

# NEW PATIENTS - PLEASE COMPLETE BEFORE YOU SEE MEDICAL PROVIDER

## GETTING YOU TO GOAL HISTORY FORM

Please help us get this information into your file. By answering the following questions, you will allow us to insure you receive the best possible care from TienaHealth, where we strive to:  
*"Add Years to Your Life and Life to Your Years by Empowering You to Take Control of Your Health!"*

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Marital Status:     Married     Single     Divorced     Widowed

How have you been feeling:     Well     Fatigued     Illness  
 What changes would you like to make in the next year?(mark all that apply)  
 Better food choices     More regular exercise     Better management of medical issues  
 Caught up on labs and immunizations     None    Drug Allergies: \_\_\_\_\_  
 How would you rank your Quality of Life at this time?  
 Excellent     Good     Fair     Poor  
 What is your greatest health concern? \_\_\_\_\_

Current Prescription Medications:     None

Name of Drug	Dose/mg/mcg)	#tablets/day	# times per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Past Medical, Family and Social History

List any personal past illness and/or surgeries. Date they occurred.	Date (Year)	List all serious illnesses in your immediate family (parents, siblings, children)	Family Relationship
Heart Disease    Y   N		Heart Disease    Y   N	
High Blood Pressure    Y   N		High Blood Pressure    Y   N	
High Cholesterol    Y   N		High Cholesterol    Y   N	
Diabetes    Y   N		Diabetes    Y   N	
Metabolic Syndrome    Y   N		Metabolic Syndrome    Y   N	
Obesity    Y   N		Obesity    Y   N	
Osteoporosis    Y   N		Osteoporosis    Y   N	
Pneumonia    Y   N		Pneumonia    Y   N	
Breast Cancer    Y   N		Breast Cancer    Y   N	
Prostate Cancer    Y   N		Prostate Cancer    Y   N	

Do you have:    Advanced Directive or Living Will    Yes/No    Tattoos:    Yes/No  
 Do you use Tobacco in any form?    Yes/No    If Yes, how much? \_\_\_\_\_  
 Do you drink Alcohol?    Yes/No    If Yes, how much? \_\_\_\_\_  
 Do you exercise regularly?    Yes/No    If Yes, how much? \_\_\_\_\_  
 Are you on a special diet?    Yes/No    If yes, how much? \_\_\_\_\_  
 Do you watch TV?    Yes/No    If yes, number of hrs/week \_\_\_\_\_

Last mammogram (year) \_\_\_\_\_ Last Pap Smear (year) \_\_\_\_\_ Last Bone Density(year) \_\_\_\_\_  
 Last Prostate Exam(year) \_\_\_\_\_ Last Colonoscopy(year) \_\_\_\_\_  
 Most Recent Immunization (year): Flu \_\_\_\_\_ Pneumonia \_\_\_\_\_ Tetanus \_\_\_\_\_  
 TB Test \_\_\_\_\_ (Positive/Negative) Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_

# ALL PATIENTS PLEASE COMPLETE THIS BEFORE YOU SEE DOCTOR

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE: \_\_\_\_\_

## REVIEW OF SYSTEMS

You may be seeing us today for a minor complaint, but it is important that we are aware of any other symptoms that you have. It may not be feasible due to time constraints for us to address a long list of symptoms today, but we can make a follow-up appointment before you leave to further address the other symptoms you are experiencing. Please help us get this key information into your life. By answering the following questions, you will allow us to insure you receive the best possible care from TienaHealth where we strive to:

**"Add Years to Your Life and Life to Your Years by Empowering You to Take Control of Your Health"**

Do you currently have any of the problems listed below? Please circle all that apply:

<b>Constitutional Symptoms:</b> Anorexia (loss of appetite) Fatigue Fever Chills Night Sweats Weight Gain of 10 lbs or more Weight loss of 10 lbs or more Other: _____	<b>Skin:</b> Dryness/Excessive Sweating Change in skin spot or mole New skin lesions Hair loss Nail changes Rash or skin color changes Easy bruising Other: _____	<b>Ear/Nose/Throat/Mouth:</b> Deafness/Decreased hearing Earache/Ear discharge Tinnitus (Ringing in the ears) Nosebleeds Frequent runny nose Sinus infections or pain Sore throat Other: _____
<b>HEENT:</b> Color blindness Double vision Excessive tearing Eye pain/redness Visual disturbances Visual loss Hoarseness/voice changes Oral ulcers Wears glasses/contacts Other: _____	<b>Respiratory and Heart:</b> Chronic cough Decreased exercise tolerance Shortness of breath Sputum production/color Wheezing Chest pain Rapid heart rate Palpitations or extra heart beats High blood pressure Other: _____	<b>Neurological:</b> Dizziness Headaches Seizures Decreased memory Weakness Numbness Difficulty speaking clearly Other: _____  Date of last eye exam: _____
<b>Neck and Breasts:</b> Neck mass Neck pain Neck stiffness Swollen neck glands Breast enlargement Nipple changes Nipple discharge Other: _____	<b>Gastrointestinal:</b> Abdominal pain Change in bowel habits Nausea/vomiting Diarrhea/constipation Esophageal reflux or burning Excessive gas/bloating Rectal bleeding Other: _____	<b>Musculoskeletal:</b> Decreased range of motion of joint Joint pain/joint swelling Joint redness Muscle atrophy Muscle cramps Muscle weakness Muscle pain Other: _____
<b>Women Only:</b> Pelvic pain Painful intercourse Vaginal bleeding, discharge or odor Vaginal itching or burning Vaginal dryness  <b>Menstrual Symptoms:</b> Menstrual irregularities Painful menses Irritability/Mood swings Excessive bleeding Age at first menses: _____ Number of Pregnancies: _____	<b>Urinary System:</b> Change in urine system burning with urination Flank pain(back pain around kidneys) Urinary frequency Urinary incontinence  <b>Additional Questions:</b> Loss of sex drive Erectile dysfunction Night time urination: # of times per night: _____ Other: _____	<b>Psychiatric:</b> Change in sleep pattern Excessive daytime sleepiness Insomnia Hypersomnia (sleeping too much) Interrupted sleep Early Awakening Anxiety/Panic attacks Depression Frequent crying Inability to concentrate Family or academic conflicts Suicidal thoughts or planning Other: _____

* Last Name: _____	*First Name: _____	Middle Initial _____
* Social Security #: _____	*DOB _____	*MRN: _____
* Race: _____	*Marital Status: _____	* Language: _____
* Address _____	* Zip Code: _____	
* Email Address _____		

Place of Service \_\_\_\_\_

**Patient Privacy Directive**

*In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.*

- Please provide us with the phone number(s) that we or an automated service may leave messages regarding appointments:

\_\_\_\_\_

\_\_\_\_\_

- Please provide us with the phone number(s) that we or an automated service may leave messages regarding treatments and/or test results:

\_\_\_\_\_

\_\_\_\_\_

- Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointments:

\_\_\_\_\_

\_\_\_\_\_

- Please provide us with the name(s) and phone number(s) that we may talk to regarding your treatments and/or test results:

\_\_\_\_\_

\_\_\_\_\_

- Please provide us with the name(s) and phone number(s) that we may talk to regarding your billing:

\_\_\_\_\_

\_\_\_\_\_

- Please provide an email address that his office may communicate health information to you with:

\_\_\_\_\_

- Please provide a cell phone number that we may text health information to:

\_\_\_\_\_

- Please provide us with the name and number of your emergency contact:

\_\_\_\_\_

You must inform us **in writing** of any changes in your directives.

**I acknowledge that everything above is accurate.**

Signature

Printed Name

Date

**I acknowledge I have seen or been offered a copy of the "Notice of Privacy Practices"**

Signature

Printed Name

Date

Relationship if Patient Representative

Physician Office Representative

TEXAS HEALTH PHYSICIANS GROUP  
PATIENT REGISTRATION FORM  
DISCLOSURES & CONSENTS

Patient Name: _____	Date of Birth: _____
Last Name	First Name

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize direct payment of my insurance benefits to Texas Health Physicians Group or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Health Physicians Group is unable to collect from my insurance carrier for whatever reason.

**MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:**

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to Texas Health Physicians Group or the physician on my behalf.

**AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:**

I certify that I have read and been offered a copy of the Texas Health Physicians Group. "HIPAA Notice of Privacy Practices". I hereby authorize Texas Health Physicians Group. or the physician individually to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

**AUTHORIZATION TO MAIL, CALL OR E-MAIL:**

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Texas Health Physicians Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Texas Health Physicians Group to that effect in writing.

**LAB/X-RAY/DIAGNOSTIC SERVICES:**

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

**CONSENT TO TREATMENT:**

I hereby consent to evaluation, testing, and treatment as directed by my Texas Health Physicians Group physician or those under his/her supervision.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARANTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(if different from patient)

GUARANTOR NAME (Please Print): \_\_\_\_\_

**GUARANTOR INFORMATION:** (List person or insured name responsible for bill – use full legal name, no nicknames)

Relationship of Guarantor to Patient:            Self\_\_\_\_ Spouse\_\_\_\_ Parent\_\_\_\_ Other\_\_\_\_

Last Name, First: \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address: \_\_\_\_\_ Zip Code \_\_\_\_\_

\* Employer Name: \_\_\_\_\_

**INSURANCE INFORMATION:** (Please allow receptionist to photocopy your insurance ID cards)

*IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS*

**PRIMARY INSURANCE**

Plan Name: \_\_\_\_\_ \* Insured's Name: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ \* Insured's Date of Birth: \_\_\_\_\_

\* Policy / ID #: \_\_\_\_\_ \* Group #: \_\_\_\_\_ \* Eff Date: \_\_\_\_\_

Claims Address & Phone: \_\_\_\_\_

**SECONDARY INSURANCE**

Plan Name: \_\_\_\_\_ \* Insured's Name: \_\_\_\_\_

\* Insured's Social Security #: \_\_\_\_\_ \* Insured's Date of Birth: \_\_\_\_\_

\* Policy / ID #: \_\_\_\_\_ \* Group #: \_\_\_\_\_ \* Eff Date: \_\_\_\_\_

Claims Address & Phone: \_\_\_\_\_

**\* REQUIRED FILEDS – PLEASE COMPLETE FOR BILLING \***

**\* ATTACH COPY OF INSURANCE CARDS \***



## DISCLOSURE REGARDING ANCILLARY SERVICES/RESEARCH PROGRAMS

### Ancillary Services

Your physician may refer you to one or more "Ancillary Services" in connection with your medical care. An "Ancillary Service" is a service relating to your medical care or treatment. The following types of services are Ancillary Services:

Magnetic Resonance Imaging (MRI)	Bone Density Imaging
Mammography	Nuclear Imaging
Ultrasound	Laboratory
Computer Tomography (CT)	Durable Medical Equipment (DME)
Positron Emission Tomography (PET)	Echo Cardiograph
X-Ray	Sleep Therapy
Infusion Therapy	Audiology

**Your physician may have an economic interest in or a business relationship with the company or person who provides the Ancillary Services. You are not obligated to use the provider that your physician refers you to. You are free to use any provider you choose.**

### Research Programs

Your physician may ask if you would like to participate in a clinical trial or other research program. These programs may be sponsored by a drug company or may be part of a governmental research program. **Your physician may be compensated for services rendered in connection with these programs. You are not obligated to participate in any research program and your permission will be obtained prior to your participating in a program your physician believes may be appropriate for you.**

Please feel free to ask your physician if you have any questions about a particular Ancillary Service or Research Program.

Printed Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_