Pt Acct #_____ **DeKalb Physicians Clinic** Allergies: _____

Preferred Pharmacy_____ City_____ TX_____

Email:_____ Mobile # for text reminders _____

LAST NAME:_____FIRST NAME:_____ MI_____

MR___MRS___MISS___MS___ MALE___ FEMALE___ SINGLE___MARRIED___DIVORCED___SEP___WIDOW___

DOB:____/____/____ AGE:_____ PATIENTS SS#_____-_____-_____

HOME PH (____) _____-_____ MOBILE PH (____) _____-_____ WORK PH (____) _____-_____

HOME ADDRESS: _____ CITY_____ TX___ZIP_____

EMPLOYER:_____ OCCUPATION:_____

RETIREMENT DATE:_____ DISABILITY DATE:_____ DL# _____

IN CASE OF EMERGENCY, PLEASE LIST TWO CONTACTS WE MAY NOTIFY:

NAME:_____ RELATIONSHIP:_____ PHONE:_____

NAME:_____ RELATIONSHIP:_____ PHONE:_____

(if patient is a minor) PATIENT/GUARDIAN NAME:_____ SS#_____DL#_____

We file your insurance as a courtesy to you. If, for any reason, your claims are denied YOU will be responsible for all charges incurred. It also is your responsibility to notify us of any change of insurance. ALL DEDUCTIBLES/COPAYS ARE DUE AT THE TIME OF SERVICE, NO EXCEPTIONS!

PRIMARY INS:_____ ID#_____GR#_____

Address:_____ City: _____ST: _____Zip :_____

Name of policy holder:_____ Policy holder DOB:_____

Relation to patient:_____ Policy holder SS#: _____

SECONDARY INS: _____ID#_____GR#_____

Address: _____ City: _____ ST:_____Zip:_____

Name of policy holder:_____ Policy holder DOB:_____

Relation to patient:_____ Policy holder SS#: _____

I attest that the information provided above is true and accurate to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I will be financially responsible for any remaining balances after my insurance has paid. I also authorize DeKalb Physicians Clinic or my insurance company to release any information required to process my claims.

SIGNATURE REQUIRED: X_____DATE:____/____/____

My signature indicates that I have been offered information about how medical information is used and disclosed in the office. This includes the Notice of Privacy Pamphlet.

X_____ _____

Patient/Guardian Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION

We cannot discuss the patients' medical information with anyone other than the patient (or parent if patient is a minor)

This includes medical history, lab results, medications prescribed, etc. *In order for anyone else to have access to this information, you must designate them by completing the following information and signing the release.*

I,_____ grant the following named persons the authority to discuss or obtain any or all information contained in my medical record at Dekalb Physicians Clinic. No one other than the following persons may have access to my information except for my insurance company if it is necessary in the processing of my claims.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

X_____ _____

Patient/Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Compliance/Privacy Officer: Dekalb Physicians Clinic 216 N. Centre Street DeKalb, TX 75559 Ph (903)667-2273 Fax (903)667-7597

I hereby acknowledge that I received/read a copy of Dekalb Physicians Clinics' Notice of Privacy Practices.

I would like to receive a copy of any amended Notice of Privacy Practices. Yes:_____ No:_____(check one)

X_____ _____

Patient/Guardian Signature Date

X_____ _____

Printed Name of Patient/Guardian Phone Number

DEKALB PHYSICIAN CLINIC
HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthday_____ Primary Care Physician_____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- o Chills
- o Depression
- o Dizziness
- o Fainting
- o Fever
- o Forgetfulness
- o Headaches
- o Loss of sleep
- o Loss of weight
- o Nervousness
- o Numbness
- o Sweats

GENITO*URINARY

- o Blood in urine
- o Frequent urination
- o Painful urination

GASTROINTESTINAL

- o Appetite poor
- o Bloating
- o Bowel changes
- o Constipation
- o Diarrhea
- o Excessive hunger
- o Excessive thirst
- o Gas
- o Hemorrhoids
- o Indigestion
- o Nausea
- o Rectal bleeding
- o Stomach pain
- o Vomiting
- o Vomiting blood

MUSCLE/JOINT/BONE

- o Arms
- o Back
- o Feet
- o Hands
- o Hips
- o Legs
- o Cramping when walking
- o Neck
- o Shoulders

CARDIOVASCULAR

- o Chest pain
- o High blood pressure
- o Irregular heartbeat
- o Low blood pressure
- o Poor circulation
- o rapid heartbeat
- o swelling of ankles
- o varicose veins

SKIN

- o Bruise easily
- o Hives
- o Itching
- o Change in moles
- o Rash
- o Scars
- o Sore throat won't heal

EYE, EAR, NOSE, THROAT

- o Bleeding gums
- o Blurred vision
- o Crossed eyes
- o Difficulty swallowing
- o Double vision
- o Earache
- o Ear discharge
- o Hay fever
- o Hoarseness
- o Loss of hearing
- o Nosebleeds
- o Persistent cough
- o Ringing in ears
- o Sinus problems
- o Vision- Flashes
- o Vision- Halos

CONDITIONS Check (✓) symptoms you currently have or have had in the past year.

- o AIDS
- o Alcoholism
- o Anemia
- o Anorexia
- o Appendicitis
- o Arthritis
- o Asthma
- o Bleeding Disorders
- o Breast Lump
- o Bronchitis
- o Bulimia
- o Cancer
- o Cataracts
- o Chemical Dependency
- o Chicken Pox
- o Diabetes
- o Emphysema
- o Epilepsy
- o Glaucoma
- o Goiter
- o Gonorrhea
- o Gout
- o Heart Disease
- o Hepatitis
- o Hernia
- o Herpes
- o High Cholesterol
- o HIV positive
- o Kidney Disease
- o Liver Disease
- o Measles
- o Migraine Headaches
- o Miscarriage
- o Mononucleosis
- o Multiple Sclerosis
- o Mumps
- o Pacemaker
- o Pneumonia
- o Polio
- o Prostate Problem
- o Psychiatric Care
- o Rheumatic Fever
- o Scarlet Fever
- o Stroke
- o Suicide Attempt
- o Thyroid Problems
- o Tonsilitis
- o Tuberculosis
- o Typhoid Fever
- o Ulcers
- o Vaginal Infections
- o Vaginal Disease

ALLERGIES To medications or substances

_____

_____

_____

_____

DEKALB PHYSICIAN CLINIC

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of health	Age at death	Cause of death	Check (✓) If, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay fever	
Brothers					Cancer	
					Chemical dependency	
					Diabetes	
					Heart diseases, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes please give approximate dates_____

SURGICAL HISTORY	DATE	OUTCOME	HEALTH HABITS Check (✓) which substances you use and describe how much you use		
				Caffeine	
				Tobacco	
				Drugs	
				Alcohol usage	
				Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

Dekalb Physician Clinic

NAME: ______________________________ DOB: ______________________

Medications

Drug Name Ex: Metoprolol	Dose 50 mg	Take 1 tablet	Frequency Twice a day	How long have you taken this med? Weeks/Months/Years

PHYSICIANS CLINIC

216 N. Centre St.
DeKalb, Texas 75559
(903) 667-2273 Fax (903) 667-7597
Kyle Groom, D. O.

DeKalb Physicians Clinic PREFERS scheduled appointments. Our walk-ins are limited to "sick visits". All visits for medicine refills will be by appointment only.

If, for some reason, patient cannot keep scheduled appointment, please call to office to cancel or reschedule twenty-four (24) hours ahead of scheduled appointment. All no-call no-show appointments will be billed a $25.00 fee that will need to be paid prior to being seen the next time.

Thank you for your consideration.

I have read and understood this policy of the DeKalb Physicians Clinic

Print name _____

Signature _____

Date _____

DeKalb
PHYSICIANS CLINIC
216 N. Centre St.
DeKalb, Texas 75559
(903) 667-2273 Fax (903) 667-7597
Kyle Groom, D. O.

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Form must be completed for all persons under the age of 18 years

The Texas Family Code allows only certain people to consent to medical treatment for minors if parental consent cannot be obtained. These are:

1. A grandparent
2. An adult sister or brother
3. An adult aunt or uncle
4. An educational institution in which your child is enrolled, which has written authorization to consent to treatment
5. Any adult who has care and control of the child and who has written authorization from the parent to consent to treatment

I, _____, am

☐ The parent

☐ The guardian (specify relationship)

of the minor child,_____, and hereby authorize

Dekalb Physician Clinic and its authorized agents, to consent to whatever medical treatment they may deem necessary while said minor is under their care in accordance with Texas Family Code Section 32.001.

Date treatment is expected to begin:_____

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize and request the following medical records be sent to:

Dekalb Physicians Clinic

216 N Centre Street

Dekalb, TX 75559

PH: 903-667-2273 FAX: 903-667-7597

As required by the Health Ins Portability and Accountability Act (HIPPA) of 1996 our office may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by coming into the clinic and signing and dating the revocation section of this form.

Name of Patient: _____

Address of Patient: _____

_____

DOB: _____/_____/_____ SS#: _____

Print Your Name (if different from patient) _____

Signature X _____ DATE: _____

REQUESTING RECORDS FROM:

Doctor/Clinic Name: _____

Address: _____

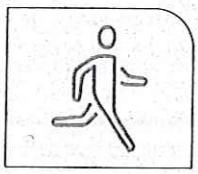
Phone: _____ Fax: _____

PLEASE DO NOT FAX RECORDS IF OVER 10 PAGES, MAIL THEM TO:

216 NORTH CENTRE ST DEKALB, TX 75559

_____ All my records _____ Lab Reports _____ Xray Reports _____ OP Reports _____ H & P

I understand that information disclosed pursuant to this auth may be re-disclosed to additional parties and no longer protected. I understand that I may revoke this auth at any time by signing the revocation section of this form or by submitting a written request. I further understand that any such revocation does not apply to the extent that persons authorized to use of disclosed health information have already acted in reliance on this auth. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this auth or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this auth.



LET'S TALK

During today's visit, use this handout as a guide to discuss health concerns or needs with your doctor or health care provider.

Patient name:_____

Today's date:_____

LET'S TALK // FALLS

- ☐ Have you fallen in the past year? Y // N
- ☐ Do you feel unsteady standing or walking? Y // N
- ☐ Do you worry about falling? Y // N
- ☐ Do you use a cane or walker? Y // N
- ☐ Have you seen a physical therapist in the past year? Y // N

LET'S TALK // BLADDER CONTROL

- ☐ Is bladder control a problem for you? Y // N
- ☐ In the past 60 days, has urine leakage changed your daily activities or interfered with your sleep? Y // N
- ☐ If urine leakage is a problem for you, would you be willing to try:
  - Medications Y // N
  - Exercise Y // N
  - Surgery Y // N

LET'S TALK // PHYSICAL HEALTH

- ☐ How often does physical health interfere with your daily activities? Almost never / Occasionally / Frequently
- ☐ Approximately how many days each week are you physically active? 0-1 days / 2-3 days / 4 or more
- ☐ Are you as active as other persons your age? Y // N
- ☐ How often do you choose to take the stairs over an elevator or escalator? Almost never / Occasionally / Frequently

LET'S TALK // EMOTIONAL HEALTH

- ☐ How would you describe your emotional health? Calm / Energetic / Downhearted
- ☐ In the last month, has your emotional health (feeling anxious or depressed) interfered with your daily activities? Y // N
- ☐ How many hours of sleep do you typically get each night? 5 or less hours / 6-7 hours / 8 or more
- ☐ In the last month, have you accomplished less than you would like or been more careless at work or while performing daily activities? Y // N

LET'S TALK // MEDICATIONS

- ☐ Remembering to take your medications can sometimes be challenging. In the last two weeks, have you forgotten to take your medications? Y // N
- ☐ Understanding how and when to take medication and knowing why it was prescribed is important. Do you have any questions on how and when to take your medication or why it was prescribed? Y // N
- ☐ Some medications are difficult to afford, even with help from copayments. Do you have any medications that are unaffordable? Y // N
- ☐ Every medication can have side effects. Do you have any unanswered worries or questions related to your medication's side effects? Y // N

#StartWithHealthy

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