Peterson Medical Associates

PATIENT INFORMATION SHEET

Patient Name (last, first, MI):		Gender: M F	Date of Birth (MM/DD/YY):	Social Security Number:
Mailing Address:			Home Phone (Primary Y/N):	Work Phone:
City: State: Zip:			Cell Ph #/Pager (Primary Y/N):	Marital Status:
Ethnicity/Race:			Maiden Name:	Driver's License #:
Preferred Local Pharmacy: Preferred Mail-In Pharmacy:			How did you hear about us?	
Employment Status: (Circle One) Employed Full-Time Student Part-Time Student Retired			Occupation:	
Patient's Employer:			Employer's Address:	
Emergency Contact with Phone and Relationship to Contact:			Patient Email Address:	
Spouse's Name:			Spouse's SSN:	Spouses DOB:
Spouse's Employer & Telephone Number:			Other Household Members:	
Responsible Party (Fill out only if other than patient.)				
Name:			Relationship to Patient:	
Address:			Employer & Telephone Number:	
Home Phone:	Cell Phone:		Social Security Number:	Date of Birth:
Health Insurance Information				
Primary Insurance Health Care Plan:			Secondary Insurance Health Care Plan:	
ID#	Group #		ID#	Group #
Name of Policy Holder (last, first, MI):			Name of Policy Holder (last, first, MI):	
Policy Holder's Address:			Policy Holder's Address:	
Telephone Number:	Date of Birth:		Telephone Number:	Date of Birth:
Social Security Number:	Relationship to Patient:		Social Security Number:	Relationship to Patient:

AFTER CLINIC HOURS (4:45 PM TO 8:00 AM) AND WEEKENDS: You may reach the ON-CALL PMA Physician by calling our office at 830-258-7762 and following the instructions as given.

All services rendered are the financial responsibility of the patient or the patient's parent or guardian. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered. I also authorize release of medical information for the purpose of further evaluation or treatment.

Signature ______________________________________ Date ____________________

Peterson Medical Associates

PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Thank you for your cooperation.

First Time Visit: Please arrive at least 15 minutes prior to your appointment time. A nurse will go over your past medical history. Please bring all of your medications in their original containers. <u>If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk</u>. If you are a self-pay patient, payment will be due at the time of service.

Follow-Up Visits: Please arrive 5 – 10 minutes before your schedule appointment time. It is our goal for you to be ready to see your physician on time. Follow-ups are scheduled based on the particular needs of specific disease processes. <u>If you have multiple chronic illnesses, you may be scheduled for multiple follow-up visits.</u>

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule appointments *at least* 24 hours in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 2 appointments without following the cancellation protocol then you will be charged $25.00. If you miss 3 appointments without following the cancellation protocol, you may be dismissed from the practice. You will receive a written warning notification if you miss 2 appointments.

Sick Visits: Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only. Depending on the availability of your physician, you may be asked to see another provider.

Medication Refills: For non-emergency, and routine medication refills, please allow 48 hours and ask your pharmacy to send us a refill request. For any narcotic medications (ex. Norco, ADD meds) please allow 5 days notice. Also, please let a nurse or physician know if you need a 90 day prescription. Narcotic medications will only be written for a 30 day supply at a time. Additional refills to the original prescription will be at the doctor's discretion. Early refills will not be given. You may be requested to contact your pharmacy to ask them to fax a refill request to our office to assure that exact fill dates are documented accurately. You may also be asked for a follow-up appointment for certain refill requests.

AFTER CLINIC HOURS (4:45 PM TO 8:00 AM) AND WEEKENDS: You may reach the ON-CALL PMA Physician by calling our office at **830-258-7762** <u>and</u> following the instructions as given.

Please remember that your appointment is to focus on your medical needs. *If your family member, who is also our patient, has any medical needs (including medication refills), we will be happy to schedule an appointment for them at the conclusion of your office visit.*

<u>As a courtesy, please turn off or silence your cell phone during your office visit.</u>

I have read and understand the above office policies and agree to abide by them.

______________________________ ____________________

Signature Date

Peterson Medical Associates

575 Hill Country Drive, Suite 101
Kerrville, TX 78028
(830) 258-7762

PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name ______________________________ **Date of Birth** ____________________

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOUR DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM.

1. I authorize Peterson Medical Associates to disclose my protected health information to:

_________ Family member(s) (List): _________________________ Ph #: ____________________

_________________________ Ph #: ____________________

_________ Non-family member(s) (List): ____________________ Ph #: ____________________

_________ Myself only

2. I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

_________ Test results, reports, and general health updates

_________ Nothing beyond general health questions & updates

3. I may be contacted with medical information by:

e-mail:____

_________ Please send a detailed message to my email address.

_________ Please send a message that only includes a call-back number and name at the doctor's office.

Home: ________________________ **Cell:** __________________________________

_________ Please leave a detailed message on my answering machine/voice mail.

_________ Please leave information with any of the individuals listed above.

_________ Please leave a message with only call-back information with either an individual or on my answering machine / voice mail. Call back information will include doctor's name and staff member's name.

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Manager.

______________________________________ ____________________________

Patient Signature Date

PETERSON MEDICAL ASSOCIATES

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that as a part of the provision of healthcare services, Peterson Medical Associates creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnosis's, treatment, and any plans for future care or treatment.

The Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information is posted on the first floor at 575 Hill Country Drive in the foyer. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon your request, we will provide you with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as the original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

______________________________	______________________________
PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN'S NAME PRINTED	DATE
______________________________	______________________________
PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN SIGNATURE	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
______________________________	______________________________
WITNESS	DATE

Name_________________________ Today's date:_______________

Date of Birth_________________________

What is the reason for your visit?

____

Past Medical History – Have you ever had? (Circle **Yes or No**)

Condition			Condition		
High Blood Pressure	Yes	No	Liver Disease	Yes	No
Heart Attack	Yes	No	Kidney Disease	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Arthritis	Yes	No
Asthma	Yes	No	Stomach Ulcers	Yes	No
High Cholesterol	Yes	No	Thyroid(Hyper/Hypo)	Yes	No
COPD	Yes	No			

Other Medical Problems:

____

____

Past Surgical History – Have you ever had Surgery for? (Circle **Yes or No**)

Surgery			Surgery		
Heart	Yes	No	Back or Spine	Yes	No
Gall Bladder	Yes	No	Tonsils	Yes	No
Appendix	Yes	No	Hysterectomy	Yes	No

Other Surgeries:

____

Past Social History (Circle **Yes or No**)

Tobacco Use	Yes	No	Alcohol Use	Yes	No

Per day_______________ never/moderate/freq__________

_______________________ _______________________

Other Physicians Preferred Pharmacy

575 Hill Country Drive, Suite 101 • Kerrville, Texas 78028 • (830) 258-7762 • Fax (830) 258-7198

PETERSON
MEDICAL ASSOCIATES

Name________________________ Today's Date______________

Date of Birth____________________

Any Allergies to Medicine:____

____

Patient Medication List

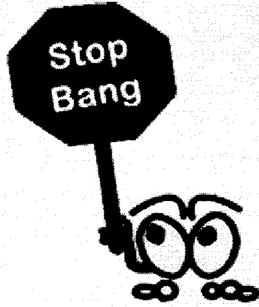
Current Medications	Dose (ie mg or mcg)	How taken? (mouth or injection)	How many times taken daily?

Name: ______________________________ Date of Birth: _____________ Date: ___________

Screening
STOPBang Questionnaire

Is it possible that you have ...
Obstructive Sleep Apnea (OSA)?

Please answer the following questions below to determine if you might be at risk.



Yes

No

Snoring ?
Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?
Yes

No

Tired ?
Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?
Yes

No

Observed ?
Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep ?
Yes

No

Pressure ?
Do you have or are being treated for **High Blood Pressure** ?
Yes

No

Name: ____________________ Date of Birth: __________ Date: __________

Body Mass Index more than 35 kg/m^2?

Body Mass Index Calculator

( ) cm / kg ( ) inches / lb

Height:

Weight:

BMI:

Yes

( )

No

( )

Age older than 50 ?

Yes

( )

No

( )

Neck size large ? (Measured around Adams apple)

For male, is your shirt collar 17 inches / 43cm or larger?
For female, is your shirt collar 16 inches / 41cm or larger?

Yes

( )

No

( )

Gender = Male ?

See Result

For general population

OSA - Low Risk : Yes to 0 - 2 questions
OSA - Intermediate Risk : Yes to 3 - 4 questions
OSA - High Risk : Yes to 5 - 8 questions
or Yes to 2 or more of 4 STOP questions + male gender
or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m^2
or Yes to 2 or more of 4 STOP questions + neck circumference 17 inches / 43cm in male or 16 inches / 41cm in female

Epworth Sleepiness Scale

Name: ______________________________ Today's date: ____________

Your age (Yrs): __________ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	___
Watching TV	___
Sitting, inactive in a public place (e.g. a theatre or a meeting)	___
As a passenger in a car for an hour without a break	___
Lying down to rest in the afternoon when circumstances permit	___
Sitting and talking to someone	___
Sitting quietly after a lunch without alcohol	___
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION

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