PETERSON
MEDICAL ASSOCIATES

575 Hill Country Drive / Kerrville, Texas 78028
Phone: (830) 258-7762 Fax: (830) 258-7198

Dear New Patient,

We have enclosed your new patient paperwork with this letter. Please complete the forms in their entirety. The paperwork may be returned in person, by mail or fax to # (830) 258-7198. You will be contacted once the paperwork is returned to schedule your appointment.

On the day of your appointment, please bring with you:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- If you use a mail-in prescription service, bring your drug formulary list that shows which medicines they pay for.
- Any over-the-counter supplements.

Thank you for choosing Peterson Medical Associates as your healthcare provider. We look forward to meeting you. If you have any questions, please let us know at 830-258-7762.

Sincerely,

Peterson Medical Associates Staff

Peterson Medical Associates

575 Hill Country Drive / Kerrville, Texas 78028 / Phone: (830) 258-7762 / Fax: (830) 258-7198

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:		**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 (5:00 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

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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 10 – 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. If you have co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. If you are a self-pay patient, payment will be collected after you see the doctor. Payment is 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. If you have multiple chronic illnesses, you may be scheduled for multiple follow-up visits.

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. 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 (5:00 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.

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.

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

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

PLEASE CIRCLE THE MEDICAL PROBLEMS/COMPLAINTS YOU ARE HAVING TODAY

NAME_____ DATE OF BIRTH_____ AGE _____ DATE _____

CONSTITUTIONAL
fatigue
fever
chills
malaise
body aches

EYES
discharge from eye
eye discomfort
eye pain
changes in vision
foreign body sensation

HENT
headaches
vertigo
lightheadedness
recent head injury
sinus pain
nasal congestion
nose bleeding
nasal discharge
postnasal drip
sore throat
ear pain
ear fullness
oral lesions
painful swallowing

CARDIOVASCULAR
chest pain
irregular heart beats
rapid heart rate
shortness of breath on exertion
swelling of legs
dizziness

RESPIRATORY
shortness of breath
wheezing
cough:
dry or productive
hoarseness

GASTROINTESTINAL
nausea
vomiting
diarrhea
constipation
loss of appetite
heartburn
reflux
hematemesis
excessive belching
abdominal pain
jaundice
blood in stools
hematochezia
melena
hemorrhoids
fatty stools
tenesmus
excessive flatulence
bloating
early satiety
retching
fecal incontinence
changes in caliber stool
difficulty swallowing

GENITOURINARY
urgency
frequency
dysuria
nocturia
hematuria
change in urine color
incontinence
difficulty voiding
urinary hesitancy
decreased stream
post-voiding dribbling
decreased libido
genital sores
irregular menses
dysmenorrhea
menorrhagia
metrorrhagia
vaginal discharge
possible pregnancy
amenorrhea
hot flashes
impotence
scrotal pain / scrotal mass / penile lesions/ penile discharge
painful intercourse
hernia

INTEGUMENT
rash
itching
pigmentation
skin dryness
nail changes
new skin lesions
changes of existing lesions
hair changes

NEUROLOGIC
altered mental status
muscular weakness
incoordination
tingling or numbness
memory difficulties
speech difficulties
seizures
tremors
loss of balance

MUSCULOSKELETAL
joint pain
joint swelling
muscle pain
limitation of motion
muscular weakness
muscle cramps
neck pain
back pain
shoulder pain
elbow pain
wrist pain
hip pain
knee pain
ankle pain
foot pain
muscle spasms

ENDOCRINE
loss of hair
cold intolerance
heat intolerance
central obesity
excessive urination
excessive thirst

PSYCHIATRIC
anxiety
depression
hallucinations
feeling confused
difficulty sleeping
compulsive behavior
suicidal ideation
homicidal ideation
excessive anger
withdrawn

HEME-LYMPH
easy bleeding
easy bruising
lymph node enlargement

ALLERGY-IMMUNOLOGY
sinus allergy symptoms
allergic dermatitis

List Additional Symptoms: _____

_____

Name _____ DOB _____ Date _____

PAST MEDICAL HISTORY
(Circle all that apply)
*Cancer (yes / no) Type: _____
*No pertinent Past Medical History
Asthma
BPH (enlarged Prostate)
CHF
Colon Polyps
Constipation
COPD
Diabetes Mellitus, Type II
Erectile Dysfunction
GERD
Heart Disease
High Blood Pressure
High Cholesterol
Hyperthyroidism, Acquired
Hypothyroidism
IBS
Kidney Disease
Menopausal Syndrome
Osteoarthritis
Peripheral Neuropathy
Peripheral Vascular Disease
Rheumatoid Arthritis
Seizure Disorder
Stroke
Ulcerative Colitis
Urinary Incontinence
Vertigo
Other:_____

PREVENTATIVE SERVICES
(date last performed)
Bone Density (DEXA) _____
Lipid/Cholesterol _____
Mammogram _____
Pap Smear _____
PSA/Prostate _____
Sigmoidoscopy _____
Colonoscopy _____

PAST SURGICAL HISTORY
(list ALL surgeries with reason and date)

_____
_____
_____
_____
_____

GYNECOLOGIC HISTORY

Pregnancies ___; # Deliveries ___; # Miscarriages ___

IMMUNIZATIONS

Flu (Y / N) Date: _____
Pneumonia (Y / N) Date: _____
Shingles (Zostavax) (Y / N) Date: _____
Tetanus (Y / N) Date: _____

FAMILY MEDICAL HISTORY
Indicate which family member: father, mother, sister, brother, maternal grandparent, paternal grandparent, aunt/uncle
*Cancer _____ Where? _____
Alcoholism _____
Asthma _____
Bleeding/Clotting _____
COPD _____
Depression _____
Diabetes Mellitus _____
Heart Disease _____
High Blood Pressure _____
High Cholesterol _____
Kidney Disease _____
Liver Disease _____
Obesity _____
Stroke _____
Suicide _____

Deceased Immediate Family Members
Mother:
Cause _____ Age _____
Father:
Cause _____ Age _____
Brother:
Cause _____ Age _____
Sister:
Cause _____ Age _____

Please list any other significant family medical issues not previously addressed: _____

_____

_____

_____

SOCIAL HISTORY

Education Level _____
Exercise level (circle) *None / Low / Moderate / High*
Infection Risk (circle) HIV MRSA Hep B
Marital Status(circle) Single/ Married / Divorced / Widowed
Occupation _____
Substance Use:
Alcohol: yes / no Drinks/week _____
Tobacco: never / yes Packs/day _____
Other substance use: _____
_____

OTHER PHYSICIANS

_____

_____

_____

Peterson Medical Associates

Date: ___________ Patient Name: ____________________________ DOB ___________

Patient PRESCRIPTION MEDICATION List

Please list any ALLERGIES to Medications:

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

Peterson Medical Associates

Date: ___________ Patient Name: ___________________________ DOB ____________

Patient "OVER THE COUNTER / SUPPLEMENT" List			
Name Supplement / Vitamin		**Dose (ex: mg or mcg)**	**How many times taken daily?**

Peterson Medical Associates
575 Hill Country Drive Ste 101 · Kerrville, TX 78028
Phone: (830) 258-7762 · **Fax:** (830) 258-7098

Authorization for Release of Medical Information

Name: _____
Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____

I hereby authorize (please list physician name and/or facility):

Dr. Name/Facility Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone#: _____ Fax #: _____

to disclose information from my medical records to Peterson Medical Associates for the purpose of primary care. The specific information I wish to have released:

PLEASE SEND *ONLY* THE MOST RECENT OF THE FOLLOWING

Colonoscopies	Dexa Scans / Bone Density
Labs	Mammograms
PE / Wellness	Pap
Progress Note	Stress Tests
Xrays / Scans	Immunization Record
Living Wills, POA	Other: _____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

_____ _____
Signature Date

Expires: _____
Witness: _____

This medical record may contain information about drug abuse, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.
□ DO consent / □ DO NOT consent to have this information disclosed.

_____ _____
Signature Date

This medical record may contain information concerning HIV testing and /or AIDS diagnosis treatment. Separate consent must be given before this information can be released.
□ DO consent / □ DO NOT consent to have this information disclosed.

_____ _____
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

Peterson Medical Associates

575 Hill Country Drive / Kerrville, Texas 78028 / Phone: (830) 258-7762 / Fax: (830) 258-7198

PEDIATRIC INTAKE FORM

Patient's name: _____ Today's date: _____

Age: _____ Date of Birth: _____ Gender: Female / Male

Reason for today's visit: _____

Prenatal History
Mother's age at child's birth: _____ Mother's health during pregnancy (circle any that apply): bleeding, hypertension, diabetes, cigarettes, alcohol, drug use, thyroid problems, medications, illnesses, physical trauma

Birth History
Term: (circle) Full Premature Late Length of labor: _____ Birth Weight: _____
Did your child have any of the following problems shortly after birth? (circle any than apply): rashes, jaundice, colic, birth injuries, seizures, fever, cerebral palsy, blue baby, birth defect, other (specify)_____
Breast fed? Yes / No If yes, how long? _____ Formula type: milk soy other
Any food allergies noted so far? (specify)_____
Age began: sitting _____ crawling _____ walking _____ talking _____

Diet/Exercise
What is your child's main source of fluid intake? _____ Favorite food: _____
Does your child drink sodas of any kind? Yes / No If yes, how many per day? _____
Does your child eat fast food more than twice per week? Yes / No If yes, how many times per week? _____
Does your child participate in any regular sports activity? Yes / No Which sport(s)? _____

School Environment
What type of school does your child attend? Public Private Homeschool Other Grade: _____
Is your child currently experiencing any academic difficulties? Yes / No If yes, please describe briefly:_____

Medical History
Medication allergies: (list) _____ Environmental allergies: _____
Has your child had or have: (circle) chicken pox, pneumonia, rheumatic fever, frequent colds, tonsillitis (# of times____), ear infections (# of times____), strep throat (# of times____), asthma, diabetes, head concussion
List any medications your child is currently taking: _____
_____
Has your child had any of the following:(circle) hearing test, speech or language test, psychological evaluation, electroencephalogram(EEG), injuries requiring surgery or hospitalization? Please list: _____

_____

Does your child wear glasses, contact lenses, braces, retainers, or any prosthesis? _____

Does your child use a seat belt or sit in a child safety seat EVERY time they ride in a car? Yes / No

Does your child wear a helmet when he/she rides a bike? Yes / No

Did you bring your child's immunization record with you today? Yes/ No

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PEDIATRIC REGISTRATION FORM

Patient Name: _____ Date of Birth: _____ Date: _____

IF EITHER PARENT HAS A DIFFERENT LAST NAME THAN ABOVE, PLEASE INDICATE:

Patient's address: _____

Home telephone: _____ Parent Cell: _____Parent(s) work phone: _____

Parent's email address: _____ Patient's Age: _____

Preferred pharmacy: _____ City: _____

Mother/Guardian: _____ Date of Birth: _____ SS#: _____

Father/Guardian: _____ Date of Birth: _____ SS#: _____

Father's Employer: _____ Work phone: _____

Mother's Employer: _____ Work phone: _____

Primary Insurance Co: _____ Address:_____

Policy #: _____ID#: _____Group #: _____ Effective Date:_____

Policy Holder: _____ Office visit co-pay amount: _____

Emergency contact: _____ Relationship to patient: _____

Phone #: _____ Responsible Party's Driver's License #:_____

How did you hear about our practice?

_____

I understand that I am responsible for all professional services performed by the physician or his staff. I am responsible for all services not covered or denied by my insurance company. Copayments are due at time of visit.

X_____ **Date**_____