529 W Wheatland Rd
Duncanville Tx 75116
Ph: 972.298.2427
Fax: 972.298.2429

Patient Registration:

Full Legal Name: Last:_____ First:_____ M.I.:_____

Marital Status: M S W D Sep Date of Birth: _____ Gender: _____

Home Address: _____City/State/Zip_____

Social Security # _____ Home#: _____ Cell#: _____

Email Address: _____ Preferred method of contact: _____

Occupation: _____ Employer: _____

Is it OK to leave messages on your Voicemail? _____ Text Reminders? _____

Guarantor: (If same as patient leave blank)

Full Legal Name: Last:_____ First:_____ M.I.:_____

Home Address: _____

Social Security #: _____ Home#: _____ Cell#: _____

Email: _____ Preferred method of contact: _____

Emergency Contact:

Contact #1
Name: _____ Relationship: _____

Cell#: _____ Home#: _____

Contact #2
Name: _____ Relationship: _____

Cell#: _____ Home#: _____

Do you have a living will? Yes No Do you have a Medical Power of Attorney? _____
Are you an Organ Donor? Yes No

NORTH TEXAS CARE CLINIC

Medical History

Name: _____ DOB: _____

Your answers to the following questions will help us to understand your medical history and the concerns you would like to discuss with your practitioner. Please fill out as much of this questionnaire as possible. If you can not answer some of the questions or feel uncomfortable answering, leave them blank.

Reason for your appointment: _____

Medication Allergies: _____

Environmental Allergies: Yes No

Are you taking an Aspirin: Yes No

Please circle to indicate if you have ever had the following conditions: None

Alzheimer's Disease	Gout	Seizures
Anemia	Heart Attack	Stroke
Anxiety	Hepatitis	Thyroid Disease
Arrhythmia/Palpitations	High Blood Pressure	Tuberculosis
Arthritis/Bursitis	High Cholesterol	Vertigo/Dizziness
Asthma	Incontinence	Cancer
Congestive Heart Failure	Intestinal Problems	
Constipation/Diarrhea	Kidney Disease	
Coronary Artery Disease	Liver Disease	
Depression	Menopause	
Diabetes Type I or II	Migraine Headaches	
Edema	MRSA Infections	
Emphysema/COPD	Osteoporosis	
Enlarged Prostate	Parkinson's Disease	
GERD/Acid Reflux	Peptic Ulcer/GI Bleed	

Have you had any Surgeries? Yes No

If yes, please specify with Date/Year

_____ _____

_____ _____

Have you had any other medical problems or serious injuries that are not listed above? Yes No

_____

_____

Who is your Primary Care Provider? _____

Are you currently seeing any other providers? Yes No

_____

_____

NORTH TEXAS CARE CLINIC

Medical History

Name: _____ DOB: _____

Please List all medications, including Vitamins, natural, and prescription medications that you are currently taking. Please note the dosage if possible.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Pharmacy Name, Number, Address:

_____

_____

Have you had any of the following test done? Please note approximate dates.

Pap Smear	_____	Tetanus shot	_____
Mammogram	_____	Influenza	_____
Colonoscopy	_____	Pneumonia	_____
Stress Test	_____	Bone Density	_____

Height: _____ Weight: _____

Do you smoke or use tobacco products? Yes No Quit? _____

Number of cigarettes daily? _____

How many years? _____

Do you drink alcohol? Yes No

How often? _____

Do you use recreational drugs? Yes No

If yes, are you currently using them? Yes No

Are you sexually active? Yes No With: Men Women Both

Do you feel like you are at risk of having a sexually transmitted disease? Yes No

Do you feel at risk for having AIDS/HIV? Yes No

Are you pregnant? Yes No Last menstrual cycle? _____

Have you ever been pregnant? Yes No

How many times? _____

Miscarriages? _____ Abortions? _____ C-Sections? _____

Do you use any form of Birth Control? Yes No

Which Brand? _____

NORTH TEXAS CARE CLINIC

Medical History

Name: _____ DOB: _____

Please check any of the Diseases that run in your family and please note who:

	Mother	Father	Sister	Brother	Child
Alcohol or Drug use					
Cancer/ Type					
Diabetes					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Mental Illness					
Osteoporosis					
Stroke					
Alzheimer's					
Thyroid problems					

Review of Systems: Are you experiencing any of the following?

Chest pain? Yes No

Headaches? Yes No

Nausea? Yes No

Dizziness? Yes No

Fatigue? Yes No

Abdominal Pain? Yes No

Numbness/Tingling to extremities? Yes No

Are there any other symptoms you would like to discuss in today's visit?

_____

_____

_____

NORTH TEXAS CARE CLINIC

New Patient Welcome Letter

Welcome to North Texas Care Clinic. We are honored you have chosen us as your health care provider. Our goal is to provide the highest quality care for all our patients in a timely and respectful manner.

The clinic is managed by a board-certified Nurse Practitioner who hold a Doctor of Nursing Practice Degree which is a terminal clinical practice doctorate that is the highest level of academic preparation. Please note that you may be seen by other health care providers as well. North Texas Care Clinic does collaborate with other specialists, Nurse Practitioners, and or Physicians should your case require such care.

We will do our best to provide you with same day office visits. You will need to bring your ID and Insurance card with you for each appointment. Please let our office staff know if any of your information changes. If you are unable to provide us with necessary information, your appointment will need to be rescheduled.

All copays and past due balances are expected at time of service, unless a prior agreement has been made with the clinic administrator.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises, and we may be running late for your visit. You will have the option to re-schedule or to stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all your prescription and over-the-counter medications with you at each visit.

Our office policy for a missed appointment is:

- If it is an appointment for a new patient, the appointment will not be rescheduled;
- Two (2) no-show appointments will result in dismissal from the practice.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. North Texas Care Clinic does not offer chronic pain management and will not dispense chronic pain medication (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our healthcare provider (nurse practitioner and/or physician).
2. If you are prescribed or taking a psychotropic or controlled substance medication/s you will be required to undergo urine toxicology drug screening and monitoring for your safety.

Patient Name (Printed): _____ Date: _____

Patient or Guardian Signature: _____

529 W Wheatland Rd
Duncanville Tx 75116
Ph: 972.298.2427
Fax: 972.298.2429

Medical Records Release Form

I _____, hereby authorize:

Name of Facility or Provider: (Who we are requesting from)

_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: _____ Fax: _____

To Release Medical Records to **North Texas Care Clinic** at the address or fax number listed above.

Patient Name: _____ DOB:_____

Please send the Following medical information checked below:

☐ All Medical Records ☐ Progress Notes ☐ Labs, X Rays, MRI'S etc…

☐ Other:_____

This consent is subject to revocation by: _____ or at any time. This Authorization will expire in six months from the date signed below.

_____ _____

Print Patient Name or Patient's Representative Relationship

_____ _____

Signature of Patient or Representative of Patient Today's Date

NORTH TEXAS CARE CLINIC

Consent to Medical Treatment
Consent for Billing and Services Rendered
Acknowledgment of Receipt of Privacy Practices Notice

Patient Name: _____ DOB: _____

Initial: _____ I hereby consent to and authorize the performance of medical or minor surgical procedures, including emergency life-saving measures, which may be considered necessary or advisable by the healthcare providers that include care provided by nurse practitioners and physician assistants of North Texas Care Clinic.

Initial: _____ I authorize payment of medical benefits to North Texas Care Clinic providers or supplier for medical services, to include government assigned benefits. I authorize the release of any medical or other information necessary to process this claim.

Initial: _____ Financial Arrangement: I hereby agree that I am financially responsible for charges incurred at the time of rendered services. I acknowledge that I have received the financial policy. Should my account be referred to an attorney or agency for collection, the undersigned shall pay reasonable attorney fees and collection expenses.

Initial: _____ I hereby acknowledge that I have received the HIPPA Notice of Privacy Practices for Personal Health Information and New Patient Welcome Letter.

_____ _____
Patient Name (Printed) Date

_____ _____
Patient Signature or Patient Representative Relationship

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE _____

ID # _____ POLICY/GROUP # _____ POLICY HOLDER NAME/DOB _____

SECONDARY MEDICAL INSURANCE _____

ID # _____ POLICY/GROUP # _____ POLICY HOLDER NAME/DOB _____

NORTH TEXAS CARE CLINIC

Patient Name: _____ DOB: _____ Date: _____

Your answers to the following questions will help us to understand your medical history and the concerns you would like to discuss with your practitioner. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering, leave them blank.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More often	Nearly daily
1. Little to no interest/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, that you're a failure, or let yourself down?	0	1	2	3
7. Trouble concentrating on things, such as reading or watching TV?	0	1	2	3
8. Moving or speaking slowly so much so that others notice? Or opposite?	0	1	2	3
9. Thoughts that you would be better off dead, or harming yourself?	0	1	2	3
1. Feeling Nervous, Anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

On a scale of 1-10

The symptoms have disrupted your Work/School activity	1	2	3	4	5	6	7	8	9	10
The symptoms have Social Life/Leisure Activity:	1	2	3	4	5	6	7	8	9	10
The symptoms have disrupted your Family Life/Home Responsibilities:	1	2	3	4	5	6	7	8	9	10

How many days in the last week have your symptoms caused you to miss school/work or leave you unable to carry out your normal daily responsibilities? _____

How many days in the last week have you felt so impaired by your symptoms that, even though you went to school or work, your productivity was reduced? _____

Office use only
GAD-7: _____
PHQ-9: _____
Total: _____

NORTH TEXAS CARE CLINIC

Vitamin B12 Questionnaire

Patient Name: _____ DOB: _____

Weight: _____ BP: _____

Height: _____ Pulse: _____

1. Do you suffer from fatigue or weakness?	Yes	No
2. Do you have a swollen or sore tongue?	Yes	No
3. Do you experience numbness/tingling in hands or feet?	Yes	No
4. Do you suffer from low mood or depression?	Yes	No
5. Do you have difficulty concentrating or poor memory?	Yes	No
6. Is your skin unusually pale?	Yes	No
7. Is the inside of your mouth pale?	Yes	No
8. Do you experience dizziness or lightheadedness?	Yes	No
9. Do you have brittle nails?	Yes	No
10. Do you have indigestion, gas, bloating, diarrhea, or constipation?	Yes	No
11. Have you experienced unexplained weight loss?	Yes	No
12. Do you experience difficulty sleeping or feel unrested?	Yes	No
13. Do you have cold hands or feet?	Yes	No
14. Do you suffer from shortness of breath with minimal exertion?	Yes	No
15. Do you experience difficulty walking?	Yes	No
16. Do you regularly drink alcohol?	Yes	No
17. Are you vegetarian or vegan?	Yes	No
18. Do you experience frequent headaches?	Yes	No
19. Do you have Celiac's, Crohn's, Inflammatory bowel disease or gastric bypass?	Yes	No

Initial: _____

Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____) _____ **ALT. PHONE** (_____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name North Texas Care Clinic
Address 529 W. Wheatland Road
City Duncanville State Tx Zip Code 75116
Phone (972) 298-2427 Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**