☑ if your blood relatives have had:

☑	Disease	Relation to you
	Ovarian Cancer	
	Bleeding Tendency	
	Breast Cancer	
	Colon Cancer	
	Depression	
	Diabetes	
	Heart Disease*	
	High Blood Pressure	
	Other:	

*Men < 55 years, Women <65 years

HEALTH HABITS (check ☑ which substances you use and describe how much you use.)

☑	SUBSTANCES	How much do you use?
	Caffeine	
	Alcohol	
	Cocaine, Heroin, Marijuana, etc.	

TOBACCO USE	Yes	No
Do you currently smoke or chew tobacco?		
Have you ever smoked or chewed tobacco?		
Pack(s) per day_____ for _____ years.		

EXERCISE AND DIET

Do you regularly exercise? ☐ Yes ☐ No

Type of exercise? _____

Do you follow a special diet? ☐ Yes ☐ No

Type of diet? _____

SEXUAL CONTACTS

Are you sexually active? ☐ Yes ☐ No

If yes, do you have sex with: ☐ Men ☐ Women ☐ Both

WOMEN'S HEALTH

Date of last period? _____

Date of last PAP Smear? _____

Date of last Mammogram? _____

Have you ever been pregnant? ☐ Yes ☐ No

If yes, did you have diabetes during your pregnancy? ☐ Yes ☐ No

Number of Pregnancies: _____

Number of Births: _____

LIST SYMPTOMS YOU ARE HAVING:

Do you have a Living Will or Durable Power of Attorney for Healthcare? ☐ Yes ☐ No
If Yes, attach copy.

Patient Signature _____ Date _____ Physician Signature _____

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

PrimeCareMDs

Release of Medical Information Authorization

Patient Name _____

(Please Print)

Date of Birth_____

The above named patient authorization PrimeCare MDs and its employees to discuss my medical information (test results, care and treatment, prescriptions and any other information necessary for my well being_ with the person(s) named below.

Name Relationship to Patient

1. _____
2. _____
3. _____
4. _____

I understand that results will not be given to any person(s) (with the exception of medical personnel) than those named above. I understand that PrimeCare MDs will not leave my test results on any recording device. If I cannot be reached, a letter will be sent to my home with instructions. It is my sole responsibility to update any changes in address or insurance information.

Signature: _____

Date: _____

Witness: _____

Texas Statutory Advance Medical Directive

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Instructions for completing this document:

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

DIRECTIVE

I, _____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

_____
_____
_____

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values:

1._____

2._____

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas. If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed_____ Date_____ City, County, State of Residence _____

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness 1 may not be a person designated to make a treatment decision for

the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 _____ Witness 2 _____

Definitions:

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:
(1) that may be treated, but is never cured or eliminated;
(2) that leaves a person unable to care for or make decisions for the person's own self; and
(3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

PrimeCareMDs

2655 W. Baker Rd
Baytown, TX 77521
Office: 281-425-9205
Fax: 281-422-9408

Right to Choose Disclosure Agreement

PrimeCare MD's or any provider rendering services under PrimeCareMD's have no financial or non-financial associating with any outside facility where you may be referred for further testing.

Patients have the right to choose the testing facility of their choice. Our referral is based upon quality of the testing facility, your insurance type and appointment availability. Please verify your insurance coverage prior to the test day. PrimeCareMD's will not be responsible for any out-of-network charges that you may incur.

Patient Signature: _____

DOB:_____/_____/_____

Date: _____/_____/_____