Northeast Tarrant Internal Med Assoc
469 Westpark Way
Euless, Texas 76040

phone (817) 283-2888
fax (817) 283-1181

PATIENT INFORMATION

NAME (Last, First, Middle)	SS#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	EMAIL ADDRESS	
CITY, STATE ZIP	HOME PHONE	DAYTIME NUMBER
PRIMARY CARE PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (If Different Than Above)

NAME (LAST, FIRST MIDDLE	SS#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMOUNT	
CITY, STATE ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSRUANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMOUNT	
CITY, STATE ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I authorize the release of any medical information required to process claims. I also authorize payment of medical benefits to Northeast Tarrant Internal Medicine Associates if they choose to accept assisgnment. If is customary to pay for services when renedered unless other arrangements have been made. I understand that I am financially responsible for all charges. I also authorize my physician based on his/her discresion to asscess my chart for utilization management review. The above information is correct as the date below.

SIGNATURE OF PATIENT/GUARDIAN DATE

Physical Exam Information

Dear Patient:

Our goal is to provide you with the best medical care possible. Annual physical exams give us a chance to address your overall physical and emotional health. The ***preventative*** care we provide during a physical also includes an *assessment of dietary and exercise habits, review of vaccinations, discussion of screening tests, lifestyle behaviors, etc.* We often look in on chronic stable problems such as high blood pressure, arthritis, and/or other ongoing medical conditions, though we don't always charge for that, depending on the degree of difficulty or amount of time spent.

Regular office visits differ from the ***preventative*** and wellness care provided at a physical because they address *other new ongoing or poorly controlled medical problems.* These types of problems need to be addressed in an appointment separate from a ***preventative*** or physical exam. If, however, we adequately cover required preventative and wellness care during the physical, sometimes we will have time to address other issues. You OR your doctor may identify an issue that may need to be addressed during a physical, ***separate from preventative care.***

We would like to attempt to correct a misperception that is occurring at times regarding "double charges". Our goal is to address as much as we can in a quality manner during visits. Please note that the insurance companies do allow providers to address additional complaints beyond a physical examination, if there is time. If additional problems are found or addressed, an additional office evaluation code will be generated in addition to a preventative physical examination code. We are required to submit billing in this fashion, if we address care beyond preventative care at the physical examination. *This essentially generates an extra charge to the insurance company for issues addressed beyond preventative care, which in turn may require you to pay additional copay, coinsurance or deductible charges.*

The coding rules set by the health care industry, specifically state, *"If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this preventative medicine evaluation service, then the appropriate visit code should also be reported."* We can actually fail an audit if we violate these rules.

You have entrusted us with your medical care. Please also trust that we practice the highest integrity with our billing practices. Our goal is to provide excellent care and take appropriate time doing it. Please speak with your provider if you have any questions regarding the charges from your preventative care/physical today.

Sincerely,

Northeast Tarrant Internal Medicine Associates

Northeast Tarrant Internal Medicine Associates
469 Westpark Way
Euless, Texas 76040-3957
(817) 283-2888
Patient Confidentiality Questionnaire

Patient Name: ____________________________ Date of Birth: _______

1. Please list the family member (with phone numbers) or other persons, if any, whom we may inform about your general medical condition or your diagnosis:

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent, **if other than your home:**

4. Can confidential messages be left on your home answering machine or voicemail?

5. If you do not have voicemail, can a confidential message be left at your place of employment?

____ ____________
Patient Signature Date

HEALTH HISTORY QUESTIONNAIRE

Today's Date: ____________

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Occupation:** ____________	
Previous doctor (for New Patients)	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ TDAP	☐ Pneumonia- Prevnar 13
	☐ Hepatitis		☐ Pneumonia- Pneumovax 23
	☐ Influenza		☐ Shingles- Zostavax

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason/Surgery	Doctor

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of medication	Strength	Directions

Allergies to medications

Name of Medication	Reaction You Had

Social History

Tobacco use: Yes_____ No/Never_______ If yes: Years used_____ Age quit_____ Smoke exposure: yes_____ No_____ If yes, where?____________________	Any Illicit drug use: Yes_____ No_______ Alcohol use: Yes_____ No_____ If yes, how much?__________ Do you have children? Boys________Girls________ ☐ No children

Family History

☐ Adopted – no family history

Relationship to patient:	Illness (Cancer, Diabetes, Stroke, Heart Attack, High Blood Pressure, High Cholesterol etc.)	Date of onset	Age at Death
Father			
Mother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling			
Sibling			
Other			

Diagnostic History

Type of diagnostic test:	Date and ordering Doctor
Colonoscopy	
Bone Density	
Stress test	
Mammogram	
Pap Smear	
Other:	

Review of Systems

-Check the box for symptoms you have or problems recurring in the last 6 months.

CONSTITUTIONAL:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss

HEENT:
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Visual changes

RESPIRATORY:
- ☐ Chronic cough
- ☐ Cough
- ☐ Known TB exposure
- ☐ Shortness of breath
- ☐ Wheezing

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Claudication
- ☐ Edema
- ☐ Palpitations

Other:

GASTROINTESTINAL:
- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Change in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY:
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Increased urination
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention

REPRODUCTIVE MALE:
- ☐ Erectile dysfunction
- ☐ Penile discharge
- ☐ Sexual dysfunction

REPRODUCTIVE FEMALE:
- ☐ Abnormal pap
- ☐ Painful periods
- ☐ Pain with intercourse
- ☐ Hot flashes
- ☐ Irregular menses
- ☐ Vaginal discharge

NEUROLOGICAL:
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremors

INTEGUMENTARY:
- ☐ Breast discharge
- ☐ Breast lump
- ☐ Brittle hair
- ☐ Brittle nails
- ☐ Hair changes
- ☐ Abnormal facial hair
- ☐ Hives
- ☐ Itching
- ☐ Mole changes
- ☐ Rash
- ☐ Skin lesion

METOBOLIC/ENDOCRINE:
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Increased thirst
- ☐ Increased hunger

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

MUSKULOSKELETAL:
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain

HEMATOLOGIC/LYMPHATIC
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen lymph nodes

IMMUNOLOGIC:
- ☐ Contact allergy
- ☐ Environmental Allergies
- ☐ Food allergies
- ☐ Seasonal allergies

Name ______________________ DOB: ☐ No Symptoms

Northeast Tarrant Internal Medicine Associates, LLP

Patient Health Questionnaire for Pain Relief (Opioid DSM-V)

Name____________________________ **Date:**____

Are you on any of the following medications for pain relief: **If yes, please continue** the questions 1-9? **Yes** **No**

- Tylenol#3
- Tramadol
- Hydrocodone
- Morphine
- Fentanyl

1. Have you been taking the opioids in larger amounts or over a longer period than was intended? **Yes** **No**

2. Do you have a persistent desire or had unsuccessful efforts to cut down or control opioid use? **Yes** **No**

3. Have you spent a great deal of time in activities necessary to obtain or use opioids to recover from it effects? **Yes** **No**

4. Do you have a strong desire, craving, or urges to use opioids? **Yes** **No**

5. Is the opioid use effecting your obligations at work, school or home? **Yes** **No**

6. Have you continued to use opioids despite it having persistent or recurrent social or interpersonal problems caused by the use of these medications? **Yes** **No**

7. Are social, work, or recreational activities reduced because of the use of these medications? **Yes** **No**

8. Have you used opioids, recurrently in situations in which it is physically hazardous? **Yes** **No**

9. Do you continue to use opioids despite having persistent or recurrent physical or psychological problems that are likely caused or exacerbated by the medication? **Yes** **No**